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To all beneficiaries enrolled in a Prepaid Health Plan (PHP): for questions about benefits and services available on or after implementation, please contact your PHP.

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Related Clinical Coverage Policies

Refer to <https://medicaid.ncdhhs.gov/> for the related coverage policies listed below:

8A, *Enhanced Mental Health and Substance Abuse Services*

8A-1, *Assertive Community Treatment (ACT program)*

8A-6, *Community Support Team (CST)*

1.0 Description of the Procedure, Product, or Service

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

It evaluates the beneficiary's level of readiness and motivation to engage in treatment. This assessment is designed to be delivered in a team approach that results in the issuance of a written report that provides the clinical basis for the development of the beneficiary's treatment or service plan. The written report must be kept in the service record.

Elements of the Diagnostic Assessment

A diagnostic assessment must include ALL the following elements:

- a. description of the presenting problems, including source of distress, precipitating events, and associated problems or symptoms;
- b. chronological general health, past trauma history and behavioral health history (including both mental health and substance use including tobacco use) of the beneficiary's symptoms, treatment, and treatment response;
- c. current medications for medical, psychiatric, and substance use disorder treatment. Identify past medications that were ineffective or caused significant side effects or adverse reactions.;
- d. a review of biological, psychological, familial, social, developmental and environmental dimensions to identify strengths, needs, and risks in each area;
- e. evidence of beneficiary and legally responsible person's (if applicable) participation in the assessment;
- f. analysis and interpretation of the assessment information with an appropriate case formulation including determination of American Society of Addiction Medicine (ASAM) level of care when a substance use disorder is present;
- g. diagnosis using the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), or any subsequent editions of this reference material including mental health, substance use disorders, or intellectual or developmental disabilities, as well as physical health conditions and functional impairment;
- h. recommendations for additional assessments, services, supports or treatment based on the results of the diagnostic assessment;
- i. the diagnostic assessment must be signed and dated by the licensed professionals completing the assessment; and

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- j. evidence of an interdisciplinary team service note that documents the team’s review and discussion of the assessment. The involvement of the team in the delivery of the service is very important and is documented in the team note. Particular emphasis is made on the involvement and participation of all members of the team in the formulation of the diagnoses and treatment recommendations.

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

1.1 Definitions

1.1.1 Diagnostic

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

1.1.2 Person Centered Plan (PCP)

A process of determining real-life outcomes with individuals and developing strategies to achieve those outcomes.

2.0 Eligibility Requirements

2.1 Provisions

2.1.1 General

(The term “General” found throughout this policy applies to all Medicaid and NCHC policies)

- a. An eligible beneficiary shall be enrolled in either:
 1. the NC Medicaid Program (*Medicaid is NC Medicaid program, unless context clearly indicates otherwise*); or
 2. the NC Health Choice (*NCHC is NC Health Choice program, unless context clearly indicates otherwise*) Program on the date of service and shall meet the criteria in **Section 3.0 of this policy**.
- b. Provider(s) shall verify each Medicaid or NCHC beneficiary’s eligibility each time a service is rendered.
- c. The Medicaid beneficiary may have service restrictions due to their eligibility category that would make them ineligible for this service.
- d. Following is only one of the eligibility and other requirements for participation in the NCHC Program under GS 108A-70.21(a): Children must be between the ages of 6 through 18.

2.1.2 Specific

(The term “Specific” found throughout this policy only applies to this policy)

a. Medicaid

An applicant may be approved for Medicaid if the applicant meets all eligibility requirements. A beneficiary may become retroactively eligible for Medicaid while receiving covered services.

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A retroactively eligible beneficiary is entitled to receive Medicaid covered services and to be reimbursed by the provider for all money paid during the retroactive period except for any third-party payments or cost-sharing amounts. The qualified provider may file for reimbursement with Medicaid for these services.

Medicaid shall cover diagnostic assessment services for an eligible beneficiary who is 18 years of age and older when the criteria in **Section 3.0** of this policy is met.

b. NCHC

NCHC shall cover diagnostic assessment services for an eligible beneficiary who is 18 years of age until he or she reaches their 19th birthday when the criteria in **Section 3.0** of this policy is met. Retroactive eligibility does not apply to the NCHC program.

2.2 Special Provisions

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

a. 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:

1. that is unsafe, ineffective, or experimental or investigational.
2. 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

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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.

b. EPSDT and Prior Approval Requirements

1. 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.
2. **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/>

2.2.2 EPSDT does not apply to NCHC beneficiaries

2.2.3 Health Choice Special Provision for a Health Choice Beneficiary age 6 through 18 years of age

NC Medicaid shall deny the claim for coverage for an NCHC beneficiary who does not meet the criteria within **Section 3.0** of this policy. Only services included under the NCHC State Plan and the NC Medicaid clinical coverage policies, service definitions, or billing codes are covered for an NCHC beneficiary.

3.0 When the Procedure, Product, or Service Is Covered

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.

3.1 General Criteria Covered

Medicaid and NCHC shall cover the procedure, product, or service related to this policy when medically necessary, and:

- a. the procedure, product, or service is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the beneficiary’s needs;
- b. the procedure, product, or service can be safely furnished, and no equally effective and more conservative or less costly treatment is available statewide; and
- c. the procedure, product, or service is furnished in a manner not primarily intended for the convenience of the beneficiary, the beneficiary’s caretaker, or the provider.

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3.2 Specific Criteria Covered

3.2.1 Specific criteria covered by both Medicaid and NCHC

Medicaid and NCHC shall cover Diagnostic Assessment when the following criteria are met:

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

Continued Stay Criteria

Not applicable.

Discharge Criteria

Not applicable

3.2.2 Medicaid Additional Criteria Covered

None apply.

3.2.3 NCHC Additional Criteria Covered

None apply.

3.3 Service Type and Setting

A diagnostic assessment is a direct periodic service that can be provided in any location.

4.0 When the Procedure, Product, or Service Is Not Covered

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.

4.1 General Criteria Not Covered

Medicaid and NCHC shall not cover the procedure, product, or service related to this policy when:

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

4.2 Specific Criteria Not Covered

4.2.1 Specific Criteria Not Covered by both Medicaid and NCHC

Medicaid and NCHC shall not cover a diagnostic assessment on the same day as Assertive Community Treatment Team, Intensive In-Home, Multisystemic Therapy or Community Support Team services. If psychological testing or specialized assessments are indicated, they are covered separately using

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appropriate CPT codes for psychological, developmental, or neuropsychological testing.

For Medicaid beneficiaries this service cannot be provided in an institution for mental disease (IMD) (for adults) or in a public institution (jail, detention center).

NC Medicaid and NCHC shall not cover conversion therapy.

4.2.2 Medicaid Additional Criteria Not Covered

For a Medicaid beneficiary under the age of 21, additional products, services, or procedures may be requested even if they do not appear in the N.C. State Plan or when coverage is limited to those over 21 years of age. Service limitations on scope, amount, or frequency described in the coverage policy may not apply if the product, service, or procedure is medically necessary

4.2.3 NCHC Additional Criteria Not Covered

- a. In addition to the specific criteria not covered in **Subsection 4.2.1** of this policy, NCHC shall not cover...
- b. NCGS § 108A-70.21(b) “Except as otherwise provided for eligibility, fees, deductibles, copayments, and other cost sharing charges, health benefits coverage provided to children eligible under the Program shall be equivalent to coverage provided for dependents under North Carolina Medicaid Program except for the following:
 1. No services for long-term care.
 2. No nonemergency medical transportation.
 3. No EPSDT.
 4. Dental services shall be provided on a restricted basis in accordance with criteria adopted by the Department to implement this subsection.”

5.0 Requirements for and Limitations on Coverage

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.

5.1 Prior Approval

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

Note: A diagnostic assessment equals one event.

5.2 Prior Approval Requirements

5.2.1 General

The provider(s) shall submit to the Department of Health and Human Services (DHHS) Utilization Review Contractor the following:

- a. the prior approval request; and
- b. all health records and any other records that support the beneficiary has met the specific criteria in **Subsection 3.2** of this policy.

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5.2.2 Specific

Utilization management of covered services is a part of the assurance of medically necessary service provision. Authorization, which is an aspect of utilization management, validates approval to provide a medically necessary covered service to an eligible beneficiary.

5.3 Additional Limitations or Requirements

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

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

6.0 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:

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

6.1 Provider Qualifications and Occupational Licensing Entity Regulations

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

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

6.2 Provider Certifications

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

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

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

7.0 Additional Requirements

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.

7.1 Compliance

Provider(s) shall comply with the following in effect at the time the service is rendered:

- a. All applicable agreements, federal, state and local laws and regulations including the Health Insurance Portability and Accountability Act (HIPAA) 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).

7.2 Expected Clinical Outcomes

Results from a diagnostic assessment include an appropriate case formulation, an interpretation of the assessment information including recommendations for services, supports, treatment or additional assessments; appropriate case formulation, a service order for immediate needs; and the development of PCP. For a beneficiary with a substance-use disorder diagnosis, a diagnosis assessment must recommend the American Society of Addiction Medicine (ASAM) level of care determination.

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Policy Implementation and History
Original Effective Date: January 1, 2004

History:

Date	Section or Subsection Amended	Change
<u>XXXX</u>	<u>All Sections and Attachment(s)</u>	Currently covered Diagnostic Assessment services are removed from Attachment D of NC Medicaid CCP 8A Enhanced Mental Health and Substance Abuse Services, to a new stand-alone clinical coverage policy. ASAM criteria added as a requirement for beneficiaries with SUD diagnosis.

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Attachment A: Claims-Related Information

Provider(s) shall comply with the, *NCTracks 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 and NCHC:

A. Claim Type

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.

B. International Classification of Diseases and Related Health Problems, Tenth Revisions, Clinical Modification (ICD-10-CM) and Procedural Coding System (PCS)

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

C. Code(s)

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

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

HCPCS Code(s)
T1023

Unlisted Procedure or Service

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

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

D. Modifiers

Provider(s) shall follow applicable modifier guidelines.

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E. Billing Units

Provider(s) shall report the appropriate code(s) used which determines the billing unit(s).

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

F. Place of Service

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

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

***Note:** For Medicaid beneficiaries, this service cannot be provided in an institution for mental disease (IMD) (for adults) or in a public institution (jail, detention center).

G. Co-payments

For Medicaid refer to Medicaid State Plan:

<https://medicaid.ncdhhs.gov/get-involved/nc-health-choice-state-plan>

For NCHC refer to NCHC State Plan:

<https://medicaid.ncdhhs.gov/get-involved/nc-health-choice-state-plan>

H. Reimbursement

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

For a schedule of rates, refer to: <https://medicaid.ncdhhs.gov/>

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