

Transforming Lives. Building Community Well-Being.

# 2024-2025 State-Funded Outpatient Behavioral Health Services Benefit Plan

Service Code(s): Services Included (Sorted by Alphabetical Order):

90791, 90792 Clinical Assessment

96110, 96112, 96113 Developmental testing

99202 - 99205, 99211 - 99215, 99305 - 99310, <u>Evaluation & Management</u>

99315 – 99316, 99341 – 99350

90846, 90847 <u>Family Therapy</u>

90849, 90853, 90785, YP835 Group Therapy

90832, 90833, 90834, 90836, 90837, 90838 <u>Individual Therapy</u>

96116, 96121, 96136, 96137, 96138, 96139, 96132, Neuropsychological Testing

96133

90839, 90840 <u>Psychotherapy for Crisis</u>

Codes / modifier combinations not mentioned for specialized services will be found within contracts.

For State-Funded services (unless otherwise noted): Child services are available from age 3 through age 18. Adult services are available from age 18 and older.





#### **Person-Centered Plan Requirements & Guidance**

Providers can use the PCP template or develop their own template, but the PCP <u>must</u> contain all the required elements: 1) Assessment of life domains; 2) Person-Centered Interview Questions; 3) An action plan; 4) An enhanced crisis intervention plan, and; 5) A signature page. The PCP should be based on a comprehensive assessment that examines the individual's symptoms, behaviors, needs and preferences across the life domains listed below. Additional info can be found on the <u>NCDHHS Person-Centered Planning Training</u> webpage (PCP Guide). See the <u>JCB #445 Timelines for Implementation</u> for the implementation requirements for the new PCP guidance and templates.

#### <u>Life Domains</u> (PCP Guide)

Each life domain should provide a written picture of what is currently happening, what the individual's vision for a preferred life is for that area, and what the provider is doing to support the individual to move closer to living their preferred life.

- Daily Life and Employment Domain: What a person does as part of everyday life.
- Community Living Domain: Where and how someone lives.
- Safety and Security Domain: Staying safe and secure (finances, emergencies, relationships, neighborhood, legal rights, etc.).
- Healthy Living Domain: Managing and accessing health care and staying well.
- Social and Spirituality Domain: Building/strengthening friendships and relationships, cultural beliefs, and faith community.
- *Citizenship and Advocacy Domain*: Building valued roles, understanding personal rights, making choices, sexual orientation, self-identification, setting goals, assuming responsibility and driving how one's own life is lived.

#### Person-Centered Interview Questions (PCP Guide)

These identify what the person wants to work on, what they would like to accomplish, their identified strengths, and any identified obstacles preventing them from reaching their goals.

#### Action Plan (PCP Guide)

Revised: 06-24-2024

The Action Plan section of the PCP includes the individual's long-term goal, short-term goals, and interventions or the action steps to be taken to achieve these goals. For each desired long-term goal, the Action Plan will include short-term goal(s) as well as interventions.

- Long-Term Goal Development: what motivates the person to engage in services and make changes. These are personal to that individual, often reflect one or more Life Domains, and typically take time to achieve. Ideally, long-term goals are oriented toward quality-of-life priorities and not only the management of health conditions and symptoms.
- Short-Term Goals: help the person move closer to achieving their long-term goals. They reflect concrete changes in functioning/skills/activities
  that are meaningful to the person and are proof they are making progress. Short-term goals build on strengths while also addressing identified
  needs from the assessment that interfere with the attainment of the valued, long-term life goal(s). Short-term goals are written in SMART
  (Specific/Straightforward/Simple, Measurable, Achievable, Relevant, and Time-Limited) language.
- Interventions: reflect how all team individuals contribute to helping the person achieve their short-term goals. Interventions are the specific tasks the provider and individual agree on. The language of interventions should include: WHO is offering the intervention/support, WHAT specifically will be provided or done (e.g., title of service or action), WHEN it is being offered frequency and duration (e.g., once a month for 3 months), and WHY it is needed (i.e., how the intervention relates to the individual's specific goal).



#### Enhanced Crisis Intervention Plan (PCP Guide)

A crisis plan includes supports/interventions aimed at preventing a crisis and the supports/interventions to employ if there is a crisis. It must include:

- Significant event(s) that may create increased stress and trigger the onset of a crisis.
- Early warning signs which indicate a possible upcoming crisis.
- Crisis prevention and early intervention strategies
- Strategies for crisis response and stabilization
- Specific recommendations for interacting with the person receiving a crisis service.
- Diagnosis and insurance information,
- Name and contact information for medical and mental health provider
- List of medications including doses and frequency, allergies, and other medical and dental concerns.
- Living situation and planning for any pets and people, etc. in case of a crisis if applicable.
- Employment/ Educational status and plan for notification if applicable
- Preferred method of communication and language.
- Names and contact information of formal and informal support persons
- Suicide prevention and intervention plan, behavior plan, youth in transition plan and Psychiatric Advance Directive (PAD), if applicable.
- Crisis follow-up planning to include: 1) The primary contact who will coordinate care if the individual requires inpatient or other specialized care; 2) Name of the person who will visit the individual while hospitalized, and; 3) Provider responsible to lead a review/debriefing following a crisis and the timeframe.

#### Signature Page (PCP Guide)

Revised: 06-24-2024

Signatures are authenticated when the individual signing enters the date next to their signature. Check boxes left blank on the signature pages of the PCP will be returned as incomplete. A signature page must include:

- Person Receiving Services Dated signature is required when the person is his/her own legally responsible person. A provider may not bill
  Medicaid for services until this signature is acquired if the individual is his or her own legally responsible person.
- Legally Responsible Person Dated signature when the person receiving services is not his/her own LRP. A provider may not bill Medicaid for services until this signature is acquired, when applicable.
- Person Responsible for the Plan Dated signature is required. Inclusion of the required information on the signature page of the PCP template
  by the Person Responsible for the Plan is also required for individuals under the age of 21 (Medicaid) or under age 18 (State) who are receiving
  enhanced services and are actively involved with the Department of Juvenile Justice and Delinquency Prevention or the Criminal Court System.
- Service Order/Confirmation of Medical Necessity Dated signature is required, plus confirmation of medical necessity, indication of whether review of the comprehensive clinical assessment occurred, and indication if the LP signing the service order had direct contact with the individual.

Service & Code	Brief Service Description	Auth Submission Requirements	Authorization Parameters	Source
	A Comprehensive	Pass-Through Period:	<u>Units</u> : The appropriate procedure code(s) determines the	State-Funded
Clinical	Clinical	1. Up to 12 unmanaged visits for	billing unit(s). One service code = 1 unit of service.	<u>Outpatient</u>
Assessment	Assessment (CCA)	adults & 24 unmanaged visits for		<u>Behavioral</u>
	is an intensive	children/ adolescents each fiscal year	Age Group: Children/ Adolescents & Adults	Health Services
Limited funding.	clinical and	of a combination of Individual		<u>Definition</u>
Not an	functional	Therapy, Family Therapy, Group	Level of Care: ASAM Level 1 or lower (if applicable). While	
entitlement.	evaluation of an	Therapy, and Psych Eval.	the LOCUS/ CALOCUS are specifically no longer required,	<u>APSM 45-2</u>
	individual's		providers are still expected to use a standardized assessment	Records
	presenting mental	Initial Requests (after pass-	tool when evaluating an individual for treatment services.	<u>Management</u>
Code(s):	health,	through):		<u>and</u>
90791: Psychiatric	developmental	1. TAR: Prior authorization is required	Service Specifics, Limitations, & Exclusions (not all	<u>Documentation</u>
Diagnostic	disability, and	after unmanaged units are exhausted.	inclusive):	<u>Manuals</u>
Evaluation (No	substance use	2. CCA: Required	1. A CCA is not required for medical providers billing E/M	
Medical Services,	disorder. This	3. Tx/ Service Plan: Required.	codes for medication management.	NC PCP
GT eligible)	assessment results	Complete PCP is required when the	2. Funding will not cover Outpatient Behavioral Health	<u>Guidance</u>
	in the issuance of a	recipient is receiving an enhanced BH	Services when the service duplicates another service	<u>Document</u>
90792: Psychiatric	written report that	services in addition to the services in	approved with another provider.	
Diagnostic	provides the clinical	the State-Funded Outpatient BH	3. Only 1 psychiatric CPT code from the State-Funded	
Evaluation with	basis for the	Services Definition.	Outpatient Behavioral Health Services policy is allowed per	
Medical Services	development of the	4. Service Order: Required	individual per day of service from the same attending provider.	
(GT eligible)	individual's	5. Submission of applicable records	Only 2 psychiatric CPT codes from this policy are allowed per	
	treatment or service	that support the recipient has met the	individual per date of service.	
Modifier(s):	plan.	medical necessity criteria.	<b>4.</b> A Psychiatric Diagnostic Interview is not allowed on the	
GT: Telehealth		Reauthorization Requests:	same day as Psychological Testing when provided by the	
		1. TAR: prior authorization required	same provider.	
		2. Tx/ Service Plan: recently reviewed	5. A CCA that demonstrates medical necessity must be	
		detailing the recipient's progress with	completed by a licensed professional prior to provision of	
		the service. Updated PCP is required	outpatient therapy services.	
		when the recipient is receiving an	6. The provider will communicate and coordinate care with	
		enhanced BH services in addition to	other professionals providing care to the recipient.	
		the	7. The CCA must contain all 9 elements detailed in the service	
		services in the State-Funded	definition. In primary or specialty medical care settings with	
		Outpatient BH Services Definition.	integrated medical and BH services, an abbreviated	
		3. Submission of applicable records	assessment is acceptable for the first 6 outpatient therapy	
		that support the recipient has met the	sessions.	
		medical necessity criteria.		

Developmental Testing Limited funding. Not an entitlement.  Limited funding. Not an entitlement.  Limited funding. Not an entitlement.  Code(s): Developmental Testing - Limited (GT eligible)  An in-depth look at a recipient's developmental pediatrician, psychologist, speech-language pathologist, or other specialist.  Developmental Testing - Limited (GT eligible)  An in-depth look at a recipient's development, usually done by a trained specialist, such as a developmental pediatrician, psychologist, speech-language pathologist, occupational therapist, or other specialist.  The specialist may observe the recipient a structured test, ask the guardian questions, or ask them to fill out questionnaires.  Poevlopmental Testing - Limited (GT eligible)  An in-depth look at a recipient's development, usually done by a trained specialist. TAR: required if the unmanaged units have been whausted. Providers may seek prior authorization if they are unsure timely prior authorization, requests must be submitted prior to the last unauthorized visit.  Level of Care: N/A  Service Specifics, Limitations, & Exclusions (not all inclusive):  1. Funding will not cover Outpatient Behavioral Health Services when the service duplicates another service approved with another provider.  2. Only 1 psychiatric CPT code from the State-Funded Outpatient Behavioral Health Services policy is allowed per individual per day of service from the same attending provider. Only 2 psychiatric CPT codes from the same attending provider. Only 2 psychiatric certains and pour leaf the unmanaged units of 96110:  1. The appropriate procedure code(s) determines the billing unit (s). One CPT code = 1 unit of 96110:  2. Up to 9 unmanaged units of 96110:  3. The samporpriate procedure code(s) determines the billing unit (s). One CPT code = 1 unit of 96110:  3. The sepcialist.  4. The samporpriate procedure code(s) determines the billing unit (s). One CPT code = 1 unit of 96110:  4. The appropriate procedure code(s) determines the billing unit (s). One CPT code = 1 u	Service & Code	Brief Service Description	Auth Submission Requirements	Authorization Parameters	Source
96113: Developmental Testing - each additional 30 minutes. Must be used with 96112.  individual per date of service.  3. The provider shall communicate and coordinate care with others providing care. When the recipient is receiving multiple BH services in addition to this service, a tx plan must be developed, and outpatient behavioral health services are to be incorporated into the tx plan.	Testing  Limited funding. Not an entitlement.  Code(s): 96110: Developmental Testing - Limited (GT eligible)  96112: Developmental Testing administrative - first hour  96113: Developmental Testing - each additional 30 minutes. Must be used with 96112.	development, usually done by a trained specialist, such as a developmental pediatrician, psychologist, speech-language pathologist, occupational therapist, or other specialist. The specialist may observe the recipient, give the recipient a structured test, ask the guardian questions, or ask	All Requests: TAR: required if the unmanaged units have been exhausted. Providers may seek prior authorization if they are unsure the recipient has reached their unmanaged visit limit. To ensure timely prior authorization, requests must be submitted prior to the last	1. The appropriate procedure code(s) determines the billing unit(s). One CPT code = 1 unit of service.  2. Up to 9 unmanaged units of 96110: Developmental Testing - Limited.  Age Group: Children/ Adolescents & Adults  Level of Care: N/A  Service Specifics, Limitations, & Exclusions (not all inclusive):  1. Funding will not cover Outpatient Behavioral Health Services when the service duplicates another service approved with another provider.  2. Only 1 psychiatric CPT code from the State-Funded Outpatient Behavioral Health Services policy is allowed per individual per day of service from the same attending provider. Only 2 psychiatric CPT codes from this policy are allowed per individual per date of service.  3. The provider shall communicate and coordinate care with others providing care. When the recipient is receiving multiple BH services in addition to this service, a tx plan must be developed, and outpatient behavioral health services are to be incorporated	Outpatient Behavioral Health Services Service Definition  APSM 45-2 Records Management and Documentation Manuals  NC PCP Guidance

Service & Code	Brief Service	Auth Submission	Authorization Parameters	Source
Evaluation & Management	Description  Evaluation and Management services provided by a Psychiatrist / MD or a Psych NP/PA.	Requirements  1. Prior authorization is not required for this service. E/M codes are not specific to mental health and are not subject to prior approval.  2. Medicaid Application: Individuals must apply for Medicaid.	Units: The appropriate procedure code(s) determines the billing unit(s). One CPT code = 1 unit of service.  Age Group: Children/ Adolescents & Adults  Level of Care: N/A  Service Specifics, Limitations, & Exclusions (not all inclusive):  1. Outpatient BH does not cover: a) sleep therapy for psychiatric disorders; b) medical, cognitive, intellectual or development issue that would not benefit from outpatient treatment services, OR; c) when the focus of treatment does not address the symptoms of the diagnosis.  2. State funds will not cover the same services provided by the same or different attending provider on the same day for the same individual  3. Only 1 psychiatric CPT code from the State-Funded Outpatient Behavioral Health Services policy is allowed per individual per day of service from the same attending provider. Only 2 psychiatric CPT codes from this policy are allowed per individual per date of service.  4. Physicians billing E/M codes with psychotherapy add-on codes must have documentation supporting that the E/M service was separate and distinct from the psychotherapy service.  5. The provider will communicate and coordinate care with other professionals providing care to the recipient.  6. Telehealth, Virtual Communication, and Hybrid Telehealth services must follow the guidelines and requirements detailed in the State-Funded Telehealth and Virtual Services service	State-Funded Outpatient Behavioral Health Services Service Definition  State-Funded Telehealth and Virtual Services  APSM 45-2 Records Management and Documentation Manuals  NC PCP Guidance Document

Service & Code	Brief Service Description	Auth Submission Requirements	Authorization Parameters	Source
	Service is focused on	Pass-Through Period:	<b>Units</b> : The appropriate procedure code(s) determines the	State-Funded
Family Therapy	reducing psychiatric	1. Up to 12 unmanaged visits for adults	billing unit(s). One service code = 1 unit of service.	Outpatient
	and behavioral	& 24 unmanaged visits for children/		Behavioral
Limited funding.	symptoms to improve	adolescents each fiscal year of a	Age Group: Children/ Adolescents & Adults	<b>Health Services</b>
Not an	the recipient's	combination of Individual Therapy,		<u>Service</u>
entitlement.	functioning in familial,	Family Therapy, Group Therapy, and	Level of Care: ASAM Level 1 or lower (if applicable). While	<b>Definition</b>
	social, educational, or	Psych Eval.	the LOCUS/ CALOCUS are specifically no longer required,	
	occupational life		providers are still expected to use a standardized	APSM 45-2
Code(s):	domains. The	Initial Requests (after pass-through):	assessment tool when evaluating an individual for treatment	Records
<b>90846</b> : Family	recipient's needs and	1. TAR: Submission required after pass-	services.	<u>Management</u>
Therapy w/o	preferences	through visit.		<u>and</u>
recipient (GT &	determine the	2. CCA: Required, to include an ASAM	Service Specifics, Limitations, & Exclusions (not all	<b>Documentation</b>
KX eligible)	treatment goals,	Score supported with detailed clinical	inclusive):	<u>Manuals</u>
	frequency, and	documentation on each of the six ASAM	1. Family therapy must be billed once per date of service for	
<b>90847</b> : Family	duration of services,	dimensions (if applicable).	the identified family recipient only. No separate billing for	NC PCP
Therapy with	as well as	3. Tx/ Service Plan: Required,	participating recipient(s) of the therapy session is	<u>Guidance</u>
recipient (GT &	measurable and	consistent with and supportive of the	permissible.	<u>Document</u>
<x eligible)<="" td=""><td>desirable outcomes.</td><td>service provided and within professional</td><td>2. Service cannot be billed while an individual is authorized</td><td></td></x>	desirable outcomes.	service provided and within professional	2. Service cannot be billed while an individual is authorized	
		standards of practice. When the	to receive ACT, IIH, MST, Day Treatment, SAIOP, or	
<u>Modifier(s):</u>		individual is receiving multiple BH	SACOT	
GT: Telehealth		services in addition to this service, a	3. Outpatient BH does not cover: a) sleep therapy for	
<b>KX</b> : Telephonic		PCP must be developed with the	psychiatric disorders; b) medical, cognitive, intellectual or	
		individual, and outpatient BH services	development issue that would not benefit from outpatient	
		are to be incorporated into the	treatment services, OR; c) when the focus of treatment does	
		individual's PCP.	not address the symptoms of the diagnosis.	
		4. Service Order: Required	<b>4.</b> State funds will not cover the same services provided by	
		5. Medicaid Application: Required w/in	the same or different attending provider on the same day for	
		the 30 days of authorization. Evidence	the same individual	
		of individual applying for Medicaid or	5. Only 1 psychiatric CPT code from the State-Funded	
		update on application status.	Outpatient Behavioral Health Services policy is allowed per	
		<b>6.</b> Submission of applicable records that	individual per day of service from the same attending	
		support the recipient has met the	provider. Only 2 psychiatric CPT codes from this policy are	
		medical necessity criteria.	allowed per individual per date of service.	
			<b>6.</b> For substance use disorders, ASAM level 1 outpatient	
		Reauthorization Requests:	services are provided for less than nine hours a week for	
		1. TAR: prior authorization required	adults and less than six (6) hours a week for adolescents.	
		2. Tx/ Service Plan: recently reviewed	7. The provider will communicate and coordinate care with	
Revised: 06-24-20		detailing the recipient's progress with  Please refer to UM notes or	other professionals providing care to the recipient.	Page 7 of 15



the service. Updated PCP is required when this service is provided in conjunction with a service found in the state-funded enhanced MH/SU service definition.  3. Submission of applicable records that support the recipient has met the medical necessity criteria.	8. Provider must verify individual's eligibility each time a service is rendered 9. If a higher LOC is indicated but unavailable or the individual is refusing the service, outpatient services can be provided until the appropriate level of care is available or to support the individual to participate in that higher LOC 10. Enrolled providers must provide, or have a written agreement with another entity, for access to 24-hour coverage for BH emergency services.	
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Service &	Brief Service	Auth Submission	Authorization Parameters	Source
Code	Description	Requirements		
	Service is focused on	Pass-Through Period:	Units: The appropriate procedure code(s) determines the	State-Funded
Group	reducing psychiatric	1. Up to 12 unmanaged visits for adults &	billing	Outpatient
Therapy	and behavioral	24 unmanaged visits for children/	unit(s). One service code = 1 unit of service.	<u>Behavioral</u>
	symptoms to improve	adolescents each fiscal year of a		Health Services
Limited	the recipient's	combination of Individual Therapy, Family	Age Group: Children/ Adolescents & Adults	<u>Service</u>
funding. Not an	functioning in familial,	Therapy, Group Therapy, and Psych Eval.		<u>Definition</u>
entitlement.	social, educational, or		Level of Care: ASAM Level 1 or lower (if applicable).	
	occupational life	Initial Requests (after pass-through):	While the LOCUS/ CALOCUS are specifically no longer	APSM 45-2
	domains. The	1. TAR: Submission required after pass-	required, providers are still expected to use a	<u>Records</u>
Code(s):	recipient's needs and	through visit.	standardized assessment tool when evaluating an	<u>Management</u>
<b>90849</b> : Group	preferences determine	<b>2.</b> CCA: Required, to include an ASAM	individual for treatment services.	<u>and</u>
Therapy (multi-	the treatment goals,	Score supported with detailed clinical		<b>Documentation</b>
family. GT &	frequency, and	documentation on each of the six ASAM	Service Specifics, Limitations, & Exclusions (not all	<u>Manuals</u>
KX eligible)	duration of services,	dimensions (if applicable).	inclusive):	
	as well as measurable	3. Tx/ Service Plan: Required, consistent	1. Service cannot be billed while an individual is	NC PCP
<b>90853</b> : Group	and desirable	with and supportive of the service provided	authorized to receive ACT, IIH, MST, Day Treatment,	<u>Guidance</u>
Therapy (GT &	outcomes.	and within professional standards of	SAIOP, or SACOT	<u>Document</u>
KX eligible)		practice. When the individual is receiving	2. Outpatient BH does not cover: a) sleep therapy for	
		multiple BH services in addition to this	psychiatric disorders; b) medical, cognitive, intellectual or	
YP835: Alcohol		service, a PCP must be developed with the	development issue that would not benefit from outpatient	
and/or Drug		individual, and outpatient BH services are to	treatment services, OR; c) when the focus of treatment	
Services,		be incorporated into the individual's PCP.	does not address the symptoms of the diagnosis.	
Group		4. Service Order: Required	3. State funds will not cover the same services provided	
		5. Medicaid Application: Required w/in the	by the same or different attending provider on the same	
Modifier(s):		30 days of authorization. Evidence of	day for the same individual	
GT: Telehealth		individual applying for Medicaid or update	4. Only 1 psychiatric CPT code from the State-Funded	
KX: Telephonic		on application status.	Outpatient Behavioral Health Services policy is allowed	
		6. Submission of applicable records that	per individual per day of service from the same attending	
		support the recipient has met the medical	provider. Only 2 psychiatric CPT codes from this policy	
		necessity criteria.	are allowed per individual per date of service.	
		•	<b>5.</b> For substance use disorders, ASAM level 1 outpatient	
		Reauthorization Requests:	services are provided for less than nine hours a week for	
		1. TAR: prior authorization required	adults and less than six (6) hours a week for adolescents.	
		2. Tx/ Service Plan: recently reviewed	<b>6.</b> The provider will communicate and coordinate care	
		detailing the recipient's progress with the	with other professionals providing care to the recipient.	
		service. Updated PCP is required when this	7. Provider must verify individual's eligibility each time a	
		service is provided in conjunction with a	service is rendered	
		service found in the state-funded enhanced	8. If a higher LOC is indicated but unavailable or the	
		MH/SU service definition.	individual is refusing the service, outpatient services can	
Revised: 06-24-2	024	Please refer to UM notes on ap	· · · · · · · · · · · · · · · · · · ·	Page 9 of 15



	<b>3.</b> Submission of applicable records that support the recipient has met the medical	be provided until the appropriate level of care is available or to support the individual to participate in that higher	
	necessity criteria.	LOC  • Enrolled providers must provide, or hove a written	
		<b>9.</b> Enrolled providers must provide, or have a written agreement with another entity, for access to 24-hour	
		coverage for BH emergency services.	



	Brief Service	Auth Submission		
Service & Code	Description	Requirements	Authorization Parameters	Source
Individual Therapy	Service is	Pass-Through Period:	Units: The appropriate procedure code(s)	State-Funded
	focused on	1. Up to 12 unmanaged visits for adults & 24	determines the billing	Outpatient
Limited funding. Not an	reducing	unmanaged visits for children/ adolescents each	unit(s). One service code = 1 unit of service.	Behavioral Health
entitlement.	psychiatric and	fiscal year of a combination of Individual Therapy,		Services Service
	behavioral	Family Therapy, Group Therapy, and Psych Eval.	Age Group: Children/ Adolescents & Adults	<u>Definition</u>
Code(s):	symptoms to			
90832: 30 Minutes (GT	improve the	Initial Requests (after pass-through):	Level of Care: ASAM Level 1 or lower (if	APSM 45-2
& KX eligible)	recipient's	1. TAR: Submission required after pass-through	applicable). While the LOCUS/ CALOCUS	<u>Records</u>
<b>90833</b> : 30 Minute add	functioning in	visit.	are specifically <u>no longer required</u> , providers	Management and
on to E&M (GT eligible)	familial, social,	2. CCA: Required, to include an ASAM Score	are still expected to use a standardized	<u>Documentation</u>
<b>90834</b> : 45 Minutes (GT	educational, or	supported with detailed clinical documentation on	assessment tool when evaluating an	<u>Manuals</u>
& KX eligible)	occupational life	each of the six ASAM dimensions (if applicable).	individual for treatment services.	
90836: 45 Minute add	domains. The	3. Tx/ Service Plan: Required, consistent with and		NC PCP
on to E&M (GT eligible)	recipient's needs	supportive of the service provided and within	Service Specifics, Limitations, &	Guidance
90837: 60 Minutes (GT	and preferences	professional standards of practice. When the	Exclusions (not all inclusive):	<u>Document</u>
& KX eligible) 90838: 60 Minute add	determine the	individual is receiving multiple BH services in	1. Service cannot be billed while an	
on to E&M (GT eligible)	treatment goals,	addition to this service, a PCP must be developed with the individual, and outpatient BH services are	individual is authorized to receive ACT, IIH, MST, Day Treatment, SAIOP, or SACOT	
on to Eaw (GT eligible)	frequency, and duration of	to be incorporated into the individual's PCP.	2. Outpatient BH does not cover: a) sleep	
Modifiers:	services, as well	4. Service Order: Required	therapy for psychiatric disorders; b) medical,	
GT: Telehealth	as measurable	<b>5.</b> Medicaid Application: Required w/in the 30 days	cognitive, intellectual or development issue	
KX: Telephonic	and desirable	of authorization. Evidence of individual applying	that would not benefit from outpatient	
Tot. relephonic	outcomes.	for Medicaid or update on application status.	treatment services, OR; c) when the focus of	
Telephonic Services	outoonnoo.	<b>6.</b> Submission of applicable records that support	treatment does not address the symptoms of	
(KX) are reserved for		the recipient has met the medical necessity criteria.	the diagnosis.	
when physical or BH		,	3. State funds will not cover the same	
status or access issues		Reauthorization Requests:	services provided by the same or different	
(transportation,		1. TAR: prior authorization required	attending provider on the same day for the	
telehealth technology)		2. Tx/ Service Plan: recently reviewed detailing the	same individual	
prevent the recipient		recipient's progress with the service. Updated PCP	4. Only 1 psychiatric CPT code from the	
from participating in-		is required when this service is provided in	State-Funded Outpatient Behavioral Health	
person or telehealth		conjunction with a service found in the state-funded	Services policy is allowed per individual per	
services.		enhanced MH/SU service definition.	day of service from the same attending	
		3. Submission of applicable records that support	provider. Only 2 psychiatric CPT codes from	
		the recipient has met the medical necessity criteria.	this policy are allowed per individual per date	
			of service.	
			<b>5.</b> For substance use disorders, ASAM level	
			1 outpatient services are provided for less	

Trillium HEALTH RESOURCES Transforming Dives, Building Community Well-Being.	2024-2025 State-Funded OPT BH Services Benefit Plan
	than nine hours a week for adults and less than six (6) hours a week for adolescents. 6. The provider will communicate and coordinate care with other professionals providing care to the recipient. 7. Provider must verify individual's eligibility each time a service is rendered 8. If a higher LOC is indicated but unavailable or the individual is refusing the service, outpatient services can be provided until the appropriate level of care is available or to support the individual to participate in that higher LOC 9. Enrolled providers must provide, or have a written agreement with another entity, for access to 24-hour coverage for BH emergency services.

Service & Code	Brief Service Description	Auth Submission Requirements	Authorization Parameters	Source
	Neuropsychological	All Requests:	Units:	State-Funded
Neuropsychological	Testing is intended	TAR: required if the	1. The appropriate procedure code(s) determines the billing	Outpatient
Testing	to assess cognition	unmanaged units	unit(s). One service code = 1 unit of service.	Behavioral Health
	and behavior,	have been	2. Up to 9 unmanaged units of testing administration.	Services Service
Limited funding. Not an	examining the	exhausted.		Definition
entitlement.	effects of any brain	Providers may seek	Age Group: Children/ Adolescents & Adults	
	injury or	prior approval if they		APSM 45-2 Records
Code(s):	neuropathological	are unsure the	Level of Care: While the LOCUS/ CALOCUS are specifically no	Management and
96116: Neurobehavioral	process that a	recipient has	longer required, providers are still expected to use a	<u>Documentation</u>
Exam (First Hour)	person may have	reached their	standardized assessment tool when evaluating an individual for	<u>Manuals</u>
	experienced.	unmanaged visit	treatment services.	
96121: Neurobehavioral		limit. To ensure		PCP Guidance
Exam (Each Add'l Hour)		timely prior	Service Specifics, Limitations, & Exclusions (not all	Documents &
		authorization,	inclusive):	<u>Templates</u>
96136: Testing Administration		requests must be	1. Testing for the following is not covered: a) for the purpose of	
(First 30 minutes)		submitted prior to	educational testing; b) if requested by the school or legal	
00407 Tablia Adalatatata		the last	system, unless MN exists for the psych testing; c) if the	
96137: Testing Administration		unauthorized visit.	proposed psych testing measures have no standardized norms	
(Each add'l 30 minutes)			or documented validity, OR; d) if the focus is not the symptoms	
06139, Testing Administration			of the DSM-5 diagnosis.  2. Only 1 psychiatric CPT code from the State-Funded	
<b>96138</b> : Testing Administration by Technician (First 30			Outpatient Behavioral Health Services policy is allowed per	
minutes)			individual per day of service from the same attending provider.	
Illiliutes)			Only 2 psychiatric CPT codes from this policy are allowed per	
96139: Testing Administration			individual per date of service.	
by Technician (Each add'l 30			3. A Psychiatric Diagnostic Interview is not allowed on the same	
minutes)			day as Psychological Testing when provided by the same	
Timideso)			provider.	
96132: Evaluation of Testing			4. Limit of eight hours of Psychological Testing allowed to be	
(First hour, GT eligible)			billed per date of service.	
			<b>5.</b> May only be performed by licensed psychologists, licensed	
96133: Evaluation of Testing			psychological associates, and qualified physicians.	
(Each add'l hour, GT eligible)			6. Testing must include all elements detailed in the service	
,			definition.	
Modifier(s):			7. The provider shall communicate and coordinate care with	
GT: Telehealth			others providing care.	

	Brief Service	Auth Submission		
Service & Code	Description	Requirements	Authorization Parameters	Source
Psychological	Psychological	All Requests:	Units:	State-Funded
Testing (Hourly)	testing involves the	1. TAR: required if the	1. The appropriate procedure code(s) determines the billing	Outpatient Behavioral
( , ,	culturally and	unmanaged units have	unit(s). One service code = 1 unit of service.	Health Services Service
Limited funding. Not	linguistically	been exhausted. Providers	<b>2.</b> Up to 9 unmanaged units of testing administration.	Definition
an entitlement.	appropriate	may seek prior approval if		
	administration of	they are unsure the	Age Group: Children/ Adolescents & Adults	APSM 45-2 Records
Code(s):	standardized tests to	recipient has reached their		Management and
<b>96136</b> : Testing	assess a recipient's	unmanaged visit limit. To	Level of Care: While the LOCUS/ CALOCUS are	Documentation
Administration (First	psychological or	ensure timely prior	specifically no longer required, providers are still expected to	Manuals
30 minutes)	cognitive	authorization, requests	use a standardized assessment tool when evaluating an	
·	functioning. Testing	must be submitted prior to	individual for treatment services.	NC PCP Guidance
<b>96137</b> : Testing	results must inform	the last unauthorized visit.		<u>Document</u>
Administration (Each	treatment selection	2. Psychological	Service Specifics, Limitations, & Exclusions (not all	
add'l 30 minutes)	and treatment	Evaluation: A copy of the	inclusive):	
	planning.	previous evaluation is	<b>1.</b> Testing for the following is not covered: a) for the purpose	
<b>96138</b> : Testing		required if the unmanaged	of educational testing; b) if requested by the school or legal	
Administration by		units have been exhausted.	system, unless MN exists for the psych testing; c) if the	
Technician (First 30		3. Service Order: required if	proposed psych testing measures have no standardized	
minutes)		the unmanaged units have	norms or documented validity, OR; d) if the focus is not the	
		been exhausted.	symptoms of the DSM-5 diagnosis.	
<b>96139</b> : Testing			2. Only 1 psychiatric CPT code from the State-Funded	
Administration by			Outpatient Behavioral Health Services policy is allowed per	
Technician (Each add'l			individual per day of service from the same attending	
30 minutes)			provider. Only 2 psychiatric CPT codes from this policy are	
			allowed per individual per date of service.	
96130: Evaluation of			3. A Psychiatric Diagnostic Interview is not allowed on the	
Testing (First hour, GT			same day as Psychological Testing when provided by the	
eligible)			same provider.	
			4. May only be performed by licensed psychologists,	
96131: Evaluation of			licensed psychological associates, and qualified physicians.	
Testing (Each add'l			5. Testing must include all 9 elements detailed in the CCP.	
hour, GT eligible)			6. The provider will communicate and coordinate care with	
			other professionals providing care to the recipient.	
Modifier(s):				
GT: Telehealth				

Service & Code	<b>Brief Service Description</b>	Auth Submission Requirements	Authorization Parameters	Source
	A crisis is defined as an	Pass-Through Period:	Age Group: Children/ Adolescents & Adults	State-Funded
Psychotherapy for	acute disturbance of	1. Prior authorization is not		<u>Outpatient</u>
Crisis	thought, mood, behavior or	required for this service.	Level of Care: N/A	<u>Behavioral</u>
	social relationships that	2. Psychotherapy for Crisis		<b>Health Services</b>
Limited funding. Not	requires an immediate	disposition may:	Service Specifics, Limitations, & Exclusions (not all	<u>Service</u>
an entitlement.	intervention, and which, if	A) Involve an immediate	inclusive):	<u>Definition</u>
	untreated, may lead to	transfer to more restrictive	1. Psychotherapy for Crisis is not covered: a) if the focus of	
	harm to the individual or to	emergency services.	tx does not address the symptoms of the DSM-5 dx or	APSM 45-2
Code(s):	others or have the	<b>B)</b> If the disposition is not an	related symptoms; b) in emergency departments, inpatient	Records
<b>90839</b> : First 60	potential to rapidly result in	immediate transfer to acute or	settings, or facility-based crisis settings, OR; c) if the	<u>Management</u>
Minutes (GT & KX	a catastrophic outcome.	more intensive emergency	recipient presents with a medical, cognitive, intellectual or	<u>and</u>
eligible)	On rare occasions,	services, the provider must	development issue that would not benefit from outpatient tx	<u>Documentation</u>
	licensed outpatient service	offer a written copy of an	services.	<u>Manuals</u>
<b>90840</b> : For each	providers are presented	individualized crisis plan to the	2. If Psychotherapy for Crisis is billed, no other outpatient	
additional 30	with an individual in crisis	individual. This plan must be	therapy services can be billed on that same day for that	NC PCP
minutes (Must be	which may require	developed in the session for	individual.	<u>Guidance</u>
used with 90839;	unplanned extended	the purpose of handling future	3. Psychotherapy for Crisis is only covered when the	<u>Document</u>
GT & KX eligible)	services to manage the	crisis situations, including	individual is experiencing an immediate, potentially life-	
	crisis in the office with the	involvement of family and	threatening, complex crisis. The service must be provided in	
	goal of averting more	other providers as applicable.	an outpatient therapy setting.	
	restrictive levels of care.	The plan must document a	<b>4.</b> The provider will complete an assessment prior to the	
	Licensed professionals	scheduled outpatient follow-up	delivery of any subsequent services following the provision of	
	may use the	session.	this service.	
	"Psychotherapy for Crisis"		5. When receiving multiple BH services in addition to	
	service codes only in those		outpatient, a PCP must be developed.	
	situations in which an		<b>6.</b> The provider will communicate and coordinate care with	
	unforeseen crisis arises		other professionals providing care to the recipient.	
	and additional time is		7. Providers must provide or have a written agreement with	
	required to manage the		another entity for access to 24-hour coverage for behavioral	
	crisis event.		health emergency services	