Peer Support Services FAQ and Provider Guide

Updates to Clinical Coverage Policy 8G (Peer Support Services), effective September 1, 2026

For more information, review [Clinical Coverage Policy 8G].

1. **Does the updated Clinical Coverage Policy (CCP) 8G include changes to prior authorization requirements?**

   Yes. **Section 5.2.2** states that NC Medicaid may cover up to 176 units of Peer Support Services (PSS) during a 60-calendar-day authorization period. No more than 88 units may be provided during any 30-calendar-day period.
   - Requests exceeding 88 units in a 30-calendar-day period require review and reauthorization every 30 calendar days.
   - For Peer Support Services beyond 9 months, reauthorization requests are required every 30 calendar days.

2. **When do these prior authorization changes take effect for Carolina Complete Health?**

   The changes are effective immediately. All initial authorization and reauthorization requests must follow the updated policy requirements.

3. **Does the updated policy include any changes related to medical necessity criteria?**

   Yes. **Sections 3.2.1, 3.2.3, and 3.2.24** outline the medical necessity criteria. These sections cover admissions, continued stay, and transition/discharge, respectively.

4. **Does the updated policy change the requirements for Comprehensive Clinical Assessments (CCAs)?**

   Yes. **Section 5.2.2** states that a new CCA or CCA addendum is required when PSS continues for more than nine (9) months. The provider must submit the new CCA or addendum with the reauthorization request. If the provider completes an addendum, please include the original CCA and the addendum with the prior authorization request.

5. **Does the updated policy change service order requirements?**

   Yes. **Section 5.4** outlines the service order requirements.
   - PSS service orders are valid for nine months.
   - Associate-licensed clinicians may no longer sign these orders.
     - An independently/fully licensed clinician must sign each service order **within the clinician's scope of practice**. Eligible clinicians include physicians, physician assistants, nurse practitioners, licensed clinical mental health counselors, licensed clinical addiction specialists, licensed marriage and family therapists, licensed clinical social workers, and licensed psychologists.

6. **Are there additional limitations providers should know about?**

Yes. **Section 5.3** contains the complete list of limitations and requirements. Key limitations include:

- PSS must not address a primary medical diagnosis unrelated to recovery from serious mental illness or a substance use disorder.
- PSS must not replace or supplement facility-based staffing requirements.
- PSS must not be provided during the same episode of care as another Medicaid service with duplicative components.
- Transportation is not covered as a component of PSS.

7. **Are there changes to service/progress note documentation requirements?**

Yes. Peer support progress notes must include the service duration and the start and stop times. **Section 5.5.1** lists all required items of the service notes.

8. **Are there new certification-tracking requirements for Certified Peer Support Specialists (CPSS)?**

Yes. **Section 6.2** requires providers to maintain a roster of the CPSS staff they employ. The roster must be accessible and available to the provider's contracted PHP upon request.

At a minimum, the roster must include:

- Full name of the NC CPSS
- Date of hire
- Date of initial certification
- Date of recertification, when applicable
- Date of separation, when applicable

9. **Does the updated policy change overall program requirements?**

Yes. **Section 6.3** states that PSS does not replace clinical care. Instead, PSS supports other mental health and substance use services and may help make them more effective.

The provider organization must offer PSS as part of a broader program. At a minimum, the organization must provide comprehensive clinical assessments, psychotherapy, and medication management.

- If an organization does not provide psychiatric evaluation and medication management, it must partner with a provider that offers these services. The organization must document the partnership in a signed memorandum of understanding (MOU) or memorandum of agreement (MOA).
    - The provider must provide the signed MOU or MOA to its contracted PHP upon request.

10. **Does the updated policy change the requirements for delivering PSS through telehealth?**

Yes. **Attachment A, Sections C, D, and F** explain the telehealth requirements. Telehealth and audio-only telephone services may account for no more than 10% of the total service time provided to each beneficiary during the fiscal year, from July 1 through June 30. The previous limit was 20%.

- For telehealth or telephone services, providers must report their usual place of service, such as an office, home, community, or school. They must also use the GT modifier for audio and video telehealth, or the KX modifier for telephonic (audio-only) services.