Clinical Policy: Diagnostic Assessment

Reference Number: WNC.CP.212
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]

This policy describes medical necessity criteria for Diagnostic Assessment.

Policy/Criteria[1]

I. WellCare of North Carolina® **shall cover** Diagnostic Assessment when the following criteria are met:
- A. There is a known or suspected mental health, substance use disorder, intellectual or developmental disability diagnosis based on the DSM-5 diagnostic criteria; **or**
- B. Initial assessment or triage information indicates a need for additional mental health, substance use disorder, intellectual, or developmental disabilities treatment or supports.

II. WellCare of North Carolina® **shall not** cover a diagnostic assessment:
- A. On the same day as Assertive Community Treatment Team, Intensive In-Home, Multisystemic Therapy or Community Support Team services. If psychological testing or specialized assessments are indicated, they are covered separately using appropriate CPT codes for psychological, developmental, or neuropsychological testing.
- B. In an institution for mental disease (IMD) (for adults) or in a public institution (jail, detention center).

III. WellCare of North Carolina® **shall not** cover conversion therapy.

Background

A diagnostic assessment is an intensive clinical and functional evaluation of a beneficiary's mental health, intellectual and developmental disability, or substance use condition. A diagnostic assessment determines whether the beneficiary meets medical necessity and can benefit from: mental health, intellectual disability, developmental disability, or substance use disorder services based on the beneficiary's diagnosis, presenting problems, and treatment and recovery goals. It evaluates the beneficiary's level of readiness and motivation to engage in treatment. This assessment is designed to be delivered in a team approach that results in the issuance of a written report that provides the clinical basis for the development of the beneficiary's treatment or service plan. The written report must be kept in the service record.

A. A diagnostic assessment must include **ALL** the following elements:
   1. Description of the presenting problems, including source of distress, precipitating events, and associated problems or symptoms;

2. Chronological general health, past trauma history and behavioral health history (including both mental health and substance use including tobacco use) of the beneficiary's symptoms, treatment, and treatment response;
3. Current medications for medical, psychiatric, and substance use disorder treatment. Identify past medications that were ineffective or caused significant side effects or adverse reactions;
4. A review of biological, psychological, familial, social, developmental and environmental dimensions to identify strengths, needs, and risks in each area;
5. Evidence of beneficiary and legally responsible person's (if applicable) participation in the assessment;
6. Analysis and interpretation of the assessment information with an appropriate case formulation including determination of American Society of Addiction Medicine (ASAM) level of care when a substance use disorder is present;
7. Diagnosis using the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), or any subsequent editions of this reference material including mental health, substance use disorders, or intellectual or developmental disabilities, as well as physical health conditions and functional impairment;
8. Recommendations for additional assessments, services, supports or treatment based on the results of the diagnostic assessment;
9. The diagnostic assessment must be signed and dated by the licensed professionals completing the assessment;

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

C. **The diagnostic assessment team** shall include at least two Qualified Professionals (QPs), according to 10A NCAC 27G .0104:
   1. For beneficiaries with Mental Health (MH) or Substance Use Disorder (SUD) diagnoses, both professionals must be licensed:
      a. One team member shall be an MD, DO, nurse practitioner, physician assistant, or licensed psychologist.
      b. For substance use-focused diagnostic assessment, the team must include an LCAS.
   2. For beneficiaries with intellectual or developmental disabilities:
      a. One team member shall be an MD, DO, nurse practitioner, physician assistant, or licensed psychologist
      b. One team member must be a master's level QP with at least two years of experience with individuals with intellectual or developmental disabilities.
   3. The MD, DO, NP, PA, or psychologist shall have the required experience with the population served in order to provide this service.

This assessment must be signed and dated by the MD, DO, PA, NP, or licensed psychologist and serves as the initial order for services included in the Person-Centered Plan (PCP).

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.)."

D. **A licensed clinician shall**:
   1. Complete a Diagnostic Assessment that includes an American Society of Addiction Medicine (ASAM) level of care determination on an eligible beneficiary diagnosed with a substance use disorder; and
   2. Provide documentation verifying the completion of training on the current 2013 ASAM Criteria edition, or any subsequent editions of this reference material, consisting at a 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;
      e. Identify services and modalities needed, as well as treatment planning approaches;
      f. Identify appropriate beneficiary 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 objectives are addressed. It is expected that clinician using the ASAM for Diagnostic Assessments completed on a beneficiary with a SUD seek out continuing education opportunities to maintain current knowledge of the ASAM criteria.

E. Expected Clinical Outcomes

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

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
T1023	Screening to determine the appropriateness of consideration of an individual for participation in a specified program, project or treatment protocol, per encounter

Federally recognized tribal or Indian Health Service providers may be entitled to alternate reimbursement methodologies under Federal Law and Regulations.

Reviews, Revisions, and Approvals	Reviewed Date	Approval Date
Original approval date	04/21	05/21
Reviewed HCPCS code.	08/21	11/21
Annual review. Reviewed HCPCS code. Added ASAM level of care requirement for diagnostic assessment, ASAM training clarification with required learning objectives and minimum training hours and Expected Clinical Outcomes.	08/22	08/22
NCHC verbiage removed from NC Guidance Verbiage. Removed ICD-10 Code table. Under Background C. Adding note below section that Licensed health professional employed by a tribal health program shall be exempt from licensing requirement of the State in which the tribal health program performs the services. Under HCPCS table, added note, stating "that Federally recognized tribal or Indian Health Service providers may be entitled to alternate reimbursement methodologies under Federal Law and Regulations."	03/23	

References

1. State of North Carolina Medicaid. Medicaid and Health Choice Clinical Coverage Policy No: 8A-5 Diagnostic Assessment. Program Specific Clinical Coverage Policies | NC Medicaid (ncdhhs.gov) Published February 15, 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).

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.