Clinical Policy: Peer Support Services

Reference Number: WNC.CP.231 Coding Implications
Last Review Date: 03/2025 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 member 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 Members. 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 Members with co-occurring disorders (mental health, substance use or physical health disorders) it is a priority that integrated treatment be available to these Members.

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 member 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.** Member 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 member 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. 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 member's Person-Centered Plan (PCP).

III. Continued Stay Criteria - The member 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 member's PCP;
B. The member 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 member's progress toward goals within the member's PCP.

IV. Transition and Discharge Criteria - The member meets the criteria for discharge if any **ONE** of the following applies:

A. The member'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 member has achieved positive life outcomes that support stable and ongoing recovery and is no longer in need of Peer Support Services;
C. The member 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 member chooses to withdraw from Peer Support Services, or the legally responsible person(s) chooses to withdraw the member 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 member 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 member's behavioral, physical, and cognitive abilities to participate in services provided using telephonic, audio-only communication;
D. The member'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 member's identity using two points of identification before initiating a telephonic, audio-only encounter; and,
I. Providers shall ensure that members' 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 located at WellCare North Carolina Clinical Coverage Guidelines*.

VII. 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 Member or member's family is not billable under WNC.CP.231 Peer Support Services,;
1. Medically necessary transportation for medical appointments may be covered under WellCare of North Carolina® Non-Emergency Medical Transportation benefit. Please refer to Clinical Coverage Policy WNC.CP.262 "Non-Emergency Medical Transportation," available at WellCare NC Clinical Coverage Guidelines for prior authorization information.
2. Medicaid Transportation information, for WellCare of North Carolina members, is available at WellCare NC Medicaid Transportation Services.

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 Members 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 member's Person-Centered Plan;
I. Services provided to children, spouse, parents, or siblings of the member under treatment or others in the member's life to address problems not directly related to the member's needs and not listed on the Person-Centered Plan; **and**
J. Payment for room and board.

Background[1]

PSS are based on the belief that Members 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 member or in a group setting. Providing one-on-one support builds on the relationship of mutuality between the member and CPSS; supports the member in accomplishing self-identified goals; and may further support the member's engagement in treatment. Peer Support Services provided in a group setting allow the member 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 member in his or her recovery. PSS are based on the member's needs and coordinated within the context of the member's Person-Centered Plan.
Structured services provided by PSS include:

- **Peer mentoring or coaching (one-on-one)** – to encourage, motivate, and support member moving forward in recovery. Assist member 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 member to professional and nonprofessional services and resources available in the community that can assist a member 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 member 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. For authorization requirements, please refer to WellCare of North Carolina Authorization Lookup Tool; WellCare of North Carolina Medicaid Behavioral Health Authorization List; and WellCare of North Carolina Medicaid Behavioral Health Authorization Guidelines and FAQ, for details.

II. Additional Limitations or Requirements:

A. A Member can receive PSS from only one provider organization during an episode of care.

B. Family members or legally responsible person(s) of the Member are not eligible to provide this service to the Member.
C. A Member with a sole diagnosis of Intellectual/Developmental Disabilities is not eligible for PSS funded by Medicaid.
D. Peer Support must not be provided during the same episode of care as Assertive Community Treatment Team (ACTT), as a peer support specialist is a requirement of that team.
E. Peer Support must not be provided during the same episode of care as Community Support Team (CST), as a peer support specialist may be a component of the service and a Member who is in need of CST and peer support will be offered CST providers who have peers on the team.
F. PSS must not be provided during the same time of day when a Member is receiving Substance Abuse Intensive Outpatient Program (SAIOP) or Substance Abuse Comprehensive Outpatient Treatment (SACOT), Partial Hospitalization, Psychosocial Rehabilitation, Respite, or Individual Support services.
G. PSS must not be duplicative of other Medicaid services the Member is receiving.
H. Transportation of a Member is not covered as a component for this policy. Any provision of services provided to a Member during travel must be indicated in the PCP prior to the travel and must have corresponding documentation supporting intervention provided. This limitation does not impact a Member's ability to access non-emergency medical transportation (NEMT).

Note: *PSS is not a "first responder" service. As documented in the Member's PCP Comprehensive Prevention and Intervention Crisis Plan, the PSS provider shall coordinate with other service providers to ensure "first responder" coverage and crisis response.*

III. Place of Service

A. PSS is a direct periodic service provided in a range of community settings. It may be provided in the Member's place of residence, community, in an emergency department, or in an office setting. It may not be provided in the residence of PSS staff.
B. The intent of the service is to be community-based rather than office-based. Service may be provided via telehealth or telephonic, audio-only communication. Telehealth or telephonic, audio only communication time is supplemental rather than a replacement of in-person contacts and is limited to twenty (20) percent or less of total service time provided per Member per fiscal year. Documentation of service rendered via telehealth or telephonic, audio-only communication with the Member or collateral contacts (assisting Member with rehabilitation goals) must be documented according to Subsection 5.5 of North Carolina Medicaid State Policy Site for Peer Support Services Clinical Coverage Policy No: 8G, at Program Specific Clinical Coverage Policies | NC Medicaid (ncdhhs.gov).
C. Telehealth and telephonic, audio-only communication claims should be filed with the provider's usual place of service code(s).

IV. Certified peer support program supervisors

A. Certified peer support program supervisors are expected to Conduct at least one in-person, telehealth, or telephonic, audio-only communication contact with the Member within 90 days of PSS being initiated and no less that every 90 days thereafter to monitor the Member's progress and effectiveness of the program.

V. Documentation Requirements, Provider Qualifications and Occupational Licensing Entity Regulations, Staffing Requirements and Service Requirements: Please refer to North Carolina Medicaid State Policy Site for Peer Support Services Clinical Coverage Policy No: 8G, at Program Specific Clinical Coverage Policies | NC Medicaid (ncdhhs.gov).

Note: *For additional information related to requirements of the Person-Centered Plan, providers should refer to the state's person-centered plan instruction manual and guidance document, which can be found at NCDHHS MH-DD-SUS/person-centered-planning. As per the PCP guidance document, for services where a PCP is required, it should be signed by both the member (or legal guardian of the member) as well as the professional responsible for the service provided. Services may not be billed prior to the date of the signature on the PCP, by both the member and the designated professional.*

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 2025, 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.

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.

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.

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

Reviews, Revisions, Approvals	Reviewed Date	Approval Date
Original Approval date.	04/21	06/21
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"	05/23	05/23
Annual Review. Background I.B. Added "Providers shall collaborate with member's existing provider(s) to develop an integrated plan of care." Background I.D. Added "Documentation for reauthorization requests should include information indicating progress towards goals or modifications made to the PCP in order to address any barriers to progress." Under Background I.D.2. Added "Note Any denial, reduction, suspension, or termination of PSS requires Member legally responsible person(s) of the Member be notified of their appeal rights." Background Additions include II. Additional Limitations or Requirements, VII. Place of Service, IX. Certified Peer Support Program Supervisors, X. Documentation Requirements, Contents of a Service Note, Provider Eligibility, Provider Qualification and Occupational Licensing Entity Regulations, Provider Certifications, Training Requirements and Expected Outcomes. Under Background X. Added, "Note: For additional information related to requirements of the Person-Centered Plan, providers should refer to the state's person-centered plan instruction manual and guidance document, which can be found at NCDHHS MH-DD-SUS/person-centered-planning. As per the PCP guidance document, for services where a PCP is required, it should be signed by both the member (or legal guardian of the member) as well as the professional responsible for the service provided. Services may not be billed prior to the date of the signature on the PCP, by both the member and the designated professional." ICD-10-CMS and CPT code tables removed.	05/24	05/24
Criteria II.I. deleted 'services provided without prior authorization.' Criteria VII.A. 1. And 2. Added Medicaid transportation text. Background I. deleted "Prior Approval," and added "Authorization	12/24	12/24

Reviews, Revisions, Approvals	Reviewed Date	Approval Date
Requirements." Background I.C. Initial Authorization , I.D. Re-authorization, deleted. Background II.A. text changed to 'episode of care." Background II.D. and E. changed 'authorization period,' to 'episode of care.' Background III. Admission criteria, IV. Continued Stay Criteria, V. Transition and Discharge Criteria, VI. Telephonic Specific Criteria, and VII. Telehealth Services, moved to Criteria II-VI. and "Not Covered" became Criteria VII. Background VIII. Place of Service, became Background III., etc.		
Annual Review. HCPCS codes reviewed. References updated. Removed "Medicaid and health choice' text from References	02/25	02/25
Under HCPCS code box, added "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," and "Federally recognized tribal or IHS providers may be entitled to alternate reimbursement methodologies under Federal Law." Under NC Guidance/Claims related information, updated state web address.	03/25	03/25

References

1. State of North Carolina Medicaid Clinical Coverage Policy No: 8G Peer Support Services. Program Specific Clinical Coverage Policies | NC Medicaid (ncdhhs.gov). Published January 1, 2025. Accessed March 10, 2025.

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, 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/meetingsnotices/medicaid-state-plan-public-notices

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.