Clinical Policy: Peer Support Services

Reference Number: WNC.CP.231
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]

Peer Support Services (PSS) are an evidenced-based mental health model of care that provides community-based recovery services directly to a Medicaid-eligible adult beneficiary diagnosed with a mental health or substance use disorder. PSS provides structured, scheduled services that promote recovery, self-determination, self-advocacy, engagement in self-care and wellness and enhancement of community living skills of beneficiaries. PSS services are directly provided by Certified Peer Support Specialists (CPSS) who have self-identified as a person(s) in recovery from a mental health or substance use disorder. PSS can be provided in combination with other approved mental health or substance use services or as an independent service. Due to the high prevalence of beneficiaries with co-occurring disorders (mental health, substance use or physical health disorders) it is a priority that integrated treatment be available to these beneficiaries.

Policy/Criteria[1]

I. It is the policy of WellCare of North Carolina® that Peer Support Services is a covered benefit when **ALL** following criteria are met:

A. The beneficiary has a mental health or substance use diagnosis as defined by the Diagnostic and Statistical Manual of Mental Disorders Fifth Edition (DSM-5) or any subsequent editions of this reference material, other than a sole diagnosis of intellectual and developmental disability;
B. Beneficiary with a substance use diagnosis meets the American Society of Addiction Medicine (ASAM) Level 1 criteria;
C. There is no evidence to support that alternative interventions would be equally or more effective based on North Carolina community practice standards; **and**
D. The beneficiary has documented identified needs, in at least **ONE or more** of the following areas (related to diagnosis):
   1. Acquisition of skills needed to manage symptoms and utilize community resources;
   2. Assistance needed to develop self-advocacy skills to achieve decreased dependency on the mental health system;
   3. Assistance and support needed to prepare for a successful work experience;
   4. Peer modeling needed to take increased responsibilities for his or her own recovery; **or**
   5. Peer supports needed to develop or maintain daily living skills.

II. It is the policy of WellCare of North Carolina® that the following activities of Peer Support Services **will not** be covered:

A. Transportation for the beneficiary or family members;
B. Habilitation activities;
C. Time spent performing, attending or participating in recreational activities unless tied to specific planned social skill assistance;
D. Clinical and administrative supervision of the Peer Support Specialist which is covered as an indirect cost and part of the rate;
E. Covered services that have not been rendered;
F. Childcare services or services provided as a substitute for the parent or other beneficiaries responsible for providing care and supervision;
G. Services provided to teach academic subjects or as a substitute for education personnel;
H. Interventions not identified in the beneficiary's Person-Centered Plan;
I. Services provided without prior authorization;
J. Services provided to children, spouse, parents or siblings of the beneficiary under treatment or others in the beneficiary's life to address problems not directly related to the beneficiary's needs and not listed on the Person-Centered Plan; **and**
K. Payment for room and board.

Background[1]

PSS are based on the belief that beneficiaries diagnosed with serious mental health or substance use disorders can and do recover. The focus of the services is on the person, rather than the identified mental health or substance use disorder and emphasizes the acquisition, development, and expansion of rehabilitative skills needed to move forward in recovery. The services promote skills for coping with and managing symptoms while utilizing natural resources and the preservation and enhancement of community living skills.

Peer Support Services (PSS) are provided one-on-one to the beneficiary or in a group setting. Providing one-on-one support builds on the relationship of mutuality between the beneficiary and CPSS; supports the beneficiary in accomplishing self-identified goals; and may further support the beneficiary's engagement in treatment. Peer Support Services provided in a group setting allow the beneficiary the opportunity to engage in structured services with others that share similar recovery challenges or interest; improve or develop recovery skills; and explore community resources to assist the beneficiary in his or her recovery. PSS are based on the beneficiary's needs and coordinated within the context of the beneficiary's Person-Centered Plan.

Structured services provided by PSS include:

- Peer mentoring or coaching (one-on-one) – to encourage, motivate, and support beneficiary moving forward in recovery. Assist beneficiary with setting self-identified recovery goals, developing recovery action plans, and solving problems directly related to recovery, such as finding housing, developing natural support system, finding new uses of spare time, and improving job skills. Assist with issues that arise in connection with collateral problems such as legal issues or co-existing physical or mental challenges.

- Recovery resource connecting – connecting a beneficiary to professional and nonprofessional services and resources available in the community that can assist a beneficiary in meeting recovery goals.
- Skill Building Recovery groups – structured skill development groups that focus on job skills, budgeting and managing credit, relapse prevention, and conflict resolution skills and support recovery.
- Building community – assist a beneficiary in enhancing his or her social networks that promote and help sustain mental health and substance use disorder recovery. Organization of recovery-oriented services that provide a sense of acceptance and belonging to the community, promote learning of social skills and the opportunity to practice newly learned skills.

I. Prior Approval

A. WellCare of North Carolina® shall require prior approval for Peer Support Services beyond the unmanaged unit limitation. Coverage of Peer Support Services is limited to **twenty-four (24)** unmanaged units once per episode of care per state fiscal year.

B. Initial Authorization

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 Person-Centered Plan (PCP) Medical necessity is determined by North Carolina community practice standards, and whether the clinical documentation supports the need for intensive services. Medically necessary services are authorized in the most cost-effective modes, if the treatment that is made available is similarly efficacious as services requested by the beneficiary's physician, therapist, or another licensed practitioner. The medically necessary service must be recognized as an accepted method of medical practice or treatment.
2. To request an initial authorization, the CCA, service order for medical necessity, and PCP must be submitted for review to WellCare of North Carolina.. WellCare of North Carolina will cover up to 24 units of service before prior authorization is required.

C. Reauthorization

1. Reauthorization requests will be reviewed for ongoing medical necessity per the above standards of care. The duration and frequency at which PSS is provided must be based on medical necessity and progress made by the beneficiary toward goals outlined in the PCP.
2. Additional units may be authorized as clinically appropriate. If medical necessity dictates the need for increased service duration and frequency, clinical consideration must be given to interventions with a more intense clinical component.

II. Admission Criteria

A. A comprehensive clinical assessment (CCA), that demonstrates medical necessity must be completed by a licensed clinician prior to the provision of this service. 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 and state requirements, it may be used as part of the

current CCA. Relevant clinical information must be obtained and documented in the beneficiary's Person-Centered Plan (PCP).

III. Continued Stay Criteria - The beneficiary meets criteria for continued stay if any **ONE** of the following applies:
- A. The desired outcome or level of functioning has not been restored, improved, or sustained over the time frame documented in the beneficiary's PCP;
- B. The beneficiary continues to be at risk for relapse based on current clinical assessment, and history, or the tenuous nature of the functional gains; **or**
- C. Continuation of service is supported by documentation of beneficiary's progress toward goals within the beneficiary's PCP.

IV. Transition and Discharge Criteria - The beneficiary meets the criteria for discharge if any **ONE** of the following applies:
- A. The beneficiary's level of functioning has improved with respect to the goals outlined in the PCP, inclusive of a transition plan to step down to a lower level of care;
- B. The beneficiary has achieved positive life outcomes that support stable and ongoing recovery and is no longer in need of Peer Support Services;
- C. The beneficiary is not making progress or is regressing, and all reasonable strategies and interventions have been exhausted, indicating a need for more intensive services; **or**
- D. The beneficiary chooses to withdraw from Peer Support Services or the legally responsible person(s) chooses to withdraw the beneficiary from services.

V. Telephonic-Specific Criteria
- A. Select services within this clinical coverage policy may be provided via the telephonic, audio-only communication method. Telephonic services may be transmitted between a beneficiary and provider in a manner that is consistent with the CPT and HCPCS code definition for those services.
- B. Providers shall ensure that services can be safely and effectively delivered using telephonic, audio-only communication;
- C. Providers shall consider a beneficiary's behavioral, physical and cognitive abilities to participate in services provided using telephonic, audio-only communication;
- D. The beneficiary's safety must be carefully considered for the complexity of the services provided;
- E. 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;
- F. 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;
- G. Providers shall obtain and document verbal or written consent. In extenuating circumstances when consent is unable to be obtained, this should be documented;
- H. Providers shall verify the beneficiary's identity using two points of identification before initiating a telephonic, audio-only encounter; and,
- I. Providers shall ensure that beneficiary privacy and confidentiality is protected.

VI. Telehealth Services

A. 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 Patient Communications, and Remote Patient Monitoring.*

Coding Implications[1]

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	Telephonic Eligible	Billing Unit
H0038	Self-Help/Peer Services, per 15 minutes	Yes	Yes	1 unit = 15 minutes
H0038 HQ	Self-Help/Peer Services, per 15 minutes, group services	No	No	1 unit = 15 minutes

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.

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	04/21	06/21

Reviews, Revisions, and Approvals	Reviewed Date	Approval Date
Added Telehealth Services and Telephonic Specific Criteria. Added Telehealth and Telephonic criteria to HCPCS grid.	07/21	08/21
Reviewed HCPCS code.	06/22	08/22
1.B. Technical change: deleted "the Level of Care criteria for Locus Level 1". IV.B. Technical change: separated criterion b. into two separate criteria.	08/22	08/22
Annual Review. NCHC verbiage removed from NC Guidance Verbiage. Added column for "billing unit, 1 unit = 15 minutes"	03/23	

References

1. State of North Carolina Medicaid. Medicaid and Health Choice Clinical Coverage Policy No: 8G Peer Support Services. Program Specific Clinical Coverage Policies | NC Medicaid (ncdhhs.gov). Published August 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.

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