

Peer Support Services

Clinical Coverage Policy 8G, Amended 09/01/2026

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Training Objectives and Guardrails

- Review of Clinical Coverage Policy 8G: Peer Support Services
 - Service Description & Intent
 - Covered and Non-Covered Activities
 - Service Requirements
 - Prior Authorization Guidelines
 - Provider Requirements

Providers remain responsible for:

- Individualized assessment
- Accurate signatures and attestations
- Compliance with the Medicaid policy

Overview of Peer Support Services



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Service Description & Intent

Structured, scheduled services that promote:

- Recovery
- Self-determination
- Self-advocacy
- Engagement in self-care & wellness
- Enhancement of community living skills (utilization of natural resources)

Structured services include:

- Peer mentoring/coaching
- Recovery resource connecting
- Skills building recovery groups
- Building community



Recovery within a Defined Clinical Context

The updated policy direction emphasizes that PSS should:

- Support recovery-oriented needs: Needs should be connected to the qualifying behavioral health condition
- Complement needed clinical care: Not a replacement for clinical treatment, assessment, crisis response, or case management
- Build capacity and independence: Should support progress toward recovery and use of natural or community supports

Activities Not Covered Under Peer Support Services

- Childcare services
- Services to teach academic subjects
- Any intervention not identified in the Person-Centered Plan (PCP)
- Services provided to family or others not directly tied to client's recovery needs or in the PCP
- Payment for room and board
- Digital text-based messages or email correspondence
- Transportation
- Habilitative activities or goals
- Time spent attending/participating in recreational activities (unless providing a structured intervention as documented in PCP)
- Clinical and administrative supervision of CPSS
- Services not provided
- Services for those under age 18

Service Reminders

- Peer Support Services **should**:
 - Be individualized
 - Align with national practice standards/guidelines
 - Assist clients with identifying their natural/community supports to decrease dependency on the behavioral health system
 - Support connection to other services/resources as indicated

Eligibility and Continuation of Service Requirements

Covered Services/Eligibility Criteria (section 3.2.1)

- Serious mental illness or substance use disorder, other than a sole diagnosis of intellectual and developmental disability;
- There is no evidence to support that alternative interventions would be equally or more effective
- Documented recovery-oriented needs (related to diagnosis) in at least two or more of the following areas:
 - Acquisition of self-advocacy skills to navigate the behavioral health system and access community resources;
 - Empowerment to take responsibility for their own recovery; or
 - Develop recovery skills to engage in and maintain recovery; and
- Documented rehabilitative recovery-oriented needs in at least one or more of the following areas related to diagnosis:
 - Adaptive skills (communication, problem-solving, or organizational skills);
 - Employment or education to gain employment;
 - Maintain personal safety or mitigate self-harm risk; or
 - Maintenance of active recovery from substance use, including for those receiving medication assisted treatment, and maintenance of relapse prevention skills.

Additional Eligibility Requirements (section 3.2.2)

Must have:

- Up to date Comprehensive Clinical Assessment (CCA) that demonstrates medical necessity for PSS completed by a licensed clinician within their scope of practice
- PCP with crisis plan and a service order **signed by an independently licensed clinician** required before service delivery (**orders are valid for nine months**)
- PSS is short-term, most commonly up to nine months; continuation beyond that time requires a new CCA or addendum
 - New CCAs or addendums ideally should reflect changes, updated information and indicate information about what originally brought the client in for care (in addition to the updates)

*****NOTE: CCAs and PCPs service orders must be completed by providers for which the service and diagnosis are within their scope of practice.*****

Applying Entrance/Continued Stay Criteria

Considerations when deciding if a client meets criteria for peer support services:

- Is there another service that might be more appropriate for the client's overall presentation (symptoms; social, community, recovery needs; etc.)?
- Are the needs something that can be addressed with peer support or are the client's needs more clinical in nature?
- Are the needs identified specific to the client's diagnosis?
- Are the needs identified achievable through peer support services?

Continued Service Criteria (section 3.2.3)

- At least one of the following:
 - The desired outcome or level of functioning is achievable with PSS but has not been restored, improved, or sustained over the time frame documented in the PCP;
 - Client has a high risk for relapse or self-harm based on current clinical assessment or reassessment and PSS interventions are expected to reduce the high risk, or the tenuous nature of the functional gains, **or**
 - Client has been assessed for either a step-down to natural supports or a transition to more intensive clinical services; PSS remains the most clinically appropriate option at this time; **and**
- Meets one of the following conditions:
 - Client has achieved current PCP goals, but additional goals are indicated by a clinical assessment or reassessment that reflects a client's current status; **or**
 - Continuation of service is supported by documentation of client's progress toward goals within the PCP; **or**
 - It is necessary to amend the interventions within the PCP for the client to achieve the desired outcome or level of functioning.

Transition and Discharge Criteria (section 3.2.4)

- Level of functioning has improved with respect to goals outlined in the PCP, inclusive of a transition plan; **or**
- Achievement of positive life outcomes that support stable and ongoing recovery and client is no longer in need of Peer Support Services; **or**
- Not making progress or is regressing, and all reasonable strategies and interventions have been exhausted, indicating a need for more intensive services; **or**
- Client chooses to withdraw from Peer Support Services, or the legally responsible person(s) chooses to withdraw the client from services

*****NOTE: Transition and discharge planning shall begin at admission and documented in the service record. The discharge plan shall be developed in collaboration with the client and reviewed every 60 calendar days with Peer Support Service (PSS) Program Supervisor.*****

Discharge Planning

- Per National Practice Guidelines, peer support assists clients in “grow[ing] from dependence on the system toward their chosen level of freedom and inclusion in the community of their choice.”
- Considerations for discharge planning:
 - Is building natural/community supports an ongoing discussion with clients?
 - What barriers are present if there are difficulties in identifying these unpaid supports?
 - Are other treatment/clinical services needed to assist the client with other needs?
 - Are goals being reviewed and adjusted throughout service delivery, specific to goals/interventions related to the client’s diagnosis?

Prior Approval Requirements (section 5.2.2)

- Requests (including number of units requested) should be specific and tailored to the client's needs.
- Updates to Clinical Coverage Policy 8G, effective 09/01/2026:
 - Authorizations are for up to 60 days
 - Medicaid may cover up to 176 units in a 60-day period
 - If in need of more than 88 units in 30 calendar days, authorization requests will be reviewed every 30 days
 - For services beyond nine (9) months, authorization requests will be reviewed every 30 days

Coordination of Care



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Coordination of Care

- While peer support specialists are not case managers, it is important to be aware of other providers involved in a client's care.
 - Discuss with clients the importance of self-advocacy with service providers and link to other resources as needed (i.e., individual therapy).
 - Peers should work with clients on enhancing social networks that promote and help sustain mental health and substance use disorder recovery.
- Coordination should occur with providers that can serve as a crisis response for clients with whom peers are working.

NOTE: Linkage to needed mental health services should occur within 14 calendar days and linkage to needed substance use services should occur within 72 hours of identifying a routine need

Brief Overview of Provider Requirements



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Provider Requirements

- All PSS providers should review Clinical Coverage Policy 8G and ensure ability to follow all requirements as outlined.
- Updated policy lists requirements for organizations that are providing peer support in terms of other needed clinical services. Please ensure that your organization has the ability to meet these new requirements.
- Providers should maintain a roster of their NC CPSS employed to provide services
 - Rosters must be accessible and ready to share to the PHP upon request (see section 6.2 regarding information the provider's roster must include)

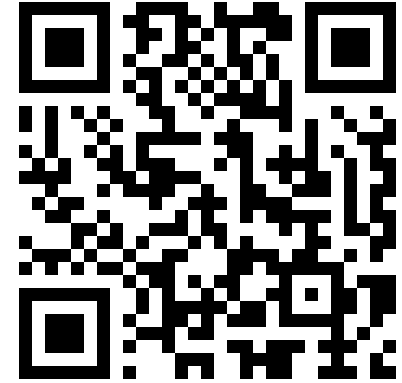
Reminders & Resources



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Resources

- [Peer Support Services \(PSS\), 8G \(PDF\)](#)
- [Peer Support National Practice Guidelines](#)
- Information on PCP developed can be found [here](#)
- [Carolina Complete Health Network Provider Resources](#)
 - [Peer Support Services FAQ and Provider Guide](#)
- Provider Relations: NetworkRelations@cch-network.com
- Provider Engagement: ProviderEngagement@cch-network.com
- Call [1-833-552-3876](tel:1-833-552-3876) for Provider Services.



We value your feedback, please fill out our brief survey,
<https://www.surveymonkey.com/r/2B8SQGG>

Thank you



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Appendix

Billing Information

- Group peer support should be billed with the HQ modifier, and may **not** be provided via telehealth.
- Services provided via telehealth (audio/video) should be billed with the usual place of service (i.e., office) and the telehealth modifier GT.
- Services provided telephonically should be billed with the usual place of service (i.e., office) and the telephonic modifier KX.
- Total time should be documented
- Start/stop times must be documented within notes

** Refer to section F in Attachment A of Clinical Coverage Policy 8G related to allowed amount of use for telehealth and audio-only peer support contacts.*

