Clinical Policy: Facility-Based Crisis Service for Children and Adolescents

Reference Number: WNC.CP.116
Last Review Date: 03/23

Coding Implications
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]

Facility-Based Crisis Service for children and adolescents is a service that provides an alternative to hospitalization for an eligible beneficiary who presents with escalated behavior due to a mental health, intellectual or development disability or substance use disorder and requires treatment in a 24-hour residential facility with 16 beds or less. Facility-Based Crisis Service is a direct and indirect, intensive short term, medically supervised service provided in a physically secure setting, that is available 24 hours a day, seven days a week, 365 days a year.
Children are defined as beneficiaries 6 years of age through 11. Adolescents are defined as beneficiaries 12 years of age through 17.

Facility-Based Crisis Service is considered an "Enhanced Service" under NC Medicaid Managed Care, and members who require use of this service, paired with certain diagnoses as outlined in the link below may meet eligibility and should be evaluated for transition to BH/I/DD Tailored Plan.

https://files.nc.gov/ncdhhs/BH-IDD-TP-Eligibility-Enrollment-Update-02.02.2021.pdf

Policy/Criteria[1]

I. It is the policy of WellCare of North Carolina® that Facility-Based Crisis Service for Children and Adolescents is **medically necessary** when the beneficiary meets the following criteria:

A. Initial Criteria

1. Has a Mental Health or Substance Use Disorder diagnosis or Intellectual Developmental Disability as defined by the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) or any subsequent editions of this reference material based on the designation of the facility;
2. If child's primary admitting diagnosis is substance use disorder, child meets American Society of Addiction Medicine (ASAM) Level 3.7 criteria as found in the current edition.
3. Is experiencing an acute crisis requiring short term placement due to serious cognitive, affective, behavioral, adaptive, or self-care functional deficits secondary to the DSM-5 diagnosis (es) which may include but are not limited to:
   a. danger to self or others;
   b. imminent risk of harm to self or others;

c. psychosis, mania, acute depression, severe anxiety or other active severe behavioral health symptoms impacting safety and level of age-appropriate functioning;
d. medication non-adherence;
e. intoxication or withdrawal requiring medical supervision, but not hospital detoxification;

4. Has no evidence to support that alternative interventions would be equally or more effective, based on current North Carolina community practice standards (such as Best Practice Guidelines of the American Academy of Child and Adolescent Psychiatry, American Psychiatric Association, and American Society of Addiction Medicine); **and**
5. The beneficiary has been determined to have no acute medical/psychiatric condition that requires a more intensive level of medical/psychiatric monitoring and treatment.

B. Continued Service Criteria
1. The desired outcome or level of functioning has not been restored, improved, or sustained over the timeframe outlined in the beneficiary's service plan or the beneficiary continues to be at risk for relapse based on history or the tenuous nature of the functional gains **or ANY** of the following applies:
a. beneficiary has achieved initial service plan goals and additional goals are indicated;
b. beneficiary is making satisfactory progress toward meeting goals;
c. beneficiary is making some progress, but the service plan (specific interventions) needs to be modified so that greater gains which are consistent with the beneficiary's pre-crisis level of functioning are possible or can be achieved;
d. beneficiary is not making progress; the service plan must be modified to identify more effective interventions;
e. beneficiary is regressing; the service plan must be modified to identify more effective interventions; **or**
f. beneficiary is not improving, remains appropriate for the listed level of care, and would not be better served at an inpatient level of care

C. Discharge Criteria
1. The beneficiary meets the criteria for discharge if one of the following applies:
a. the beneficiary has improved with respect to the goals outlined in the service plan and:
i. goals have been achieved **or**
ii. the child has regained pre-crisis level of functioning **AND**
iii. discharge to a lower level of care is indicated.
b. the beneficiary is:
i. not benefiting from treatment; **or**
ii. not making progress in treatment; **or**
iii. is regressing **AND**
iv. all realistic treatment options for this modality have been exhausted.

D. Exception

Per General Statutes 122C-261(f), 122C-262(d), and 122C 263(d)(2), if an individual with mental retardation and a co-occurring mental illness is determined to need hospitalization, arrangements must be made for an inpatient admission to a non-state hospital in collaboration with WellCare of NC. All requests for an exception are determined by the Director of the Division of MH/DD/SAS or Designee. In general, Facility Based Crisis Services should not exceed 45 days in a 12-month period, unless the member meets EPSDT criteria for additional service

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

II. It is the policy of WellCare of North Carolina® that Facility-Based Crisis Service for Children and Adolescents is **not medically necessary** when the beneficiary:

A. Is an inmate in a public correctional institution; **or**
B. Is in a facility with more than 16 beds classified as an institution for mental diseases (IMD); **or**
C. Is a child or adolescent stepping down from an inpatient level of care.

Background[1]

Under the direction of a psychiatrist, this service provides assessment and short-term therapeutic interventions designed to prevent hospitalization by de-escalating and stabilizing acute responses to crisis situations.

The Facility-Based Crisis Service includes professionals with expertise in assessing and treating mental health and substance use disorders and intellectual or developmental disabilities. The service must address the age, behavior, and developmental functioning of each beneficiary to ensure safety, health and appropriate treatment interventions.

The facility **must** ensure the physical separation of children from adolescents by living quarters, common areas, and in treatment. This separation may be accomplished by providing physically separate sleeping areas and by the use of treatment areas and common areas, i.e., dining room, dayroom, and in- and outside recreation areas, if age groups are scheduled at different times. If adults (18 years of age and older) and children and adolescents are receiving services in the same building, the facility must ensure complete physical separation between adults and children/adolescents.

I. Facility-Based Crisis Service components include:

A. Assessments and evaluation of the condition(s) that has resulted in acute psychiatric symptoms, disruptive or dangerous behaviors, or intoxication from alcohol or drugs;
B. Intensive treatment, behavior management support and interventions, detoxification protocols as addressed in the beneficiary's treatment plan;
C. Assessments and treatment service planning that address each of the beneficiary's primary presenting diagnoses if the child is dually diagnosed with mental health and

substance abuse disorders or mental health or substance abuse with a co-occurring intellectual developmental disability, with joint participation of staff with expertise and experience in each area;

D. Active engagement of the family, caregiver or legally responsible person, and significant others involved in the child's life, in crisis stabilization, treatment interventions, and discharge planning as evidenced by participation in team meetings, collaboration with staff in developing effective interventions, providing support for and input into discharge and aftercare plans;
E. Stabilization of the immediate presenting issues, behaviors or symptoms that have resulted in the need for crisis intervention or detoxification;
F. Monitoring of the beneficiary's medical condition and response to the treatment protocol to ensure the safety of the beneficiary; **and**
G. Discharge planning.

1. Discharge planning begins at admission and shall include the beneficiary, legally responsible person and WellCare of NC or delegated behavioral health care manager.
2. Discharge planning includes the following:
    a. arranging for linkage to new or existing community-based services that will provide further assessment, treatment, habilitation or rehabilitation upon discharge from the Facility-Based Crisis service;
    b. coordination of aftercare with other involved providers, including the child's Primary Care Practitioner and any involved specialist for ongoing care of identified medical condition;
    c. contact for re-entry planning purposes with the child's school or local school or Local Educational Authority as indicated;
    d. arranging for linkage to a higher level of care as medically necessary;
    e. identifying, linking to, and collaborating with informal and natural supports in the community; **and**
    f. developing or revising the crisis plan to assist the beneficiary and their supports in preventing and managing future crisis events.

II. Prior authorization is required for all units of Facility Based Crisis Services for Children and Adolescents. A service order is required on the date of admission. A verbal order is acceptable; it must be received by a Registered Nurse and must be signed within 2 business days. The service order must be completed by a physician, licensed psychologist, physician assistant, or nurse practitioner according to his or her scope of practice and must include a statement indicating that the service is medically necessary. The service order must be based on an individualized assessment of the beneficiary's needs. The following assessments and evaluations are **required**:

A. A pre-admission nursing screen conducted by a Registered Nurse or Licensed Practical Nurse under the supervision of a registered nurse to determine medical appropriateness for this level of a care to rule out acute or severe chronic comorbidities or medical conditions, such as brittle diabetes, pending birth of a child, uncontrolled seizures, that require or could potentially require complex medical intervention in a higher level of care.

B. Following admission, the RN must be complete a nursing assessment within 24 hours of admission to follow up on any medical needs identified in the screen that did not preclude admission to the facility.
C. An onsite psychiatric evaluation must be completed in-person or via telehealth by the psychiatrist within 24 hours of admission.
D. A clinical assessment at the time of admission to include:
    1. The beneficiary's presenting problem(s);
    2. The beneficiary's needs and strengths;
    3. A provisional or admitting diagnosis(es), with an established diagnosis(es) prior to discharge;
    4. A pertinent social, family, and medical history; **and**
    5. Recommendations for other evaluations or assessments as appropriate.
E. A comprehensive clinical assessment (CCA) documenting medical necessity must be completed by a licensed professional prior to discharge as part of the provision of this service. The CCA must be in compliance with the requirements of Clinical Coverage Policy *WNC.CP.117 Outpatient Behavioral Health Services Provided by Direct-enrolled Providers* and also address the following:
    1. Screening for trauma exposure and symptoms related to that exposure and recommendations for interventions;
    2. Detailed assessment of the presenting problem(s), including input from other licensed professionals if the child is dually diagnosed;
    3. Review of any available prior assessments, including functional behavior analyses; **and**
    4. Recommendations for any needed community services or supports to prevent future crises.

Note: If a substantially equivalent assessment is available, reflects the current level of functioning, and contains all the required elements as outlined in community practice standards as well as in all applicable federal, state, and DHHS requirements, it may be utilized as a part of the current comprehensive clinical assessment and in the development of the clinical assessment required upon admission.

At a minimum, the licensed professional, in coordination with all other appropriate clinical staff, the nursing staff, beneficiary, and the legally responsible person shall develop a treatment plan and a crisis plan to direct treatment and interventions during the admission. During the course of the Facility Based Crisis admission, the treatment plan must be modified as clinically indicated.

The Facility-Based Crisis Service provider shall contact WellCare of NC to determine if the member is currently enrolled with another service provider agency that has first responder responsibilities or if the beneficiary is receiving care management. If the beneficiary is not already linked with a care manager, facility-based crisis staff is expected to make a referral to the appropriate entity (WellCare of NC, the member's AMH/CIN, or LHD in the case of a child eligible for CMARC services) within 24 hours of admission into Facility Based Crisis Service.

Relevant diagnostic information must be obtained and included in the beneficiary's service plan.

III. Expected Clinical Outcomes for this service are specific to recommendations resulting from the child's clinical assessment and to meeting the identified goals that assist the beneficiary and his or her supports in:

A. Reduction of acute psychiatric symptoms that precipitated the need for this service;
B. Reduction of acute effects of substance use disorders with enhanced motivation for treatment or relapse prevention;
C. Stabilizing or managing the crisis situation;
D. Preventing hospitalization or other institutionalization;
E. Accessing services as indicated in the comprehensive clinical assessment; **and**
F. Reduction of behaviors that led to the crisis.

IV. Documentation Requirements include, at a minimum:

A. A full service note per shift by the nursing staff and a full service note per intervention (e.g., individual counseling, group, discharge planning) per date of service, written, dated, and signed by the person(s) who provided the service.
B. Documentation should reflect progress made in relation to the discharge plans or service plan for the beneficiary.
C. Each full-service note must contain:
    1. Member's name;
    2. Member's unique identifier (date of birth, member ID, etc.)
    3. Service provided (such as Facility-Based Crisis Service);
    4. Date of service;
    5. Type of contact (in-person, telehealth, telephone call, collateral);
    6. Purpose of the contact;
    7. Description of the provider's interventions, specifying the relationship of the intervention to the problems and goal(s) identified in the treatment plan;
    8. Amount of time spent performing the interventions;
    9. Description of the effectiveness of the interventions; **and**
    10. Signature and credentials of the staff member(s) providing the service (for paraprofessionals, position is required in lieu of credentials with staff signature).
D. Additional Documentation Requirements
    1. A treatment plan that includes the goal(s), objectives, treatment interventions and the individual responsible for carrying out the intervention;
    2. A discharge plan that includes the identification of the beneficiary's responsible person; the date, time and location of first follow up appointment, diagnosis and discharge medications; living and educational or vocational arrangements;
    3. An after-care plan that addresses the beneficiary's current treatment and care coordination needs and specifies the behavioral health services to be provided, the service provider's name, address and contact information and the child's primary care physician's name, contact and follow up visit(s), where indicated;

4. A crisis plan developed in partnership with the member, their legally responsible person, and the community-based treatment provider if one exists, that includes informal and formal supports and interventions to divert any readmission into a crisis setting; **and**
5. Documentation of the psychiatric, psychological, comprehensive clinical, and nursing assessments must be documented in the service record no later than 24 hours from the time the assessment was conducted.

V. Staffing Requirements

A. The **facility** shall be staffed at a **minimum** of:

1. 0.5 FTE Medical Director who is a board-eligible or board-certified Child Psychiatrist unless an exception request is granted. The exception request, with accompanying updated justification, must be requested on an annual basis. A psychiatrist shall be available 24 hours a day, 7 days a week, 365 days a year (this includes the required on-call availability). The psychiatrist shall provide clinical oversight of the Facility-Based Crisis Service. The psychiatrist shall conduct a psychiatric assessment of the member in-person or via telehealth within 24 hours of admission. The psychiatrist shall provide consultation to and supervision of staff; this supervision must be available onsite whenever needed and must occur onsite no less than one day per week, averaged over each quarter. When providing evaluation and management services to members, the psychiatrist may bill additional psychiatric evaluations (excluding the initial evaluation) and other therapeutic services separately.
2. 0.5 FTE Licensed Practicing Psychologist with a minimum of two years' experience in the treatment of children and adolescents with Intellectual/Developmental Disabilities. The psychologist must provide onsite behavioral assessment, observation and service planning within 24 hours of admission for a member with IDD. The psychologist must be available for face-to-face in person consultation with staff. The psychologist will also be responsible for conducting other assessments with a member presenting with mental health or substance use issues as clinically indicated.
3. Nursing coverage on site 24 hours a day, 7 days a week, 365 days a year must include a Registered Nurse with a minimum of one-year crisis service experience with the population to be served. All nursing staff must actively participate in the provision of treatment, monitor the member's medical progress, and provide medication administration.
4. One FTE Licensed Professional(s) with a minimum of two years' experience with the population served (at least one year postgraduate) who possesses the knowledge, skills, and abilities to treat co-occurring mental health and substance use disorders; who provides onsite observation, assessment and actively participates in the provision of treatment of individuals with mental health and substance use disorders. The Licensed Professional, with the psychiatrist, provides clinical supervision for the program. This position cannot be filled by more than two professionals; **OR**

   0.5 Licensed Professional with a minimum of two years' experience with the population served (at least one year postgraduate) who possesses the knowledge, skills, and abilities to treat persons with mental health disorders and who provides onsite observation, assessment and actively participates in the provision of treatment, and with the psychiatrist, provides clinical supervision for the program; **and**

0.5 Licensed Professional with a minimum of two years' experience with the population served (at least one year postgraduate) who possesses the knowledge, skills, and abilities to treat substance use disorders, who provides onsite observation and assessment, and who actively participates in the provision of treatment, and with the psychiatrist, provides clinical supervision for the program.
Note: A "Licensed Professional" includes both a fully Licensed Professional as well as an Associate Licensed Professional who meet the experience and knowledge, skills and abilities to assess and treat the population served in the Facility Based Crisis Child setting.

5. Additional staff including Licensed Professionals, Licensed Practical Nurse, Qualified Professionals, Associate Professional or Paraprofessionals with disability-specific knowledge, skills, and abilities as required by the age, disability and acuity of the population being served.

B. The facility-based **crisis** shall also meet the following staffing provisions:

6. The Facility Based Crisis Service provider shall designate an individual who is responsible for the programmatic operations of the facility.
7. As a facility designated for the custody and treatment of involuntary patients, the facility must have adequate staffing and provide supervision to ensure the protection of the member to be served. To be designated, the Facility Based Crisis service must demonstrate:
   a. adequacy of staff capability to manage more violent or aggressive patients;
   b. adequacy of security procedures including elopement and suicide prevention procedures;
   c. staff training in de-escalation to avoid the use of seclusion and restraint and training in seclusion and restraint policies and procedures;
   d. capacity to increase staffing levels when indicated by the acuity and number of patients being served; **and**
   e. appropriate separation of children and adolescents and adequate supervision of vulnerable patients.
8. A Facility-Based Crisis must be staffed 24 hours a day and must maintain staffing ratios that ensure the treatment, health and safety of patients served in the facility that includes:
   a. a licensed professional, in addition to the Registered Nurse, must be available 24 hours a day, 7 days a week for admissions;
   b. awake staff-to-patient ratio of no less than 1:3 on premises at all times;
   c. a minimum of two awake staff on premises at all times; **and**
   d. the capacity to bring additional staff on site to provide more intensive supervision, treatment, or management in response to the needs of individual patients.
9. At no time when a Facility-Based Crisis staff member is actively fulfilling his or her Facility-Based Crisis Service role may he or she contribute to the staffing ratio required for another service.
10. Therapeutic interventions are implemented by staff under the direction of a Licensed Professional.
11. At least one Licensed Professional providing Facility-Based Crisis Service shall demonstrate competencies in crisis response and crisis prevention. At a minimum, the licensed professional shall have a minimum of one year's experience in a crisis

management setting or service, during which the individual provided crisis response (e.g., serving as a Mental Health or Substance Use Disorder first responder for enhanced services, in an emergency department, or in another service providing 24 hours a day, 7 days a week response in emergent or urgent situations).

12. All staff providing Facility-Based Crisis Service shall complete a minimum of 20 hours of training specific to the required components of the Facility-Based Crisis Service definition, including crisis intervention strategies applicable to the populations served, impact of trauma and Person-Centered Thinking, within the first 90 calendar days of each staff member's initial delivery of this service. All staff providing Facility-Based Crisis Service shall complete a minimum of 10 hours of training per year relevant to their professional discipline and job responsibilities. These trainings could include de-escalation, seclusion and restraints, developmental disorders, children's development, substance use disorders, family systems, etc.

VI. Service Requirements

A. A Facility-Based Crisis Service is a 24-hour service that is offered seven days a week. This service must accept admissions on 24 hours a day, 7 days a week, and 365 days a year basis. The staff to patient ratio must ensure the treatment, health and safety of patients served in the facility and comply with 10A NCAC 27E .0104 Seclusion, Physical Restraint and Isolation Time Out and Protective Devices Used for Behavioral Control. A Facility-Based Crisis Service provider shall meet the criteria and be designated as a facility for the custody and treatment of involuntary clients under 10A NCAC 26C .0100. The service must be provided in a facility which meets the criteria for and is licensed under 10A NCAC 27G.5000

B. Due to the high levels of exposure to trauma and toxic stress, the Facility-Based Crisis Service staff shall create a sense of psychological and physical safety through:
   1. Training of staff in behavior management techniques and trauma informed care;
   2. Programming that creates routines of predictability and calm; **and**
   3. Screening for exposure to traumatic events and any symptoms related to that exposure.

C. The member shall be seen by the psychiatrist in-person or via telehealth within 24 hours of their admission to the Facility-Based Crisis Service. The member shall receive a nursing assessment by the RN as follow up to the pre-admission screen and a full comprehensive clinical assessment by a licensed professional prior to discharge. A member with Intellectual or Developmental Disabilities shall be seen by the psychologist on site within 24 hours of their admission to the Facility-Based Crisis Service.

D. The service must be under the supervision of a psychiatrist, and a psychiatrist shall be on call on a 24-hour per day basis.

E. The Facility Based Crisis Service must address the chronological age and developmental functioning of the population served to ensure safety, health and appropriate treatment interventions within the program milieu.

F. Interventions should be related to goals of crisis stabilization and connecting patients and families to effective services in the community.

G. When medically necessary, the Facility Based Crisis Service must make a referral to a service providing an appropriate level of care if the member's needs exceed the service capabilities.

H. All staff who provide substance use disorder treatment interventions shall be registered with the North Carolina Substance Abuse Professional Practice Board in accordance with the North Carolina Practice Act (G.S. 90-113.30).

I. For a beneficiary requiring detoxification, the Facility-Based Crisis Service must have procedures and protocols in place to initiate detoxification. When a higher level of detoxification is medically necessary, the Facility-Based Crisis Service must make a referral to a facility licensed (e.g., inpatient hospital) to provide detoxification in accordance with the American Society of Addiction Medicine (ASAM) criteria.

J. For a beneficiary who is new to the enhanced Mental Health, Developmental Disabilities, Substance Abuse (MH/DD/SAS) service delivery system, Facility-Based Crisis Service staff shall develop an aftercare plan that includes a detailed crisis plan with the member and his or her family, caregiver or legally responsible person before discharge. For a member who is currently enrolled in another enhanced service, the Facility-Based Crisis Service staff must work in partnership with the Qualified Professional responsible for the plan to recommend the needed revisions to the crisis plan component of the Person-Centered Plan. A copy of the Crisis Plan must be submitted to WellCare of NC. A copy of the plan must also be submitted to all providers, as approved by the parents or guardians involved in the implementation of the plan.

K. For each beneficiary, effective discharge planning must include collaboration with the family, caregiver or legally responsible person, their informal and natural supports and WellCare of NC, as well as other agencies involved (such as schools, Social Services, Juvenile Justice, other treatment providers) as appropriate. For a member who is engaged in receiving services from another community-based provider, the Facility-Based Crisis Service must involve the community-based provider in treatment, discharge planning, and aftercare.

VII. Place of Service:
A Facility-Based Crisis Service must be provided in a facility licensed by DHSR under 122C NCGA that is available at all times, 24 hours a day, 7 days a week, and 365 days a year. A Facility-Based Crisis Service provider must meet the criteria for and be designated as a facility for the custody and treatment of involuntary clients under 10A NCAC 26C .0100.

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 2022 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.

CPT®* Codes	Description
No applicable codes.	

HCPCS ®* Codes	Description	Telehealth Eligible	Billing Unit
S9484 HA	Crisis intervention mental health services, per hour	No	Units are billed in one-hour increments. Provider may bill up to 24 units per day, and bill for units of service provided on day of discharge

Provider(s) shall follow applicable modifier guidelines. The HA modifier is used with HCPCS code S9484 as noted above. HA indicates a child/adolescent program.

Note: As specified within this policy, components of this service may be provided via telehealth by the psychiatrist. Due to this service containing other elements that are not permitted via telehealth, the GT modifier is not appended to the HCPCS code to indicate that a service component has been provided via telehealth.

ICD-10-CM Diagnosis Codes that Support Coverage Criteria
+ Indicates a code(s) requiring an additional character

ICD-10-CM Code	Description
No applicable codes.	

Reviews, Revisions, and Approvals	Reviewed Date	Approval Date
Original approval date	01/21	05/21
Revised criteria I.E., to "45 days in a 12-month period." Added criteria I.F. regarding Telehealth Services. Added "in-person or via telehealth" to Background II.C. Deleted "face-to-face" and added "in-person, telehealth" to Background IV.C.5. Revised psychiatrist staffing requirements in Background V.A. Deleted "on-site" and added "in-person or via telehealth" to Background VI.C. Added modifier and Telehealth Eligible column to HCPCS code grid. Added note with explanation of non-use of GT modifier.	08/21	11/21
Revised Background II.A. (added LPN) and Background IV.B.3.a. (removed “on-site”)	06/22	08/22
Annual Review. NCHC verbiage removed from NC Guidance Verbiage. Criteria I.A.2. verbiage rearranged with no effect on criteria. Criteria I.E., rephrased to, “In general, Facility Based Crisis Services should not exceed 45 days in a 12-month period, unless the member meets EPSDT criteria for additional service.” Background II.E. added	03/23	

Reviews, Revisions, and Approvals	Reviewed Date	Approval Date
Policy name WNC.CP.117 Outpatient Behavioral Health Services Provided by Direct-enrolled Providers, Background II.E. Note 3rd paragraph, added "is not already linked with a care manager, facility-based crisis staff is expected to make a referral to the appropriate entity (WellCare of NC, the member's AMH/CIN, or LHD in the case of a child eligible for CMARC services) within 24 hours of admission into Facility Based Crisis Service." Background II.E. Note 4th added, "Relevant diagnostic information must be obtained and included in the beneficiary's service plan." Background V.A.1. added "unless an exception request is granted," AND Deleted, "If a provider is unable to hire a board-eligible or board-certified Child Psychiatrist, the provider must seek an exception, with justification, from the PIHP. Background VI. Service Requirements, Added "The service must be provided in a facility which meets the criteria for and is licensed under 10A NCAC 27G.5000." Background VII. Place of Service, Added, "A Facility-Based Crisis Service must be provided in a facility licensed by DHSR under 122C NCGA that is available at all times, 24 hours a day, 7 days a week, and 365 days a year. A Facility-Based Crisis Service provider must meet the criteria for and be designated as a facility for the custody and treatment of involuntary clients under 10A NCAC 26C .0100."		

References

1. State of North Carolina Medicaid. Medicaid and Health Choice Clinical Coverage Policy No: 8A-2 Facility-Based Crisis Service for Children and Adolescents. Program Specific Clinical Coverage Policies | NC Medicaid (ncdhhs.gov) Published May 15, 2022. Accessed March 8, 2023.

North Carolina Guidance

Eligibility Requirements

a. An eligible beneficiary shall be enrolled in the NC Medicaid Program (Medicaid is NC Medicaid program, unless context clearly indicates otherwise);
b. Provider(s) shall verify each Medicaid 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.

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 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

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/

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 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.

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:

a. 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.
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.
   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 - Providers shall follow applicable modifier guidelines.
e. Billing Units - Provider(s) shall report the appropriate code(s) used which determines the billing unit(s).

f. Co-payments -
For Medicaid refer to Medicaid State Plan:
https://medicaid.ncdhhs.gov/get-involved/nc-health-choice-state-plan

g. 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.