Clinical Policy: Outpatient Behavioral Health Services Provided by Direct-Enrolled Providers

Reference Number: WNC.CP.117 Coding Implications
Last Review Date: Revision Log

See Important Reminder **at the end of this policy for important regulatory and legal information.**

Note: When state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Description[1]

Outpatient behavioral health services are psychiatric and comprehensive clinical assessment, medication management, individual, group, and family therapies, psychotherapy for crisis, and psychological testing for eligible members.

Outpatient services for substance use disorders (SUD) are for members assessed as meeting, at minimum, the 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 a member's treatment needs, and to 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 member's needs and preferences are based on collaboration between the practitioner and member to determine treatment goals, frequency and duration of services and measurable and desirable outcomes.

I. Definitions:

A. Psychological Testing

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

B. Psychotherapy for Crisis

1. On rare occasions, licensed outpatient service providers are presented with a member 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.

2. 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 member 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. Telehealth Services:

1. Select services within this clinical coverage policy can be provided via telehealth.
2. Services delivered via telehealth must follow the requirements and guidance in clinical coverage Policy *WNC.CP.193, Telehealth, Virtual Communications, and Remote Patient Monitoring.*

D. Telephonic Services:

1. Select services within this clinical coverage policy can be provided via the telephonic, audio-only communication method. Telephonic services must be transmitted between a member 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:
    1. Physical or behavioral health status prevents the member from participating in in-person or telehealth services; **or**
    2. Access issues (e.g., transportation, telehealth technology) prevent the member from participating in in-person or telehealth services. Refer to Sections Criteria I.F. for Telephonic-Specific Criteria; Background III.A. or Background VII. for Prior Approval requirements in this policy; and State of North Carolina Medicaid Clinical Coverage Policy No: 8C Outpatient Behavioral Health Services Provided by Direct-Enrolled Providers. Program Specific Clinical Coverage Policies | NC Medicaid (ncdhhs.gov).Subsection 7.1 for Compliance requirements.

Policy/Criteria[1]

I. WellCare of North Carolina® shall cover Outpatient Behavioral Health Services when the member meets the following criteria:

A. Entrance Criteria - All of the following criteria are necessary for admission of a member to outpatient treatment services:

1. A Current Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition [(DSM-5) or any subsequent editions of this reference material] diagnosis;
2. The member presents behavioral, psychological, or biological dysfunction and

functional impairment, which are consistent and associated with the current diagnosis;
3. If a higher level of care is indicated but unavailable or the member is refusing the service, outpatient services can be provided until the appropriate level of care is available or to support the member to participate in that higher level of care;
4. The member is capable of developing skills to manage symptoms, make behavioral changes, and respond favorably to therapeutic interventions; **and**
5. 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).

B. Continued Service Criteria - The criteria for continued service must meet **BOTH** 1 & 2 below: "
1. Any **ONE** of the following criteria:
   a. The desired outcome or level of functioning has not been restored, improved, or sustained over the timeframe outlined in the member's treatment plan;
   b. The member continues to be at risk for relapse based on current clinical assessment, and history: **or**
   c. Tenuous nature of the functional gains;
2. Any **ONE** of the following criteria (in addition to "1.")
   a. The member has achieved current treatment plan goals, and additional goals are indicated as evidenced by documented symptoms; **or**
   b. The member 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.

C. Discharge Criteria - Any **ONE** of the following criteria must be met:
1. The member's level of functioning has improved with respect to the goals outlined in the treatment plan;
2. The member or legally responsible person no longer wishes to receive these services; **or**
3. The member, 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).

D. Psychological Testing Criteria
1. **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 member presents with behavioral, psychological, or biological dysfunction

and functional impairment, which are consistent and associated with the DSM-5 or any subsequent editions of this reference material diagnosis;
c. The member 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).

E. Psychotherapy for Crisis Medical Necessity Criteria

1. **ALL** of the following criteria are necessary entrance criteria for psychological testing services:
   a. Only covered when the member is experiencing an immediate, potentially life-threatening, complex crisis situation.
   b. The service must be provided in an outpatient therapy setting.
   c. The member must be experiencing at least **ONE** of the following, supported by session documentation:
      i. Ideation, intent, and plan for harm to oneself or others; **or**
      ii. Active psychosis possibly requiring immediate stabilization to ensure safety of self or others.

F. Screening, Brief Intervention, and Referral to Treatment (SBIRT)

1. SBIRT is an ASAM level 0.5 early intervention approach for a member with nondependent 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 Members 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.
2. Universal screening helps identify the appropriate level of services needed based on the risk level and determine if the member would benefit from brief intervention or referral to treatment services.
3. SBIRT services can be provided in a variety of settings by professionals included in Section 6.0, at State of North Carolina Medicaid Clinical Coverage Policy No: 8C Outpatient Behavioral Health Services Provided by Direct-Enrolled Providers. Program Specific Clinical Coverage Policies | NC Medicaid (ncdhhs.gov), to systematically screen and assist Members who may not seek assistance for substance use problems. SBIRT services can:
   a. Reduce health care costs;
   b. Decrease the severity of drug and alcohol use;
   c. Reduce the risk of physical trauma; and
   d. Reduce the percentage of Members who go without specialized treatment.

G. Telephonic-Specific Criteria

1. WellCare of North Carolina® shall cover telephonic services when the following criteria are met:

a. Providers shall ensure that services can be safely and effectively delivered using telephonic, audio-only communication;
b. Providers shall consider a member's behavioral, physical, and cognitive abilities to participate in services provided using telephonic, audio-only communication;
c. The member's safety shall 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 is also considered;
e. 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;
f. Providers shall obtain and document verbal or written consent. In extenuating circumstances when consent is unable to be obtained, this must be documented;
g. Providers shall verify the member's identity using two points of identification before initiating a telephonic, audio-only encounter; and
h. Providers shall ensure that member privacy and confidentiality is protected.

H. Best Practice or Evidence-Based Practice

1. 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 beneficiary 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 Background III. for additional requirements and limitations

II. WellCare of North Carolina® shall **NOT** cover Outpatient Behavioral Health Services Provided by Direct-Enrolled Providers for the following:

A. Outpatient Behavioral Health - WellCare of North Carolina® shall not cover Outpatient Behavioral Health Services for the following:

1. Sleep therapy for psychiatric disorders;
2. When services are not provided in-person or in accordance with information in CPT code box below.
3. When a member presents with a medical, cognitive, intellectual or development issue that would not benefit from outpatient treatment services;
4. When the focus of treatment does not address the symptoms of the diagnosis;
5. When the requirements and limitations in Background II, are not followed; **AND**
6. When Psychotherapy for Crisis codes are billed, the same provider shall not bill Special Services: After Hours codes. Refer to clinical coverage policy 1A-38, Special Services: After Hours, located at Program Specific Clinical Coverage Policies| NC Medicaid (ncdhhs.gov), for the same event.

B. Psychological Testing - WellCare of North Carolina® shall not cover Psychological Testing for the following:

1. For the purpose of educational testing;
2. If requested by the school or legal system, unless medical necessity exists for the psychological testing;
3. If the proposed psychological testing measures have no standardized norms or documented validity;
4. If the service is not provided in-person or according to in CPT code box below. ;
5. If the focus of assessment is not the symptoms of the current diagnosis; **and**
6. When the requirements and limitations in Background II are not followed.

C. Psychotherapy for Crisis - WellCare of North Carolina® shall not cover Psychotherapy for Crisis under the following circumstances:

1. If the focus of treatment does not address the symptoms of the current DSM-5 diagnosis or related symptoms;
2. When services are not provided in-person or in accordance with the information in CPT code box below;
3. For routine psychotherapy not meeting medical necessity criteria outlined in Criteria I, above;
4. In emergency departments, inpatient settings, or facility-based crisis settings. Refer to State of North Carolina Medicaid Clinical Coverage Policy No: 8C Outpatient Behavioral Health Services Provided by Direct-Enrolled Providers. Program Specific Clinical Coverage Policies | NC Medicaid (ncdhhs.gov). Attachment A for Place of Service.
5. If the member presents with a medical, cognitive, intellectual or development issue that would not benefit from outpatient treatment services; **and**
6. When the requirements and limitations in Background II, are not followed.

Background[1]

I. Psychological Testing

A. The appropriate allowed Psychological Testing CPT code(s) shall be utilized.

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

II. Additional Limitations or Requirements:

A. WellCare of NC® shall not allow the same services provided by the same or different attending provider on the same day for the same member.

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 Subsection 6.1 of State of North Carolina Medicaid Clinical Coverage Policy No: 8C Outpatient Behavioral Health Services Provided by Direct-Enrolled Providers. Program Specific Clinical Coverage Policies | NC Medicaid (ncdhhs.gov), 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 date 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 a member's service record on the date that the verbal service order is given. The documentation must specify the date of the verbal service order, who gave the order, who received the 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 member per day of service from the same attending provider.

F. Only two psychiatric CPT codes from this policy are allowed per member 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 member.

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 of State of North Carolina Medicaid Clinical Coverage Policy No: 8C Outpatient Behavioral Health Services Provided by Direct-Enrolled Providers. Program Specific Clinical Coverage Policies | NC Medicaid (ncdhhs.gov).

J. Outpatient Medication Management and Outpatient Psychiatric Services cannot be billed while a member is receiving Assertive Community Treatment.

K. Individual, Group, or Family Outpatient services cannot be billed while a member is receiving:

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).

L. Referral - All Outpatient Behavioral Health services provided to a member may be self-referred or referred by some other source. If the member is not self-referred, the referral must be documented in the health record.

III. Coordination of Care - The provider shall communicate and coordinate care with other professionals providing care to the Member, including but not limited to the member's care manager through WellCare of NC, or delegated care manager through the Advanced Medical Homes or Local Health Department.

IV. Comprehensive Clinical Assessment (CCA) and Individualized Plan:

A. 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. For additional details related to the CCA, individualized plan (PCP) and service notes/documentation requirements for outpatient behavioral health services, you may refer to State of North Carolina Medicaid Clinical Coverage Policy No: 8C Outpatient Behavioral Health Services Provided by Direct-Enrolled Providers. Program Specific Clinical Coverage Policies | NC Medicaid (ncdhhs.gov).

B. The CCA must be signed and dated by the licensed professional completing the assessment.

C. A **Comprehensive Clinical Assessment (CCA)** is **NOT** required in the following situations:

1. 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.
2. 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.
3. For medical providers billing E/M codes for medication management.

D. Individualized Plan

1. An individualized plan of care, service plan, treatment plan, or PCP, is required within 15 business days of the first face-to-face member contact.
2. This plan is based on the assessment and is developed in partnership with the member or legally responsible person, or both.
3. When services are provided prior to the establishment and implementation of the

plan, strategies to address the member's presenting problem shall be documented.

4. The plan must be an identifiable document in the service record.
5. The plan must contain at a minimum:
   a. Member 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 member 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 member or legally responsible person, or a written statement by the provider stating why such consent could not be obtained.
6. The treatment plan must be updated as required, but a new plan is required at least annually.
7. All treatment plans are to be developed in partnership with the member or legally responsible person, and all updated or new plans require the member 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.
8. **Note**: Members receiving medication management only would be exempt from the requirement of having to sign the treatment plan. For members receiving medication management only and who have a legally responsible person, the legally responsible person would also be exempt from this requirement. The treatment plan for members receiving only medication management would not need to be a separate document and could be integrated into service notes.

V. Expected Clinical Outcomes

A. The expected clinical outcomes must relate to the identified goals in the member's treatment plan. The outcomes must reflect changes in symptoms and behaviors that, when met, promote increased functioning such that member may no longer meet medical necessity criteria for further treatment.

B. Expected clinical outcomes for this service are the following:
1. Reduced symptomatology or abstinence, or decreased use of substances;
2. Vocational or educational gains;
3. Decreased engagement with the justice system;
4. Stability in housing; and
5. Increased social supports.

C. If a review of the need for ongoing treatment determines that continued treatment is medically necessary, documentation of continued stay must provide the following:
1. Documentation of the need for ongoing treatment;
2. Documentation of progress made; **or**

3. Documentation of efforts to address lack of progress.

VI. For authorization requirements, please refer to WellCare of North Carolina Authorization Lookup Tool; WellCare of North Carolina Medicaid Behavioral Health Authorization List; and WellCare of North Carolina Medicaid Behavioral Health Authorization Guidelines and FAQ, for details.

VII. Documentation Requirements, Provider Requirements, Provider Eligibility, Provider Qualifications & Occupational Licensing Entity Regulations, Provider Certifications, and Staff Training Requirements For additional details, **please refer to North Carolina Medicaid State Policy site for Outpatient Behavioral Health Services Provided by Direct-Enrolled Providers Clinical Coverage Policy No: 8C at**: Program Specific Clinical Coverage Policies| NC Medicaid (ncdhhs.gov).

Coding Implications

This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2024, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

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

Code	Psychiatrist / MD/DO	PMHNP	PA/NP	LP/ LPA	LCMHC LCMHCA LCSW LCSWA LMFT LMFTA LCAS LCASA CNS	ADD ON CODE 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) t	X	X
90791	X	X		X	X		X	

Code	Psychiatrist / MD/DO	PMHNP	PA/NP	LP/ LPA	LCMHC LCMHCA LCSW LCSWA LMFT LMFTA LCAS LCASA CNS	ADD ON CODE LIMITS	Telehealth Eligible	Telephonic Eligible
90792	X	X	X				X	
90832	X	X		X	X		X	X
+90833	X	X				Code must be used with E/M code	X	
90834	X	X		X	X		X	X
+90836	X	X				Code must be used with E/M code	X	
90837	X	X		X	X		X	X
+90838	X	X				Code must be used with E/M code	X	
90839	X	X		X	X		X	X
+90840	X	X		X	X	Must be used with 90839;	X	X
90846	X	X		X	X	May not be used with 90785	X	X
90847	X	X		X	X	May not be used with 90785	X	X
90849	X	X		X	X	May not be used with 90785	X	X
90853	X	X		X	X		X	X
E/M CODE: **99202-99255; 99304-99337; 99341-99350; 99417**	X	X	X				Telehealth eligible codes limited to the following: 99202-99205 99211-99215 99231-99233 99238-99239 99241-99245 99251-99255 99347-99350	

Code	Psychiatrist / MD/DO	PMHNP	PA/NP	LP/ LPA	LCMHC LCMHCA LCSW LCSWA LMFT LMFTA LCAS LCASA CNS	ADD ON CODE LIMITS	Telehealth Eligible	Telephonic Eligible
99408	X	X	X	X	X		X	
99409	X	X	X	X	X		X	
96110	X	X		X			X	
96112	X			X				
96113	X			X		Must be used with 96112		
96116	X			X			X	
96121	X			X		Must be used with 96116	X	
96130	X			X			X	
96131	X			X		Must be used with 96130	X	
96132	X			X			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		
96138	X			X				
96139	X			X		Must be used with 96138		
96146	X			X			X	

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.

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.

Note: Please refer to Clinical Coverage Policy WNC.CP.193 Telehealth, Virtual Patient Communications, and Remote Patient Monitoring for utilization and billing guidance on virtual patient communication codes (e.g., online digital E&M, telephonic E&M, and interprofessional consultation) and remote patient monitoring codes (e.g., self-measured blood pressure and remote physiologic monitoring) billable by eligible psychiatric prescribers but which are not contained in Clinical Coverage Policy 8C.

Note: 'Federally recognized tribal or IHS providers may be entitled to alternate reimbursement methodologies under Federal Law.

Note: 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 should be included in the time for other services rendered.

Reviews, Revisions, and Approvals	Review Date	Approval Date
Original approval date	01/21	06/21
Added Telehealth and Telephonic Services information. Added Telehealth & Telephonic Eligible columns to CPT grid.	07/21	08/21
Section III H.8. Acronym for Licensed Marriage and Family Therapist Associate, LMFTA, added. Section III H.10. Spelling of acronym for Licensed Clinical Addiction Specialist Associate, LCASA, corrected. Clinical Policy CPT Codes-Telephonic eligible column for add-on code 90838 unchecked. HCPCS Codes reviewed. Reference updated.	08/22	08/22
Annual review. NCHC verbiage removed from NC Guidance Verbiage. Description: Changed "biophysical profile" to "comprehensive clinical;" and "significant other" to "natural supports." and "member's needs and preferences." Added "Outpatient services for Substance Use Disorders are identified and based on the American Society of Addiction Medicine (ASAM) criteria," and "Screening, Brief Intervention, and Referral to Treatment (SBIRT) definition," Removed, "are available to eligible members" Criteria: I.A.1. deleted "Note." I.D.1 & 2. Added 'current, or any subsequent editions of this reference material diagnosis' to DMS-5." I.F. added "Screening, Brief Intervention and Referral to Treatment (SBIRT)" II.B.4. & II.C.2. Added, "in accordance with the information below;" II.B.5, C.1, added "current" Background: II. Renamed section to "Utilization Management and Additional	05/23	05/23

Reviews, Revisions, and Approvals	Review Date	Approval Date
Limitations." Background Verbiage Changes: II.A."WellCare of North Carolina shall not require prior approval for up to 20 visits of Outpatient Behavioral Health services per fiscal year, after which prior approval will be required. Refer to Background Section F, below, for limitations." II.G.1. "Unmanaged coverage is limited to 8 hours/year." IV.B.5. "coordination of care," IV.E.5.g. "changed from to current" IV.F.5 'shall to must' IV.I.1."shall to must incorporate" IV.K.2.A. "changed alcohol & other drugs to substances," IV.K.2.B. "changed employment & education(getting and keeping a job) to Vocational or educational gains." IV.K.2.C. "changed decreased criminality to decreased engagement with the justice system." Background Additions: II.D. 1-7. II.E.3. "urgent or emergent situation." III.E."If Psychotherapy for Crisis is billed, no other outpatient therapy services can be billed on that same day for that member," III.G."to be billed," III.H."For substance use disorders" III.I,"Outpatient Medication Management" III.J,"Individual, Group, or Family Outpatient" III.L"To be eligible to" III.M.#12-21. IV.E.2 and 3 ASAM Criteria and training. IV.E.5.b."past trauma history…tobacco use." IV.E.5.c."medical, psychiatric, and substance use disorder treatment. Identify past medications that were ineffective or caused significant side effects or adverse reactions," IV.E.f."including a determination of ASAM level of care when a substance use disorder is present," IV.E.5.g."or any subsequent editions of this reference material, consisting of," IV.F.7 became IV.F.6, "or comparable federal, Tribal law, or rule" and changed "parental to parental/guardian" IV.G.3."Services eligible to be provided via telehealth must be provided according to clinical coverage Policy WNC.CP.193 Telehealth, Virtual Patient Communications, and Remote Patient Monitoring," IV.H.1.C "For visits beyond the unmanaged visits, a copy of the completed authorization request form and prior approval notification from WellCare is required." IV.J.C."Medicaid identification number." IV.D.1."behavioral health urgent care center, facility-based crisis, emergency department," IV.F.1."hereinafter,"**Background deletions**: III.B. "this includes medication management services." III.M."cannot bill "incident to" a physician or any other licensed professional." IV.F.6. Removed CPT codes showing telehealth & telephonic eligibility. Added New table showing "Psychiatric Diagnostic Evaluation, Psychotherapy, Medication Management, Crisis, and Psychological Testing CPT Codes" Added CPT Codes 99408 Alcohol and/or substance (other than tobacco) abuse structured screening (e.g., AUDIT, DAST), and brief intervention (SBI) services; 15 to 30 minutes 99409 Alcohol and/or substance (other than tobacco) abuse structured screening (e.g., AUDIT, DAST), and brief intervention (SBI) services; greater than 30 minutes 99417 Prolonged outpatient evaluation and management service(s) time with or		

Reviews, Revisions, and Approvals	Review Date	Approval Date
without direct patient contact beyond the required time of the primary service when the primary service level has been selected using total time, each 15 minutes of total time (List separately in addition to the code of the outpatient Evaluation and Management service. CPT table, added Notes regarding "the + symbol," "reference to WNC.CP.193 Telehealth policy," "federally recognized Tribal or HIS providers being exempt," "federally recognized Tribal or HIS providers being entitled to alternate reimbursement," and "SBIRT services must be billed…" Removed "Related Clinical Coverage Policies" reference and links from description.		
Updated CPT code 96121 to telehealth eligible.	11/23	11/23
Annual Review. Removed CPT & HCPCS code tables. Background I.B.2. Added "…is a short-term emergency behavioral health intervention…" Background IV.B. Added "The provider shall communicate and coordinate care with other professionals providing care to the Member. The provider shall document coordination of care activities." Background IV.C.1. Added "…for which Medicaid reimburses providers." Background IV.E.4. Added "According to 10A NCAC 27G .0205(a), a comprehensive clinical assessment that demonstrates medical necessity" Background IV.F. Added "Documentation in the health record must include the following: a. the Member's presenting problem; b. the Member'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." Background IV.J. Added "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 September 2011 Medicaid Bulletin must be followed." Background IV.L.2.j. Added "Often psychological testing reports contain the information found in a Comprehensive Clinical Assessment (CCA)."	02/24	02/24
Background II.D. 4.a. and 5.a. – changed 20 to 24 in "Outpatient Behavioral Health Services have 24 unmanaged outpatient visits per state fiscal year (inclusive of assessment & therapy codes). Removed "Medicaid and Health Choice" verbiage from References. Correction to 2/24, CPT table not removed ICD-10 table removed.	06/24	06/24
Annual Review. Telehealth and Telephonic services moved to beginning of policy. Criteria I.E., added 'medical necessity.' Criteria II.A.6. added "Refer to clinical coverage policy 1A-38, Special Services: After Hours, located at Program Specific Clinical Coverage Policies| NC Medicaid (ncdhhs.gov)."	12/24	12/24

Reviews, Revisions, and Approvals	Review Date	Approval Date
Criteria II.C.3. added "in Criteria I" for clarity. Deleted Background II. A.B.C.D. Utilization Management, then E.1,2,3, became Background II.A.B.C. Background II.B. added "Outpatient Behavioral Health," and deleted, "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." Background II.F. Psych. Testing became Background III and deleted 1. "unmanaged covered visit limits…" And 2,3 became 1,2. Deleted Background II.L. Providers Eligible to Bill, and M. Provider Qualifications. Deleted Criteria IV.A Consent; B 1-6; C. provision of services; D. Outpatient Crisis Services; E. CCA 1-3,5; F. Documentation; G. Individualized Plan (1. "referred to as 'plan' consistent with and supportive of the service provided and within professional standards of practice and #6 only); H. Service Note; I. Referral & Service Access; J. Electronic Signatures; K.24 hours coverage; L. Psychological Testing. Background IV. Limitations or Requirements. Deleted IV.H. "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." Background IV.H. and I. changed "authorized to receive' to 'receiving.' Background IV. J. added 'Referral" Criteria V.B, Coordination of Care, added "including but not limited to the member's care manager through WellCare of NC, or delegated care manager through the Advanced Medical Homes or Local Health Department," Coordination of Care became Background V. CCA became Background VI. And added "Individualized Plan" to header and reference to State Policy with web link; then Individualized Plan became Background VI.D. Expected Clinical Outcomes became Background VII. Background VIII. Is Authorization Requirements. Provider qualifications moved to Background IX. Changed "Unmanaged Visit Limit" to "Notes" in CPT code box.		
Under Description removed "are intended to" and moved Background I.A. and B. to definitions I.A. and B. and Telephone and Telephonic, became I.C and D. Definitions I.D.1.b. added reference & link for Telephonic specific criteria; Criteria I. removed "are medically necessary." Criteria I.D. added "ALL of the following criteria are necessary entrance criteria for psychological testing services." Criteria I.G. added "WellCare of North Carolina® shall cover telephonic services when the following criteria are met." Criteria I.H. added "Best Practice or Evidence-Based Practice." Criteria II.A.2., B.4., and C.2. added reference to CPT code box below. Criteria II.C.4. added reference & link to State policy for place of services. Background I is now "Requirements for all WellCare of North Carolina Members." Background II.C. added reference &		

Reviews, Revisions, and Approvals	Review Date	Approval Date
link to State policy, subsection 6.1 for license professionals and text "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." Old Background III.G. deleted "There is a limit of **8** units (hours) of Psychological Testing allowed to be billed per date of service." Background II.H. added reference & link to state policy. Under CPT code table: Removed LPC, LPCA, CCS from Code header, Changed "notes" to "Add On Code Limits," Added CPT 90837 90839 90840 90846 90847 90849 90853 Telephonic Eligible, and Added text "this code is an addon to other codes" to CPT 90785. Added "Must be used…" comment to Codes 90833 90836 90838 96133 96136 96137 96139. Deleted "Federally recognized tribal or IHS providers may be entitled to alternate reimbursement methodologies under Federal Law."		

References

1. State of North Carolina Medicaid Clinical Coverage Policy No: 8C Outpatient Behavioral Health Services Provided by Direct-Enrolled Providers. Program Specific Clinical Coverage Policies | NC Medicaid (ncdhhs.gov). Published January 1, 2025 Accessed January 27, 2025.

North Carolina Guidance

Eligibility Requirements

1. An eligible beneficiary shall be enrolled in the NC Medicaid Program (Medicaid is NC Medicaid program, unless context clearly indicates otherwise);
2. Provider(s) shall verify each Medicaid beneficiary's eligibility each time a service is rendered.
3. The Medicaid beneficiary may have service restrictions due to their eligibility category that would make them ineligible for this service.

EPSDT Special Provision: Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age

- 42 U.S.C. § 1396d(r) [1905(r) of the Social Security Act]

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 beneficiary 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 practitioner).

This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his or 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 beneficiary'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 beneficiary's right to a free choice of providers.

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

I. that is unsafe, ineffective, or experimental or investigational.

II. 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 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 meets all EPSDT criteria, including to correct or improve or maintain the beneficiary'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

- If the service, product, or procedure requires prior approval, the fact that the beneficiary is under 21 years of age does NOT eliminate the requirement for prior approval.
- **IMPORTANT ADDITIONAL INFORMATION** about EPSDT and prior approval is found in the *NCTracks Provider Claims and Billing Assistance Guide*, and on the EPSDT provider page. The Web addresses are specified below:

NCTracks Provider Claims and Billing Assistance Guide:
https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html
EPSDT provider page: https://medicaid.ncdhhs.gov/

Provider(s) Eligible to Bill for the Procedure, Product, or Service
To be eligible to bill for the procedure, product, or service related to this policy, the provider(s) shall:

i. meet Medicaid qualifications for participation;
ii. have a current and signed Department of Health and Human Services (DHHS) Provider Administrative Participation Agreement; and
iii. bill only for procedures, products, and services that are within the scope of their clinical practice, as defined by the appropriate licensing entity.

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) and record retention requirements; and

B. All NC Medicaid's clinical (medical) coverage policies, guidelines, policies, provider manuals, implementation updates, and bulletins published by the Centers for Medicare and Medicaid Services (CMS), DHHS, DHHS division(s) or fiscal contractor(s).

Claims-Related Information

Provider(s) shall comply with the NC Tracks Provider Claims and Billing Assistance Guide, Medicaid bulletins, fee schedules, NC Medicaid's clinical coverage policies and any other relevant documents for specific coverage and reimbursement for Medicaid:

- Claim Type - as applicable to the service provided:
  Professional (CMS-1500/837P transaction)
  Institutional (UB-04/837I transaction)
  Unless directed otherwise, Institutional Claims must be billed according to the National Uniform Billing Guidelines. All claims must comply with National Coding Guidelines.
- 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.
- 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.
  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

- Modifiers - Providers shall follow applicable modifier guidelines.
- Billing Units - Provider(s) shall report the appropriate code(s) used which determines the billing unit(s).
- Co-payments -
  For Medicaid refer to Medicaid State Plan:
  https://medicaid.ncdhhs.gov/get-involved/nc-health-choice-state-plan

- Reimbursement - Provider(s) shall bill their usual and customary charges. For a schedule of rates, refer to: https://medicaid.ncdhhs.gov/.

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions, and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a

discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment, or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members/enrollees. This clinical policy is not intended to recommend treatment for members/enrollees. Members/enrollees should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members/enrollees, and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members/enrollees and their representatives agree to be bound by such terms and conditions by providing services to members/enrollees and/or submitting claims for payment for such services.