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

Reference Number: WNC.CP.117
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.

Related Clinical Coverage Policies

Refer to Program Specific Clinical Coverage Policies | NC Medicaid (ncdhhs.gov).for the related coverage policies listed below:
1-H, Telehealth, Virtual Communications, and Remote Patient Monitoring
1A-38, Special Services: After Hours
8A, Enhanced Mental Health and Substance Abuse Services
8A-1, Assertive Community Treatment (ACT) Program
8J, Children's Developmental Services Agencies (CDSAs)_

Description[1]

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

Outpatient services for substance use disorders (SUD) are for beneficiaries assessed as meeting, at minimum, the American Society of Addiction Medicine (ASAM) level of 0.5 (Early Intervention) or 1.0 (Outpatient Services). Services include psychiatric and comprehensive clinical assessments, medication management, individual, group and family therapies, psychotherapy for crisis, psychological testing, and Screening, Brief Intervention, Referral, and Treatment (SBIRT).

These services are intended to determine a member's treatment needs, and to provide the necessary treatment. Services focus on reducing psychiatric and behavioral symptoms in order to improve the member's functioning in familial, social, educational, or occupational life domains. Outpatient behavioral health services often involve the participation of family members, natural supports, and legally responsible person(s) as applicable, unless contraindicated.

The beneficiary's needs and preferences are based on collaboration between the practitioner and beneficiary to determine treatment goals, frequency and duration of services and measurable and desirable outcomes.

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Policy/Criteria[1]

I. It is the policy of WellCare of North Carolina® that Outpatient Behavioral Health Services are **medically necessary** based on the following criteria:

A. **Entrance Criteria** - **All** of the following criteria are necessary for admission of a member to outpatient treatment services:
   1. A Current Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition [(DSM-5) or any subsequent editions of this reference material] diagnosis;
   2. The beneficiary presents behavioral, psychological, or biological dysfunction and functional impairment, which are consistent and associated with the DSM-5 diagnosis;
   3. If a higher level of care is indicated but unavailable or the beneficiary is refusing the service, outpatient services may be provided until the appropriate level of care is available or to support the beneficiary to participate in that higher level of care;
   4. The beneficiary is capable of developing skills to manage symptoms, make behavioral changes, and respond favorably to therapeutic interventions; **and**
   5. There is no evidence to support that alternative interventions would be more effective, based on North Carolina community practice standards (e.g., Best Practice Guidelines of the American Academy of Child and Adolescent Psychiatry, American Psychiatric Association, American Board of Addiction Medicine).

B. **Continued Service Criteria** - The criteria for continued service **must** meet both “1.” and “2.” below:
   1. Any **ONE** of the following criteria:
      a. the desired outcome or level of functioning has not been restored, improved, or sustained over the timeframe outlined in the member’s treatment plan;
      b. the member continues to be at risk for relapse based on current clinical assessment, and history: **or**
      c. tenuous nature of the functional gains;
   2. Any **ONE** of the following criteria (in addition to “1.”)
      a. the member has achieved current treatment plan goals, and additional goals are indicated as evidenced by documented symptoms; **or**
      b. the member is making satisfactory progress toward meeting goals and there is documentation that supports that continuation of this service is expected to be effective in addressing the goals outlined in the treatment plan.

C. **Discharge Criteria** - Any **ONE** of the following criteria must be met:
   1. The member’s level of functioning has improved with respect to the goals outlined in the treatment plan;
   2. The member or legally responsible person no longer wishes to receive these services; **or**
   3. The member, based on presentation and failure to show improvement, despite modifications in the treatment plan, requires a more appropriate best practice or evidence-based treatment modality based on North Carolina community practice standards (for example, National Institute of Drug Abuse, American Psychiatric Association).

D. **Psychological Testing Criteria** - **ALL** of the following criteria are necessary entrance criteria for psychological testing services:

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1. A current DSM-5, or any subsequent editions of this reference material, diagnosis or suspicion of such a diagnosis for which testing is being requested;
2. The member presents with behavioral, psychological, or biological dysfunction and functional impairment, which are consistent and associated with the DSM-5 or any subsequent editions of this reference material diagnosis;
3. The member is capable of responding and engaging in psychological testing; **and**
4. There is no evidence to support that alternative tests would be more effective, based on North Carolina community practice standards (e.g., American Psychological Association).

E. **Psychotherapy for Crisis Criteria**
   1. Only covered when the member is experiencing an immediate, potentially life-threatening, complex crisis situation.
   2. The service must be provided in an outpatient therapy setting.
   3. The member must be experiencing at least **ONE** of the following, supported by session documentation:
      a. ideation, intent, and plan for harm to oneself or others; **or**
      b. active psychosis possibly requiring immediate stabilization to ensure safety of self or others.

F. **Screening, Brief Intervention, and Referral to Treatment (SBIRT)** SBIRT is an ASAM level 0.5 early intervention approach for a beneficiary with nondependent substance use to effectively help them before more extensive or specialized treatment is needed. SBIRT is a comprehensive, integrated, public health approach to the delivery of early intervention and treatment services for beneficiaries with substance use disorders, as well as those who are at risk of developing these disorders. Provider shall use a standardized screening tool, such as the Alcohol Use Disorders Identification Test (AUDIT), Drug Abuse Screening Test (DAST-10), or Screening to Brief Intervention (S2BI) tool.

   Universal screening helps identify the appropriate level of services needed based on the risk level and determine if the beneficiary would benefit from brief intervention or referral to treatment services.

   SBIRT services can be provided in a variety of settings by professionals included in Section 6.0, to systematically screen and assist beneficiaries who may not seek assistance for substance use problems. SBIRT services can:
   1. reduce health care costs;
   2. decrease the severity of drug and alcohol use;
   3. reduce the risk of physical trauma; and
   4. reduce the percent of beneficiaries who go without specialized treatment.

G. **Telephonic-Specific Criteria**
   1. Providers shall ensure that services can be safely and effectively delivered using telephonic, audio-only communication;
   2. Providers shall consider a member’s behavioral, physical and cognitive abilities to participate in services provided using telephonic, audio-only communication;
   3. The member’s safety must be carefully considered for the complexity of the services provided;

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4. In situations where a caregiver or facilitator is necessary to assist with the delivery of services via telehealth, their ability to assist and their safety should also be considered;
5. Delivery of services using telephonic, audio-only communication must conform to professional standards of care including but not limited to ethical practice, scope of practice, and other relevant federal, state and institutional policies and requirements including Practice Act and Licensing Board rules;
6. Providers shall obtain and document verbal or written consent. In extenuating circumstances when consent is unable to be obtained, this should be documented;
7. Providers shall verify the member's identity using two points of identification before initiating a telephonic, audio-only encounter; **and**
8. Providers shall ensure that member privacy and confidentiality is protected.

II. It is the policy of WellCare of North Carolina® that Outpatient Behavioral Health Services Provided by Direct-Enrolled Providers is **not medically necessary** for the following:

A. Outpatient Behavioral Health
1. Sleep therapy for psychiatric disorders;
2. When services are not provided in-person or in accordance with information below;
3. When a member presents with a medical, cognitive, intellectual or development issue that would not benefit from outpatient treatment services;
4. When the focus of treatment does not address the symptoms of the diagnosis;
5. When the requirements and limitations below are not followed; **and**
6. When Psychotherapy for Crisis codes are billed, the same provider shall not bill Special Services: After Hours codes.

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

C. Psychotherapy for Crisis
1. If the focus of treatment does not address the symptoms of the current DSM-5 diagnosis or related symptoms;
2. When services are not provided in-person or in accordance with the information below;
3. For routine psychotherapy not meeting medical necessity criteria outlined above;
4. In emergency departments, inpatient settings, or facility-based crisis settings.
5. If the member presents with a medical, cognitive, intellectual or development issue that would not benefit from outpatient treatment services; **and**
6. When the requirements and limitations below are not followed.

Background[1]

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I. Definitions

A. Psychological Testing

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

B. Psychotherapy for Crisis

1. On rare occasions, licensed outpatient service providers are presented with individuals in crisis situations which may require unplanned extended services to manage the crisis in the office with the goal of averting more restrictive levels of care. Licensed professionals may use the "Psychotherapy for Crisis" CPT codes only in those extreme situations in which an unforeseen crisis situation arises and additional time is required to manage the crisis event.
2. A crisis is defined as an acute disturbance of thought, mood, behavior or social relationships that requires an immediate intervention, and which, if untreated, may lead to harm to the individual or to others or have the potential to rapidly result in a catastrophic outcome. The goal of Psychotherapy for Crisis is stabilization, mobilization of resources, and minimization of further psychological trauma. Psychotherapy for crisis services are restricted to outpatient crisis assessment, stabilization, and disposition for acute, life-threatening situations.

II. Utilization Management and Additional Limitations

A. WellCare of North Carolina shall not require prior approval for up to 20 visits of Outpatient Behavioral Health services per fiscal year, after which prior approval will be required.. Refer to Background Section F, below, for limitations.

B. Prior authorization is not a guarantee of claim payment.

Note: Providers can seek prior approval if they are unsure the beneficiary has reached their unmanaged visit limit.

D. The member may receive an unlimited number of visits.

E. 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.

1. Services are based upon a finding of medical necessity, must be directly related to the beneficiary's diagnostic and clinical needs, and are expected to achieve the specific rehabilitative goals detailed in the beneficiary's service plan. Medical necessity is determined by North Carolina community practice standards, by 10A NCAC 25A .0201, and as verified by the Cherokee Indian Hospital Authority (CIHA), PIHP, PHP, or utilization management contractor who evaluates the request to determine if medical necessity supports intensive services.
2. Medically necessary services are authorized in the most cost-effective modes, if the treatment that is made available is similarly effective as services requested by the beneficiary's physician, therapist, or another licensed practitioner. The medically

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necessary service must be recognized as an accepted method of medical practice or treatment.

3. To request an authorization after the unmanaged units have been used, the Comprehensive Clinical Assessment (CCA) or Diagnostic Assessment (DA), service order for medical necessity, the treatment plan or Person-Centered Plan (PCP), and the required NC Medicaid authorization request form must be submitted to WellCare utilization management contractor prior to the unmanaged units ending. Refer to Subsection 7.3.3.Background IV.E.4.
4. Medicaid Beneficiaries under the Age of 21 –
   a. Outpatient Behavioral Health Services have 20 unmanaged outpatient visits per state fiscal year (inclusive of assessment & therapy codes).
   b. To ensure timely authorization, requests must be submitted prior to the 19th visit.
5. Medicaid Beneficiaries Ages 21 and Over
   a. Outpatient Behavioral Health Services have 20 unmanaged outpatient visits per state fiscal year (inclusive of assessment and therapy codes).
   b. To ensure timely authorization, requests must be submitted prior to the 19th visit.
6. Authorization for multiple providers for the same service - If clinically appropriate, providers may submit the same authorization request for up to three Medicaid Provider Numbers (MPNs) in one billing practice. All attending MPNs listed may be authorized for identical service codes, frequencies, and durations if the service request is deemed medically necessary.
7. Psychological testing prior approval requirements Refer to Background IV.J. for psychological testing prior approval requirements.

F. **Requirements For All WellCare of North Carolina Members**.
1. A written service order by a Physician, Licensed Psychologist (doctorate level), Nurse Practitioner (NP) or physician assistant (PA) is required for Associate Level Professionals prior to or on the first date of treatment (excluding the initial assessment)
2. Services provided by the licensed professionals listed below, other than the Associate Level Professionals, do not require a separate written service order. These licensed professionals shall document the service or services they are providing, document the medical necessity of the service(s) being provided, and this documentation shall be signed by the licensed professional providing the service. The service order shall be signed prior to or on the first date of treatment (excluding the initial assessment).
3. If an urgent or emergent situation presents the need for a verbal service order, basic procedures must be followed for the verbal service order to be valid. Treatment may proceed based on a verbal service order by the appropriate professional as long as the verbal service order is documented in a beneficiary's service record on the date that the verbal service order is given. The documentation must specify the date of the verbal service order, who gave the order, who received the order, and identify each distinct service that was ordered. The documentation should reflect why a verbal service order was obtained in lieu of a written service order. The appropriate

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professional must countersign the service order with a dated signature within seventy-two (72) hours of the date of the verbal service order.

G. **Psychological Testing**

1. Unmanaged coverage is limited to eight (8) hours of service per state fiscal year for Psychological Testing services. Prior approval is required for services that will exceed the unmanaged limit. Prior approval assures medical necessity and authorizes the number of hours necessary to complete the psychological testing.
2. The appropriate allowed Psychological Testing CPT code(s) shall be utilized.
3. Billing for performing the Psychological Testing must occur only on a date(s) when the member is seen in-person. However, allowed Psychological Testing activities may occur on other dates when the member is not seen in-person and be billed utilizing the appropriate Psychological Testing CPT code(s).

III. Limitations or Requirements

A. WellCare of NC shall not allow the same services provided by the same or different attending provider on the same day for the same member.
B. Only one psychiatric CPT code from this policy is allowed per member per day of service from the same attending provider.
C. Only two psychiatric CPT codes from this policy are allowed per member per date of service. These codes must be provided by two different attending providers.
D. Family therapy must be billed **once** per date of service for the identified family member only. No separate billing for participating member(s) of the therapy session, other than the identified family member, is permissible.
E. If Psychotherapy for Crisis is billed, no other outpatient therapy services can be billed on that same day for that beneficiary
F. A Psychiatric Diagnostic Interview is not allowed on the same day as Psychological Testing when provided by the same provider.
G. There is a limit of **8** units (hours) of Psychological Testing allowed to be billed per date of service.
H. For substance use disorders, ASAM level 1 outpatient services are provided for less than nine hours a week for adults and less than six (6) hours a week for adolescents.
I. Outpatient Medication Management and Outpatient Psychiatric Services cannot be billed while a beneficiary is authorized to receive Assertive Community Treatment.
J. Individual, Group, or Family Outpatient services cannot be billed while a beneficiary is authorized to receive:
    1. Assertive Community Treatment (ACT);
    2. Intensive In-Home (IIH);
    3. Multisystemic Therapy (MST);
    4. Day Treatment;
    5. Substance Abuse Intensive Outpatient (SAIOP); or
    6. Substance Abuse Comprehensive Outpatient Treatment (SACOT).
K. All Outpatient Behavioral Health services provided to a member may be self-referred or referred by some other source. If the member is not self-referred, the referral must be documented in the health record.

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L. To be eligible to bill for the procedure, product, or service related to this policy, the provider(s) shall:
   1. meet Medicaid qualifications for participation;
   2. have a current and signed Department of Health and Human Services (DHHS) Provider Administrative Participation Agreement, or be credentialed and contracted by the Cherokee Indian Hospital Authority; and
   3. bill only for procedures, products, and services that are within the scope of their clinical practice, as defined by the appropriate licensing entity

M. In addition to physicians, the following providers may bill for these services. These licensed professionals are required to be currently licensed in North Carolina.
   1. Licensed Psychologist (LP)
   2. Licensed Psychological Associate (LPA)
   3. Licensed Professional Counselor (LPC) or Licensed Clinical Mental Health Counselor (LCMHC)
   4. Licensed Professional Counselor Associate (LPCA) or Licensed Clinical Mental Health Counselor Associate (LCMHCA)
   5. Licensed Clinical Social Worker (LCSW)
   6. Licensed Clinical Social Worker Associate (LCSWA)
   7. Licensed Marriage and Family Therapist (LMFT)
   8. Licensed Marriage and Family Therapist Associate (LMFTA)
   9. Licensed Clinical Addiction Specialist (LCAS)
   10. Licensed Clinical Addiction Specialist – Associate (LCASA)
   11. Licensed Physician Assistant (PA)
   12. Nurse Practitioner (NP), including Psychiatric Mental Health Nurse Practitioner (PMHNP);
   13. Licensed Physician Assistants and Nurse Practitioners can be eligible to provide substance use disorder treatment prescriber services in an Opioid Treatment Program setting to Medicaid beneficiaries diagnosed with a substance use disorder if they meet the Federal opioid treatment standards under 42 CFR 8.12 and have an approved exemption from the Substance Abuse Mental Health Services Administration (SAMHSA.) These PAs and NPs must be supervised by a psychiatrist or other physician with experience practicing addiction medicine;
   14. Certified Clinical Nurse Specialist (CNS) certified by the American Nurses Credentialing Center or the American Psychiatric Nurse Association as an adult or child/adolescent Psychiatric Mental Health Clinical Nurse Specialist – Board Certified.
   15. The licensed professional shall be direct enrolled with Medicaid and have their own Medicaid Provider Number (MPN) and National Provider Identifier (NPI). Only the individual licensed professional assigned to those numbers can use those numbers for authorization and billing of services. These licensed providers cannot bill "incident to" a physician or any other licensed professional.
   16. Professionals shall only provide treatment within the scope of practice, training, and expertise according to statutes, rules, and ethical standards of his or her professional occupational licensing board, and, as relevant, according to the scope outlined in a clinical supervision agreement.

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17. All PAs and NPs providing psychiatric services must practice under the supervision of a psychiatrist.
18. Note: Per 25 USC 1621t "Licensed health professionals employed by a tribal health program shall be exempt, if licensed in any State, from the licensing requirements of the State in which the tribal health program performs the services described in the contract or compact of the tribal health program under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.)."

N. 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.*

O. Telephonic Services

1. Select services within this clinical coverage policy may be provided via the telephonic, audio-only communication method. Telephonic services may be transmitted between a patient and provider in a manner that is consistent with the CPT code definition for those services. This service delivery method is reserved for circumstances when:
   a. the beneficiary's physical or behavioral health status prevents them from participating in in-person or telehealth services; **or**
   b. access issues (e.g., transportation, telehealth technology) prevent the beneficiary from participating in in-person or telehealth services.

IV. Service Records and Documentation

A. Consent

1. At the time of the initial service, the provider shall obtain the written consent from the legally responsible person for treatment for members of all ages.

B. **Coordination of Care** - The following are examples of coordination of care activities:

1. Written progress or summary reports;
2. Telephone;
3. Treatment planning processes;
4. an individualized plan of care, service plan, treatment plan, or Person-Centered Plan (PCP), consistent with and supportive of the service provided and within professional standards of practice, is required according to Background IV.F. below. When the member is receiving multiple behavioral health services in addition to the services in this policy, a PCP must be developed with the member, and outpatient behavioral health services are to be incorporated into the member's PCP;
5. Coordination of care with the beneficiary's delegated care manager at the Advanced Medical Home (AMH), Clinically Integrated Network (CIN), Care Management Agency (CMA), the WellCare care manager, the Community Care of North Carolina (CCNC)/Carolina Access (CA) care manager, Tribal Option Care Manager, primary care, CCNC/CA physician or other NC DHHS recognized integrated care providers; **and**
6. Coordination of care with WellCare.

C. Provision of Services

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1. Providers shall maintain health records that document the provision of services.
2. Provider organizations shall maintain, in each member's service record, at a minimum, the following documentation:
    a. demographic information: the member's full name, contact information, date of birth, race, gender, and admission date;
    b. the member's name must be on each page generated by the provider agency;
    c. the service record number of the member must be on each page generated by the provider agency;
    d. the Member's Identification Number must be on all treatment plans, service note pages, accounting of release, or disclosure logs, billing records, and other documents or forms that have a place for it;
    e. an individualized treatment plan;
    f. documentation of entrance criteria, continued service criteria, and discharge criteria;
    g. a copy of any testing, summary and evaluation reports;
    h. documentation of communication regarding coordination of care activities; **and**
    i. all evaluations notes and reports must contain the full date the service was provided (month, day, and year).

D. **Outpatient Crisis Services** - Licensed professionals utilizing Psychotherapy for Crisis codes shall follow the following guidelines:
    1. Disposition may involve an immediate transfer to more restrictive emergency services (e.g., behavioral health urgent care center, facility-based crisis, emergency department inpatient hospitalization) if documentation supports this decision.
    2. If the disposition is not an immediate transfer to acute or more intensive emergency services, the provider must offer a written copy of an individualized crisis plan to the member. This plan shall be developed in the session for the purpose of handling future crisis situations, including involvement of family and other providers as applicable. The plan must document a scheduled outpatient follow-up session.

E. **Comprehensive Clinical Assessment (CCA)**
    1. An intensive clinical and functional evaluation of a member's presenting mental health, developmental disability, and substance use disorder. This assessment results in the issuance of a written report that provides the clinical basis for the development of the member's treatment or service plan. The CCA written report must be kept in the service record.
    2. A licensed clinician shall complete a CCA that contains an ASAM level of care determination on an eligible beneficiary diagnosed with a substance use disorder; and shall have documentation verifying the completion of training on the current 2013 ASAM Criteria edition, or any subsequent editions of this reference material, consisting at minimum of the following learning objectives:
        a. Review paradigm shifts and evolutions in generations of care that led to The ASAM Criteria;
        b. Apply The ASAM Criteria's decisional flow;
        c. Identify and describe the six ASAM criteria assessment dimensions;
        d. Rate risk and severity across all dimensions;

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e. Identify services and modalities needed, as well as treatment planning approaches;
f. Identify appropriate levels of care;
g. Review special populations and emerging research about addiction; and
h. Develop strategies to overcome real-world barriers to implementing The ASAM Criteria.

3. Training must be a minimum of ten (10) hours to ensure the above identified learning objectives are addressed. It is expected that clinicians using the ASAM for CCAs completed for beneficiaries with a SUD seek out continuing education opportunities to maintain current knowledge of the ASAM criteria. Federally recognized tribal and IHS providers may complete an alternate curriculum to satisfy the identified learning objectives.
4. Must be completed by a licensed professional prior to provision of outpatient therapy services, including individual, family and group therapy. The clinician may complete the CCA upon admission or update a recent CCA from another clinician if a substantially equivalent assessment is available and reflects the current level of functioning. Information from that assessment may be utilized as a part of the current comprehensive clinical assessment. Relevant diagnostic information must be obtained and be included in the treatment or service plan.
5. The format of a CCA is determined by the individual provider, based on the clinical presentation. Although a CCA does not have a designated format, the assessment (or collective assessments) used must include **ALL** of 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 (consisting of mental health and substance use, and tobacco use) of the member's symptoms, treatment, and treatment response;
   c. current medications, 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 member 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 a determination of ASAM level of care when a substance use disorder is present;
   g. diagnoses using current DSM-5, or any subsequent editions of this reference material, consisting of including mental health, substance use disorders, or intellectual and developmental disabilities, as well as physical health conditions and functional impairment; **and**
   h. recommendations for additional assessments, services, support, or treatment based on the results of the CCA.
   i. The CCA must be signed and dated by the licensed professional completing the assessment.
6. A CCA is not required in the following situations:

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   a. in primary or specialty medical care settings with integrated medical and behavioral health services, an abbreviated assessment is acceptable for the first six outpatient therapy sessions. If additional therapy sessions are needed, then a CCA must be completed.
   b. due to the nature of crisis services, a CCA is not required prior to Psychotherapy for Crisis services. However, the provider shall comply with the 10A NCAC 27G .0205(a) requirement for an assessment prior to the delivery of any subsequent services.
   c. for medical providers billing E/M codes for medication management.

F. Individualized Plan

1. An individualized plan of care, service plan, treatment plan, or PCP, referred to as "plan," consistent with and supportive of the service provided and within professional standards of practice, is required within 15 business days of the first face-to-face member contact.
2. This plan is based on the assessment and is developed in partnership with the member or legally responsible person, or both.
3. When services are provided prior to the establishment and implementation of the plan, strategies to address the member's presenting problem shall be documented.
4. The plan shall be an identifiable document in the service record.
5. The plan must include at a minimum:
   a. member outcomes that are anticipated to be achieved by provision of the service and a projected date of achievement;
   b. strategies;
   c. staff responsible;
   d. a schedule for review of the plan (in consultation with the member or legally responsible person or both) as needed but at least annually to review goals and strategies to promote effective treatment;
   e. basis for evaluation or assessment of outcome achievement; **and**
   f. written consent or agreement by the member or legally responsible person, or a written statement by the provider stating why such consent could not be obtained.
6. For a child or adolescent receiving outpatient substance abuse services, the plan must document both the staff and the child or adolescent's signatures demonstrating the involvement of all responsible parties in the development of the plan and the child or adolescent's consent or agreement to the plan. Consistent with N.C.G.S. § 90-21.5, or comparable federal, Tribal law, or rule, the plan may be implemented without parental/guardian consent when services are provided under the direction and supervision of a physician. When services are not provided under the direction and supervision of a physician, the plan must require the signature of the parent or legally responsible person for the child or adolescent demonstrating the involvement of the parent or legally responsible person in the development of the plan and the parent's or legally responsible person's consent to the plan.
7. The treatment plan must be updated as required, but a new plan is required at least annually.
8. All treatment plans are to be developed in partnership with the member or legally responsible person, and all updated or new plans require the member or legally

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responsible person's signature, and the licensed professional's signature. The licensed professional's signature on the updated or new plan can serve as the service order.

9. **Note**: Members receiving medication management only would be exempt from the requirement of having to sign the treatment plan. For members receiving medication management only and who have a legally responsible person, the legally responsible person would also be exempt from this requirement. The treatment plan for members receiving only medication management would not need to be a separate document and could be integrated into service notes.

G. **Service Notes and Progress Notes** - There must be a progress note for each treatment encounter that documents the following information:
   1. Date of service;
   2. Name of the service provided (e.g., Outpatient Therapy – Individual);
   3. Type of contact (in-person, telehealth, telephonic, or collateral); ; Services eligible to be provided via telehealth must be provided according to clinical coverage Policy WNC.CP.193 Telehealth, Virtual Patient Communications, and Remote Patient Monitoring,
   4. Purpose of the contact (tied to the specific goals in the plan);
   5. Description of the treatment or interventions performed. Treatment and interventions must include active engagement of the member and relate to the goals and strategies outlined on the member's plan;
   6. Effectiveness of the intervention(s) and the member's response or progress toward goal(s);
   7. The duration of the service, length of the assessment or treatment in minutes;
   8. Signature, with credentials, degree, and licensure of clinician who provided the service. A handwritten note requires a handwritten signature; however, the credentials, degree, and licensure may be typed, printed, or stamped; **and**
   9. Service notes must be written in such a way that there is substance, efficacy, and value. Interventions, treatment, and supports must all address the goal(s) listed in the plan. They must be written in a meaningful way so that the notes collectively outline the member's response to treatment, interventions, and supports in a sequential, logical, and easy-to-follow manner over the course of service.

   Note: The exception to the above service note policy is the documentation required for medical providers offering medication management and billing E/M codes. In this case, the medical provider must document the chosen E/M code with all of the necessary elements as outlined in the current edition of the American Medical Association's Current Procedural Terminology (CPT) manual.

H. **Referral and Service Access Documentation**
   1. The following documentation must be kept in the health record:
      a. the provider's signed treatment plan serves as the service order.
      b. A copy of the written order by the physician, licensed psychologist, nurse practitioner, or physician assistant for the services of the associate level professional.
      c. For visits beyond the unmanaged visits, a copy of the completed authorization request form and prior approval notification from WellCare is required.

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   d. all outpatient behavioral health services provided to a Medicaid member may be self-referred or referred by some other source. If the member is not self-referred, the referral must be documented in the health record.

I. 24-Hour Coverage for Behavioral Health Crises

1. Enrolled providers shall provide, or have a written agreement with another entity, for access to 24-hour coverage for behavioral health emergency services. Enrolled providers shall arrange for coverage in the event that they are not available to respond to a member in crisis. This coverage must incorporate the ability for the member to speak with the licensed clinician on call either in-person, via telehealth, or telephonically.

J. **Psychological Testing** - The following are additional requirements pertaining to Psychological Testing services

1. A service note must be written for each Psychological Testing service(s) contact that includes:
   a. name of the individual receiving this service
   b. service record number of the individual
   c. Medicaid Identification Number
   d. date(s) of service including month, day, and year
   e. name of the service provided and CPT codes(s)
   f. purpose of the psychological testing
   g. name(s) of the individual tests administered
   h. total amount of time to be billed on this date of service for psychological testing
   i. signature and date signed of the psychologist, LPA, or physician with degree and licensure

   Note: Only one service note is required to be written for a Psychological Testing code(s) and an add-on code(s) if services are provided on the same day and by the same provider.

   This information serves to document the psychological testing service. The timeline for service notes documenting psychological testing is the same as other service notes and must be written or dictated within 24 hours of the day that the service was provided. After 24 hours the note is considered a late entry. If the note is not written or dictated within seven days of the day that the service was provided, the service may not be billed. After 24 hours, the note must be indicated as a late entry and must include a dated signature.

2. In addition to a service note for each encounter with the member, a written report of the psychological testing must be completed and sent to the individual or organization making the referral in a time frame according to member needs and clinical best practice standards. At a **minimum,** this report **must** include the following:
   a. reason for the referral
   b. Psychological tests/procedures utilized
   c. review of records as appropriate
   d. results of the psychological tests
   e. interpretation of the psychological tests
   f. summary

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g. Diagnosis or Diagnostic Impression
h. recommendations
i. signature, date signed, degree, and license of the psychologist, LPA, or physician

K. Expected Clinical Outcomes

1. The expected clinical outcomes must relate to the identified goals in the member's treatment plan. The outcomes must reflect changes in symptoms and behaviors that, when met, promote increased functioning such that member may no longer meet medical necessity criteria for further treatment.
2. Examples of expected clinical outcomes for this service are the following:
   a. reduced symptomatology or abstinence, or decreased use of substances;
   b. Vocational or educational gains;
   c. Decreased engagement with the justice system;
   d. stability in housing; and
   e. increased social supports.
3. If a review of the need for ongoing treatment determines that continued treatment is medically necessary, documentation of continued stay must provide the following:
   a. documentation of the need for ongoing treatment;
   b. documentation of progress made; **or**
   c. documentation of efforts to address lack of progress.

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.
Telehealth Claims: Modifier **GT** must be appended to the CPT or HCPCS code to indicate that a service has been provided via interactive audio-visual communication. This modifier is not appropriate for services provided via telephonic, audio-only communication.

Telephonic Claims: Modifier **KX** must be appended to the CPT or HCPCS code to indicate that a service has been provided via telephonic, audio-only communication.

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

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Code	Psychiatrist/ MD/DO	PMHNP	PA/NP	LP/LPA	LCMHC, LCMHCA, LPC, LPCA, LCSW, LCSWA, LMFT, LMFTA, LCAS, LCASA, CCS, CNS	Code Guidance/Unmanaged Visit Limits	Telehealth Eligible	Telephonic Eligible
+90785	X	X	X	X	X	This code is an "add-on" to other codes (90791, 90792, 90832-90838, 90853) that do have PA and visit limits	X	X
90791	X	X		X	X	BH visit limits apply	X	
90792	X	X	X			BH visit limits apply	X	
90832	X	X		X	X	BH visit limits apply	X	X
+90833	X	X				BH visit limits apply; code must be used with E/M code	X	
90834	X	X		X	X	BH visit limits apply	X	X
+90836	X	X				BH visit limits apply; code must be used with E/M code	X	
90837	X	X		X	X	BH visit limits apply	X	X
+90838	X	X				BH visit limits apply; code must be used with E/M code	X	
90839	X	X		X	X	No PA required	X	X
+90840	X	X		X	X	Must be used with 90839;	X	X
90846	X	X		X	X	BH visit limits; may not be used with 90785	X	X
90847	X	X		X	X	BH visit limits; may not be used with 90785	X	X
90849	X	X		X	X	BH visit limits; may not be used with 90785	X	X
90853	X	X		X	X	BH visit limits apply	X	X
Code	**Psychiatrist/ MD/DO**	**PMHNP**	**PA/NP**	**LP/LPA**	**LCMHC, LCMHCA, LPC, LPCA, LCSW, LCSWA, LMFT, LMFTA, LCAS, LCASA, CCS, CNS**	**Code Guidance/Unmanaged Visit Limits**	**Telehealth Eligible**	**Telephonic Eligible**
E/M CODE	X	X	X			No limit	X	

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S: 99202- 99255; 99304- 99337; 99341- 99350; 99417							Telehealth eligible codes are limited to the following: • 99202-99205 • 99211-99215 • 99231-99233 • 99238-99239 • 99241-99245 • 99251-99255 • 99347-99350	
99408	X	X	X	X	X	No PA required	X	
99409	X	X	X	X	X	No PA required	X	
96110	X	X		X		BH visit limits apply	X	
96112	X			X		BH visit limits apply		
96113	X			X		BH visit limits apply; Must be used with 96112		
96116	X			X		No PA required	X	
96121	X			X		BH visit limits apply; Must be used with 96116		
96130	X			X		BH visit limits apply	X	
96131	X			X		BH visit limits apply; Must be used with 96130	X	
96132	X			X		No PA required	X	
96133	X			X		Must be used with 96132	X	
96136	X			X		Must be used with 96130 or 96132		
96137	X			X		Must be used with 96136		
96138	X			X		No PA required		
96139	X			X		Must be used with 96138		
96146	X			X		No PA required	X	

Note: The “+” symbol identifies add-on codes that are performed in addition to the primary service or procedure code when medically necessary and must never be reported as stand-alone codes.

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

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Note: Federally recognized tribal and Indian Health Service providers may be exempt from one or more of these items in accordance with Federal law and regulations:

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

Note: SBIRT services must only be billed when a clinician provides screening and brief intervention. If a brief intervention is not clinically indicated, time spent providing the screening should be included in the time for other services rendered.

HCPCS ®* Codes	Description
No applicable codes.	

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	06/21
Added Telehealth and Telephonic Services information. Added Telehealth & Telephonic Eligible columns to CPT grid.	07/21	08/21
SECTION III H. 8. Acronym for Licensed Marriage and Family Therapist Associate, LMFTA, added. SECTION III H. 10. Spelling of acronym for Licensed Clinical Addiction Specialist Associate, LCASA, corrected. CLINICAL POLICY CPT CODES- Telephonic eligible column for add-on code 90838 unchecked. HCPCS Codes reviewed. Reference updated.	08/22	08/22
Annual review. NCHC verbiage removed from NC Guidance Verbiage Added: 'Related Clinical Coverage Policies' added- 8A Enhanced Mental Health and Substance Abuse Services, 8A-1 Assertive Community Treatment (ACT) Program, and 8J- Children's Developmental Services Agencies (CDSAs). Under Description, changed "biophysical profile" to "comprehensive clinical" Under Description added statement: Outpatient services for Substance Use Disorders are identified and based on the American Society of Addiction Medicine (ASAM) criteria. Under Description, removed "are available to eligible members" and changed "significant other" to "natural supports." Under Description, Added, Screening, Brief Intervention, and Referral to Treatment (SBIRT) definition. Under Description, adjusted verbiage to "beneficiary's needs and preferences,." Criteria I.A.1.removed "Note." Criteria I.A.3. replaced 'individual' with 'beneficiary,' Criteria I.D.1. & 2. Added 'current, or any subsequent editions of this reference material diagnosis' to DMS-5. Added Criteria I.F. Screening, Brief Intervention and Referral to Treatment (SBIRT) Criteria II.A. change verbiage to "WellCare of	03/23	

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Reviews, Revisions, and Approvals	Reviewed Date	Approval Date
North Carolina shall not require prior approval for up to 20 visits of Outpatient Behavioral Health services per fiscal year, after which prior approval will be required."Criteria II. B. 4. & C.2.. Added, "in accordance with the information below;" Criteria II.B.5., C.1., added "current" Background II. Renamed section Utilization Management and Additional Limitations. Background II.A. Edited sentence to state 'Medicaid shall not require prior approval for Outpatient Behavioral Health Services' referred to Background Section F, below, for limitations." Background II.E. added, sections 1-7. Background II.F.3. added verbiage for "urgent or emergent situation." Background II.G.1. Reworded Unmanaged coverage is limited to 8 hours/year. Background III.B. Removed "this includes medication management services." Background III.E. Added "If Psychotherapy for Crisis is billed, no other outpatient therapy services can be billed on that same day for that beneficiary," Background Added III.G. "to be billed,"Background III. H. added, "For substance use disorders…" Background III. I., added, "Outpatient Medication Management…" Background III.J., added, "Individual, Group, or Family Outpatient…" Background III. L., added, "To be eligible to…" Background III.M. deleted "cannot bill "incident to" a physician or any other licensed professional." Background III.M. added 12-21. Background IV.B.5. changed verbiage in "coordination of care," Background IV.D. 1. Added "behavioral health urgent care center, facility-based crisis, emergency department," Background IV.E.2 and 3, for ASAM Criteria and training. Background IV.E.5.b.added "past trauma history…tobacco use." Under IV.E.5.c. added, "medical, psychiatric, and substance use disorder treatment. Identify past medications that were ineffective or caused significant side effects or adverse reactions," Background IV.E.f. added "including a determination of ASAM level of care when a substance use disorder is present," Background IV.E.5.g. "changed from to current" and added "or any subsequent editions of this reference material, consisting of," Background IV.F.1. removed "hereinafter," Background IV.F.5 changed 'shall to must' Deleted IV.F.6. regarding 10ANCAC27G.0205" Background IV.F.7 changed to 6 and added "or comparable federal, Tribal law, or rule" and changed "parental to parental/guardian" Background IV.G.3. added "Services eligible to be provided via telehealth must be provided according to clinical coverage Policy WNC.CP.193 Telehealth, Virtual Patient Communications, and Remote Patient Monitoring," Background IV.H.1. added C "For visits beyond the unmanaged visits, a copy of the completed authorization request form and prior approval notification from WellCare is required." Background IV.I.1. changed "shall to must incorporate" Background IV.J.C. Added "Medicaid identification number." Background IV.K.2 A. "changed alcohol & other drugs to substances," Background IV.K.2.B. "changed employment & education(getting and keeping a job) to Vocational or educational gains." Background IV.K.2.C. "changed decreased criminality to decreased engagement with the justice system." Removed CPT codes showing telehealth		

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Reviews, Revisions, and Approvals	Reviewed Date	Approval Date
& telephonic eligibility & Added New table showing "Psychiatric Diagnostic Evaluation, Psychotherapy, Medication Management, Crisis, and Psychological Testing CPT Codes" Added CPT Codes 99408 Alcohol and/or substance (other than tobacco) abuse structured screening (e.g., AUDIT, DAST), and brief intervention (SBI) services; 15 to 30 minutes 99409 Alcohol and/or substance (other than tobacco) abuse structured screening (e.g., AUDIT, DAST), and brief intervention (SBI) services; greater than 30 minutes 99417 Prolonged outpatient evaluation and management service(s) time with or without direct patient contact beyond the required time of the primary service when the primary service level has been selected using total time, each 15 minutes of total time (List separately in addition to the code of the outpatient Evaluation and Management service. Under CPT table, added Notes regarding "the + symbol," "reference to WNC.CP.193 Telehealth policy," "federally recognized Tribal or HIS providers being exempt," "federally recognized Tribal or HIS providers being entitled to alternate reimbursement," and "SBIRT services must be billed…"		

References

1. State of North Carolina Medicaid. Medicaid and Health Choice Clinical Coverage Policy No: 8C Outpatient Behavioral Health Services Provided by Direct-Enrolled Providers. Program Specific Clinical Coverage Policies | NC Medicaid (ncdhhs.gov).. Published March 1, 2023. Accessed March 20, 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).

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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:

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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

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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.

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Providers, members/enrollees and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members/enrollees and their representatives agree to be bound by such terms and conditions by providing services to members/enrollees and/or submitting claims for payment for such services.

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