

Table of Contents

General Information.....	1
1.0 Description of the Service.....	1
2.0 Eligible Recipients.....	1
2.1 General Provisions.....	1
2.2 EPSDT Special Provision: Exception to Policy Limitations for Recipients under 21 Years of Age.....	1
2.3 Retroactively Eligible Recipients.....	2
3.0 When Services Are Covered.....	2
4.0 When Services Are Not Covered.....	3
5.0 Requirements for and Limitations on Coverage.....	3
5.1 Service Orders.....	3
5.2 Medicaid Service Summary.....	4
5.3 Clinical/Professional Supervision.....	5
5.4 Utilization Management and Authorization of Covered Services.....	6
5.5 Person-Centered Plans.....	6
5.5.1 Developing the Person-Centered Plan.....	6
5.5.2 Person-Centered Planning.....	6
5.5.3 Person-Centered Plan Reviews/Annual Rewrite.....	7
5.6 Documentation Requirements.....	7
5.6.1 Purpose.....	7
5.6.2 Who Is Responsible for Documentation.....	7
5.6.3 Documentation Frequency.....	7
5.6.4 Documentation Format.....	7
5.6.5 Medicaid Service Documentation Requirements.....	8
6.0 Providers Eligible to Bill for the Service.....	9
6.1 General Information.....	9
6.2 Staff Definitions.....	9
7.0 Additional Requirements.....	10
7.1 Audits.....	10
7.2 Appeal Rights for Medicaid Recipients.....	10
7.2.1 Federal Requirements.....	11
7.2.2 Appeal Hearings.....	11
7.2.3 Office of Administrative Hearings (OAH).....	11
7.2.4 Appeal of Service Denial from Other Mental Health Services.....	11
7.2.5 Appeal of Service Reduction, Suspension or Termination.....	11

**Division of Medical Assistance
Enhanced Mental Health
and Substance Abuse Services**

**Clinical Coverage Policy No.: 8A
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8.0	Billing Guidelines	12
8.1	Notifying Recipients of Payment Responsibility and Billing Recipients	12
8.2	Billing for Medicare Crossovers	13
9.0	Policy Implementation/Revision Information.....	13
	Attachment A: Goal Writing.....	17
	Attachment B: Documentation – Best Practice Guidelines	19
	Attachment C: HCPCS Codes.....	20
	Attachment D: Service Definitions	24
	Community Support – Adults (MH/SA) Medicaid Billable Service	24
	Community Support – Children/Adolescents (MH/SA) Medicaid Billable Service	34
	Mobile Crisis Management (MH/DD/SA).....	44
	Diagnostic/Assessment (MH/DD/SA)	48
	Intensive In-Home Services.....	51
	Multisystemic Therapy (MST)	56
	Community Support Team (CST) (MH/SA)	61
	Assertive Community Treatment Team (ACTT).....	67
	Psychosocial Rehabilitation.....	75
	Child and Adolescent Day Treatment (MH/SA).....	81
	Partial Hospitalization.....	87
	Professional Treatment Services in Facility-Based Crisis Program	90
	SUBSTANCE ABUSE SERVICES	93
	Substance Abuse Intensive Outpatient Program	94
	Substance Abuse Comprehensive Outpatient Treatment Program	98
	Substance Abuse Non-Medical Community Residential Treatment	102
	Substance Abuse Medically Monitored Community Residential Treatment.....	107
	Substance Abuse Halfway House	111
	DETOXIFICATION SERVICES	113
	Ambulatory Detoxification	113
	Social Setting Detoxification	115
	Non-Hospital Medical Detoxification.....	117
	Medically Supervised or ADATC Detoxification/Crisis Stabilization.....	119
	Outpatient Opioid Treatment	121

General Information

This document describes policies and procedures that local management entities (LMEs) and direct-enrolled providers must follow to receive reimbursement for covered enhanced benefit behavioral health services provided to eligible Medicaid recipients.

1.0 Description of the Service

This policy sets forth the basic requirements for qualified providers to bill mental health and/or substance abuse services to Medicaid. The following rules give the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS) the authority to set the requirements included in this chapter:

- a. *Rules for Mental Health, Developmental Disabilities and Substance Abuse Facilities and Services, APSM 30-1*
- b. *N.C. Mental Health, Developmental Disabilities, and Substance Abuse Laws, 2001 (G.S. 122-C)*

2.0 Eligible Recipients

All Medicaid recipients are eligible to receive covered behavioral health services.

2.1 General Provisions

Medicaid recipients may have service restrictions due to their eligibility category that would make them ineligible for this service.

2.2 EPSDT Special Provision: Exception to Policy Limitations for Recipients under 21 Years of Age

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 recipients 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 clinician). This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his/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 recipient'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 recipient's right to a free choice of providers.

EPSDT does not require the state Medicaid agency to provide any service, product, or procedure

- a. that is unsafe, ineffective, or experimental/investigational.
- b. 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/or 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 will correct or improve or maintain the recipient'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**

- a. If the service, product, or procedure requires prior approval, the fact that the recipient is under 21 years of age does NOT eliminate the requirement for prior approval.
- b. IMPORTANT ADDITIONAL INFORMATION about EPSDT and prior approval is found in the Basic Medicaid Billing Guide, sections 2 and 6, and on the EPSDT provider page. The Web addresses are specified below.

Basic Medicaid Billing Guide: <http://www.ncdhhs.gov/dma/medbillcaguide.htm>

EPSDT provider page: <http://www.ncdhhs.gov/dma/EPSDTprovider.htm>

2.3 Retroactively Eligible Recipients

Occasionally, individuals become retroactively eligible for Medicaid while receiving covered services from a provider other than an LME. This often involves recipients who are receiving residential treatment at the time they become retroactively eligible.

Retroactively eligible recipients are entitled to receive Medicaid-covered services and to be reimbursed by the provider for all money paid during the period of eligibility, with the exception of any third party payments or cost sharing amounts. The qualified provider may file for reimbursement with Medicaid for these services. (Refer to 10A NCAC 22J.0106.)

3.0 When Services Are Covered

IMPORTANT NOTE: EPSDT allows a recipient less than 21 years of age to receive services in excess of the limitations or restrictions below and without meeting the specific criteria in this section when such services are **medically necessary health care services** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem]; that is, documentation shows how the service, product, or procedure will correct or improve or maintain the recipient'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 DOES NOT ELIMINATE THE REQUIREMENT FOR PRIOR APPROVAL IF PRIOR APPROVAL IS REQUIRED. For additional information about EPSDT and prior approval requirements, see **Section 2.0** of this policy.

All Medicaid services are based upon a finding of medical necessity. Medical necessity is determined by generally accepted North Carolina community practice standards as verified by independent Medicaid consultants. There must be a current diagnosis reflecting the need for treatment. All covered services must be medically necessary for meeting specific preventive, diagnostic, therapeutic, and rehabilitative needs of the patient.

- a. **Preventive** means to anticipate the development of a disease or condition and preclude its occurrence.
- b. **Diagnostic** means to examine specific symptoms and facts to understand or explain a condition.
- c. **Therapeutic** means the treatment and cure of disease or disorders; may also serve to preserve health.
- d. **Rehabilitative** means to restore that which one has lost, to a normal or optimum state of health.

Refer to **Attachment D, Service Definitions**, for service-specific medical necessity criteria.

Refer to the clinical coverage policies for Inpatient Services, Outpatient Services, Residential Treatment Facility Services, Psychiatric Residential Treatment Facility Services and Case Management Services for Adults and Children At Risk of Abuse, Neglect or Exploitation for detailed information on coverage criteria and service requirements (<http://www.ncdhhs.gov/dma/mp/mpindex.htm>).

4.0 When Services Are Not Covered

IMPORTANT NOTE: EPSDT allows a recipient less than 21 years of age to receive services in excess of the limitations or restrictions below and without meeting the specific criteria in this section when such services are **medically necessary health care services** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem]; that is, documentation shows how the service, product, or procedure will correct or improve or maintain the recipient'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 DOES NOT ELIMINATE THE REQUIREMENT FOR PRIOR APPROVAL IF PRIOR APPROVAL IS REQUIRED. For additional information about EPSDT and prior approval requirements, see **Section 2.0** of this policy.

Services are not covered when the criteria listed above are not met or when the policy guidelines are not followed.

5.0 Requirements for and Limitations on Coverage

5.1 Service Orders

Service orders are a mechanism to demonstrate medical necessity for a service and are based upon an assessment of each individual's needs. They are required for each individual service and may be written by a physician, licensed psychologist, nurse

practitioner or physician’s assistant. Backdating of service orders is not allowed. (Refer to **Attachment D, Service Definitions**, for the basic criteria to assure medical necessity.)

Service orders must indicate the **date** the service was ordered. Service orders must be signed and dated by the authorizing professional. A service order must be in place **prior** to or on the day that the service was initially provided in order to bill Medicaid for the service. In the event of retroactive eligibility for Medicaid for a recipient, the provider will not be able to bill Medicaid without a valid service order.

5.2 Medicaid Service Summary

Medicaid Service	Age	Supervision	Order
Assertive Community Treatment Team	Adults	All QPs	MD or Licensed Psychologist (i.e., HSP-P) NP or PA
Community Support – Adults	Adults	All QPs	MD or Licensed Psychologist (i.e., HSP-P) NP or PA
Community Support – Children	Children	All QPs	MD or Licensed Psychologist (i.e., HSP-P) NP or PA
Community Support Team – Adults	Adults	All QPs	MD or Licensed Psychologist (i.e., HSP-P) NP or PA
Day Treatment – Child and Adolescent	Children and Adolescents	All QPs	MD or Licensed Psychologist (i.e., HSP-P) NP or PA
Diagnostic/ Assessment	Children and Adults	N/A	MD, PA, DO, NP, or Licensed Psychologist (i.e., HSP-P)
Intensive In-home Services	Children	All QPs	MD or Licensed Psychologist (i.e., HSP-P) NP or PA
Mobile Crisis Management	Children and Adults	All QPs	MD or Licensed Psychologist (i.e., HSP-P) NP or PA
Multisystemic Therapy	Children and Adults	All QPs	MD or Licensed Psychologist (i.e., HSP-P) NP or PA
Partial Hospitalization	Children and Adults	All QPs	MD or Licensed Psychologist (i.e., HSP-P) NP or PA
Professional Treatment Services in Facility-Based Crisis Programs	Adults	All QPs	MD or Licensed Psychologist (i.e., HSP-P) NP or PA

Medicaid Service	Age	Supervision	Order
Psychosocial Rehabilitation	Adults	MD	MD or Licensed Psychologist (i.e., HSP-P) NP or PA
Substance Abuse Comprehensive Outpatient Treatment Program	Adults	All QPs	MD or Licensed Psychologist (i.e., HSP-P) NP or PA
Substance Abuse Intensive Outpatient Service	Children and Adults	QP with SA competency	MD or Licensed Psychologist (i.e., HSP-P) NP or PA
Substance Abuse Medically Monitored Community Residential Treatment	Adults	All QPs	MD or Licensed Psychologist (i.e., HSP-P) NP or PA
Substance Abuse Non-medical Community Residential Treatment	Adults	All QPs	MD or Licensed Psychologist (i.e., HSP-P) NP or PA
Ambulatory Detoxification	Adults and Children	All QPs	MD or Licensed Psychologist (i.e., HSP-P) NP or PA
Non-hospital Medical Detoxification	Adults	All QPs	MD or Licensed Psychologist (i.e., HSP-P) NP or PA
Medically Supervised or ADATC Detoxification/ Crisis Stabilization	Adults	MD	MD or Licensed Psychologist (i.e., HSP-P) NP or PA
Outpatient Opioid Treatment	Adults and Children	MD, Pharmacist, RN, LPN	MD

5.3 Clinical/Professional Supervision

Supervision is provided as follows: Covered services are provided to recipients by agencies directly enrolled in the Medicaid program, who employ qualified professionals, associate professionals, and paraprofessionals. Medically necessary services delivered by associate and paraprofessionals are delivered under the supervision and direction of the qualified professional.

The qualified professional personally works with consumers to develop the person-centered individualized treatment plan and meets with consumers periodically during the course of treatment to monitor the services being delivered and to review the need for continued services. The supervising qualified professional assumes professional responsibility for the services provided by associate and paraprofessionals and spends as

much time as necessary directly supervising services to ensure that recipients are receiving services in a safe and efficient manner in accordance with accepted standards of practice.

The terms of the qualified professional's employment with the directly enrolled agency providing service ensures that the qualified professional is adequately supervising the associate and paraprofessionals. The agencies ensure that supervisory ratios are reasonable and ethical and provide adequate opportunity for the qualified professional to effectively supervise the associate and paraprofessional staff assigned. Documentation is kept to support the supervision provided to associate and paraprofessional staff in the delivery of medically necessary services.

5.4 Utilization Management and Authorization of Covered Services

Utilization management of covered services is a part of the assurance of medical necessary service provision. Authorization, which is an aspect of utilization management, validates approval to provide a medically necessary covered service to eligible recipients.

Refer to the specific service definition for utilization management and authorization requirements.

Note: In the Piedmont catchment area (Cabarrus, Davidson, Rowan, Stanly, and Union counties), utilization management and authorization is obtained from Piedmont Cardinal Health Plan.

5.5 Person-Centered Plans

5.5.1 Developing the Person-Centered Plan

In order to bill a service to Medicaid, a written person-centered plan for the delivery of medically necessary services must be in place. The person-centered plan must be completed at the time the individual is admitted to a service. When limited information is available at admission, staff should document on the person-centered plan the limited information known and update/revise the person-centered plan when additional information becomes available.

5.5.2 Person-Centered Planning

Person-centered planning is a process of determining real-life outcomes with individuals and developing strategies to achieve those outcomes. The process supports strengths and recovery and applies to everyone supported and served in the system. Person-centered planning provides for the individual with the disability to assume an informed and in-command role for life planning, and treatment, service and support options. The individual with a disability and/or the legally responsible person directs the process and shares authority and responsibility with system professionals about decisions made.

For all individuals receiving services, it is important to include people who are important in the person's life such as family, legal guardian, professionals, friends and others as identified by the individual (i.e., employers, teachers, faith leaders, etc.). These individuals can be essential to the planning process and help drive its success. Person-centered planning uses a blend of paid and unpaid, natural and public specialty resources uniquely tailored to the individual/family needs and desires. It is important for the person-centered planning process to explore and utilize both.

5.5.3 Person-Centered Plan Reviews/Annual Rewrite

A systematic method of reviewing the quality, appropriateness, and comprehensiveness of the person-centered plan, and a process for initiating plan revisions based on the results of such reviews must be established. At a minimum, the person-centered plan must be reviewed by the responsible professional based upon the target date assigned to each goal, whenever the consumer's needs change or when a service provider changes or before the goal(s) expire. Each goal on the person-centered plan must be reviewed separately, based on the target date associated with each goal. For Medicaid recipients who receive psychosocial rehabilitation services, the person-centered plan shall be reviewed every six months. All person-centered plans must be reviewed at least annually.

5.6 Documentation Requirements

5.6.1 Purpose

The service record documents the nature and course of an individual's progress in treatment. In order to bill Medicaid, documentation must be consistent with requirements contained in this policy and in the service definitions.

5.6.2 Who Is Responsible for Documentation

The staff that provides the service is responsible for accurately documenting the services billed to and reimbursed by Medicaid:

- a. A qualified professional is not required to countersign service notes written by a non-qualified staff person. A qualified provider may choose to use countersigning to demonstrate supervision as a part of their internal policy and procedures, but MH/DD/SAS does not require countersignatures.
- b. The staff person who provides the service must sign the written entry, including credentials and/or job title. A clinician may provide multiple services. For example, if an MSW provides case management and outpatient services, the entry would be documented with the name or initials and "MSW."

5.6.3 Documentation Frequency

The frequency and format for documentation vary according to the service provided.

- a. Periodic and Day/Night Services:
 1. The duration (actual time must be documented for both periodic and day/night services).
 2. For day/night services, the duration is required for each day the service is provided – not an accumulation of time over the week, month or quarter.
- b. 24-hour Services: The bed count or census at midnight constitutes one (1) billable unit of service.

5.6.4 Documentation Format

The frequency and format for documentation vary according to the service provided. Service notes must include the following:

- a. **Date** of service provision
- b. **Duration** of service
- c. **Purpose** of the contact as it relates to goal(s) in the person-centered plan
- d. **Description** of the activity and the staff person's **intervention**
- e. **Assessment** of recipient's progress towards goal(s)
- f. **Signature** of the staff member who provided the service (For professionals, signature and credentials, degree, or licensure of the service provider; and for paraprofessionals, signature and position of the individual who provided the service.)
- g. **Each page must** be identified with client name and Medicaid identification number

5.6.5 Medicaid Service Documentation Requirements

Service	Frequency	Format
Assertive Community Treatment Team	Each Event	Service Note
Community Support – Adults	Each Event	Service Note
Community Support – Children	Each Event	Service Note
Community Support Team	Each Event	Service Note
Day Treatment – Child and Adolescent	Each Event	Service Note
Diagnostic/Assessment	Each Event	Service Note
Intensive In-home Services	Daily	Service Note
Mobile Crisis Management	Each Event	Service Note
Multisystemic Therapy	Each Event	Service Note
Partial Hospitalization	Each Event	Service Note
Professional Treatment Services in Facility-Based Crisis Programs	Shift	Service Note
Psychosocial Rehabilitation	Daily	Service Note
Substance Abuse Comprehensive Outpatient Treatment Program	Each Event	
Substance Abuse Intensive Outpatient Service	Each Event	Service Note
Substance Abuse Medically Monitored Community Residential Treatment	Each Shift	Service Note
Substance Abuse Non-medical Community Residential Treatment	Each Shift	Service Note
Ambulatory Detoxification	Daily	Service Note
Non-hospital Medical Detoxification	Each Shift	Service Note

Service	Frequency	Format
Medically Supervised or ADATC Detoxification/Crisis Stabilization	Each Shift	Service Note
Outpatient Opioid Treatment	Each Event	Service Note

6.0 Providers Eligible to Bill for the Service

6.1 General Information

Competencies of Qualified Professionals and Associate Professionals are documented along with supervisory requirements to maintain that competency (10A NCAC 27G.0203). Competencies and Supervision of Paraprofessionals are documented along with supervisory requirements to maintain that competency (10A NCAC 27G.0204).

Some services distinguish between the professional and paraprofessionals that may provide a particular service. (Refer to **Attachment D, Service Definitions**, for service-specific requirements.)

Qualified providers must be endorsed by the LMEs and direct enrolled with the Medicaid Agency for each individual service they wish to provide. Provider numbers are assigned by DMA to qualified providers who bill Medicaid directly.

6.2 Staff Definitions

Staff must be licensed and/or certified according to N.C. General Statutes and practice within the scope of practice as defined by the individual practice board.

- a. Licensed Professional Counselor (LPC)
- b. Licensed Clinical Addiction Specialist (LCAS)
- c. Certified Clinical Supervisor (CCS)
- d. Licensed Marriage and Family Counselor
- e. Certified Substance Abuse Counselor (CSAC)
- f. Clinical Staff Member
- g. Licensed Clinical Social Worker
- h. Doctor of Osteopathy
- i. Licensed Psychologist
- j. Licensed Psychological Associate
- k. Certified Clinical Supervisor
- l. Certified Substance Abuse Prevention Consultant
- m. Registered Nurse
- n. Clinical Nurse Specialist
- o. Nurse Practitioner
- p. Physician's Assistant
- q. Psychiatrist
- r. Qualified Professional

- s. Paraprofessional
- t. Associate Professional

7.0 Additional Requirements

7.1 Audits

DMH/DD/SAS and DMA (DHHS team) jointly conduct annual audits of a sample of Medicaid-funded mental health, developmental disabilities, and/or substance abuse services. The purpose of the Medicaid audit is to ensure that these services are provided to Medicaid recipients in accordance with federal and state regulations and to ensure the accuracy and integrity of documentation and billing practices of directly enrolled providers. This quality control process is utilized to ensure medical necessity and quality of service provision.

Any identified deficiencies are forwarded to DMA's Program Integrity Section. The following information is forwarded to Program Integrity from the DHHS audits:

- a. Cover letter that summarizes overview of the issues identified, time period covered by the review, and type of sampling.
- b. Copies of financial and medical records, showing the specific billing errors identified in the audit and through the area program/LME/provider own reviews. This document includes recipient's name, Medicaid identification number, county of residence, dates of service, procedure code and number of units billed in error, per recipient, amount billed, amount paid and paid date, and reason for error.

Refunds or requests for withholdings from future payments should be sent to

Office of Controller
DMA Accounts Receivable
2022 Mail Service Center
Raleigh, N.C. 27699-2022

7.2 Appeal Rights for Medicaid Recipients

Qualified providers shall have procedures to meet the federal law (42 CFR 431 Sub-Part E) regarding appeal rights afforded to Medicaid recipients. The qualified provider's decisions are based on whether or not the specific covered service is medically necessary. The procedures discussed below apply to appeals regarding mental health and/or substance abuse services for which qualified providers bill Medicaid. The appeal rights apply to situations in which a recipient is

denied a requested service; **OR**

informed that a current service will be reduced, suspended, or terminated.

If the utilization review vendor(s) reviews the actual or proposed treatment of a Medicaid recipient and determines that the services are **not medically necessary**, the vendor(s) shall notify both the Medicaid recipient and provider of this determination, in writing. This written notification must include the following:

- a. Explanation of the determination and the reason
- b. Notice that Medicaid will not pay for the service

- c. Options for appropriate alternative Medicaid covered services, or the option to pay for the service at the recipient's own expense as a non-covered service
- d. Notice of available appeal rights

7.2.1 Federal Requirements

Federal law requires that Medicaid recipients receive notification of their appeal rights:

at the time a requested service is denied; **AND**

before the date a current service is reduced, suspended or terminated.

7.2.2 Appeal Hearings

There are two options available for hearings when a requested service is denied, or a service is reduced, suspended or terminated by an LME. A current or potential service recipient may choose either option:

An informal hearing by DMA, **OR**

A formal or evidentiary hearing by the Office of Administrative Hearings (OAH) (Raleigh).

7.2.3 Office of Administrative Hearings (OAH)

A current or potential service recipient has the right to appeal directly to OAH.

- a. Provide necessary information with the denial letter informing the current or potential service recipient of their right to appeal directly to OAH. Include phone number and time frame information.
- b. OAH must receive the Petition Form from the current or potential service recipient with 60 days from the date of the denial letter.
- c. Formal hearing before an administrative judge is scheduled by OAH.

7.2.4 Appeal of Service Denial from Other Mental Health Services

Appeals of service denials from Medicaid utilization contract agencies should be sent to DMA (10A NCAC 22H .0102, 10A NCAC 22H .0103).

7.2.5 Appeal of Service Reduction, Suspension or Termination

A current service recipient must be informed in writing by the qualified provider **before** the service in question is reduced, suspended or terminated. The process for appealing is the same as above, with the additional stipulation that a letter must be sent to the service recipient at least ten days **before** any interruption of the service in dispute.

If the service recipient requests either an informal hearing or an OAH hearing before the date the service reduction, suspension or termination is to occur, he or she has the right to continue to receive the service in dispute until resolution of the appeal if the denial is upheld.

8.0 Billing Guidelines

Some Medicaid-billable services are unique to mental health, developmental disabilities, and/or substance abuse services, or have characteristics that are unique to those services. Only billing information that is specific to these services will be discussed here

8.1 Notifying Recipients of Payment Responsibility and Billing Recipients

Notification to current or prospective Medicaid recipients that they will be responsible for payment for services must comply with 10A NCAC 22J.0106, which limits the circumstances under which a qualified provider may bill a Medicaid recipient. All Statements of Financial Responsibility should conform to these rules. (The information below is taken from 10A NCAC 22J.0106.)

- a. A qualified provider shall not bill an individual for Medicaid services for which it receives no Medicaid reimbursement when:
 - i. The provider failed to follow program regulations; **OR**
 - ii. The agency denied the claim on the basis of a lack of medical necessity; **OR**
 - iii. The provider is attempting to bill the Medicaid recipient beyond the situations stated in 10A NCAC 22J .0106, which are:
 - (a) For allowable deductibles, co-insurance, or co-payments as specified in 10A NCAC 22C.0101 and 10A NCAC 22D.0101 or
 - (b) Prior to service delivery, the provider has informed the individual that they may be billed for a service that is not covered by Medicaid, regardless of the type of provider, or is beyond Medicaid service limits as specified under 10A NCAC 22B, 10A NCAC 22C, and 10A NCAC 22D; or
 - (c) The individual is 65 years of age or older and is enrolled in the Medicare program at the time services are received but has failed to supply a Medicaid number as proof of coverage; or
 - (d) The individual is no longer eligible for Medicaid.
- b. If a Medicaid recipient was not properly notified prior to receiving a service, the recipient cannot be billed for the service. A Medicaid recipient cannot be held responsible for payment after the fact for any service for which Medicaid does not reimburse the provider. The provider must verify Medicaid coverage prior to initiation of the service.
- c. A Medicaid recipient may be billed for **Medicaid-covered services** only if the provider does not bill Medicaid and/or does not accept Medicaid payment for **any services provided**:
 - i. The provider must inform the recipient in writing, prior to service delivery, that he/she does not accept and will not bill Medicaid for any services provided, and that the recipient will be responsible for payment for all services received.
 - ii. If the provider bills Medicaid first, or per 10A NCAC 22J.0106 otherwise accepts an individual as a Medicaid recipient, then the provider may not bill the recipient if Medicaid denies payment.
- d. A Medicaid recipient may be billed for services that are **not covered** by Medicaid if the provider informs the recipient in writing prior to the service delivery that the

services are not covered by Medicaid, or are beyond Medicaid limits and, if elected, payment will be the recipient's responsibility.

- i. If the prospective recipient elects to receive or to continue to receive, at his/her own expense, a service that the utilization review vendor(s) has determined is not medically necessary, and the provider plans to bill the prospective recipient, this provider must notify the prospective recipient, as prescribed in 10A NCAC 22J.0106 that:
 - (a) The service has been determined by Medicaid to be medically unnecessary.
 - (b) Medicaid will not cover the service in the event that the prospective recipient is approved for Medicaid.
 - (c) The prospective recipient can sign an agreement that they will be financially responsible for payment of the non-covered service, if he or she chooses to receive the service.
- e. A Medicaid recipient may not be billed for missed appointments.

8.2 Billing for Medicare Crossovers

When any qualified provider renders services to a **Medicaid** recipient, all other third-party payers, including **Medicare**, must be billed prior to submitting a claim for **Medicaid** reimbursement.

There are specific coding requirements for all claims submitted to Medicare that is substantially different than the requirements for billing Medicaid:

- a. **Diagnosis Coding** is required on all claims to Medicare. The Centers for Medicare and Medicaid Services (CMS) recognizes only the *International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM)* codes. Medicare does **NOT** recognize any DSM IV diagnosis codes.
- b. **Using the ICD-9-CM:**
 - i. Identify the appropriate code in Volume 2 of the ICD-9-CM.
 - ii. Locate the identified code in Volume 1 of the ICD-9-CM.
 - iii. Use the instructions in Volume 1 to clarify and specify the best code with which to identify an individual's condition.

For further information about Medicare, refer to the *Cigna Medicare Part B Provider Manual*, or online at www.cignamedicare.com/provman.

9.0 Policy Implementation/Revision Information

Original Effective Date: July 1, 1989

Revision Information:

Date	Section Revised	Change
9/1/05	Section 2.0	A special provision related to EPSDT was added.
12/1/05	Section 2.2	The web address for DMA's EDPST policy instructions was added to this section.
1/1/06	Section 8.1	Procedure code 90782 was end-dated and replaced with 90772.

Date	Section Revised	Change
1/1/06	Attachment C	Procedure code 90782 was end-dated and replaced with 90772; 96100 was end-dated and replaced with 96101; 96115 was end-dated and replaced with 96116; and 96117 was end-dated and replaced with 96118.
7/1/06	Policy Title	The title of the policy was changed.
7/1/06	General Information	References to direct-enrolled residential treatment providers were deleted from the policy.
7/1/06	Entire Policy	References to area programs were deleted throughout the policy.
7/1/06	Section 1.0	The reference to the Service Records Manual for MH/DD/SAS Providers was deleted as one of the rules that provide DMH/DD/SAS the authority to set requirements for behavioral health services.
7/1/06	Section 2.3	Information pertaining to services that were billed through an area program was deleted.
7/1/06	Section 3.1	References to palliative care and case management including medical necessity criteria for case management were deleted from the policy.
7/1/06	Section 3.2	This section, pertaining to the provision of mental health services through an area program, was deleted from the policy.
7/1/06	Section 5.1	The statement that providers must have a policy regarding how the service orders are documented was deleted. The statement that an approved professional must order services was deleted. The statement that each provider must have a standing order for screening and evaluation services was deleted.
7/1/06	Section 5.2	The Medicaid Services Summary table was updated to reflect who can order specific services.
7/1/06	Section 5.3	This section, pertaining to service orders for retroactively eligible recipients, was deleted from the policy and replaced with a new section pertaining to clinical/professional supervision.
7/1/06	Section 5.4	Information pertaining to the initial authorization for residential child treatment facility services, psychiatric residential facility services, outpatient services, and outpatient specialized therapies was deleted. Instructions pertaining to services that do not require authorization by an external reviewer were deleted. The rest of Section 5.0 was renumbered accordingly.
7/1/06	Section 5.5.2	This section was updated to address the person-centered planning process.
7/1/06	Section 5.5.3	The requirement that all person centered plans must be reviewed at least annually was added.
7/1/06	Section 5.6.1	The reference to the Service Records Manual was deleted.
7/1/06	Section 5.6.4	Documentation requirements for case management services were deleted. The Medicaid Service Documentation Requirements table was updated to reflect the documentation requirements for the approved service definitions.

Date	Section Revised	Change
7/1/06	Section 6.0	Information pertaining to the credentialing process was deleted.
7/1/06	Section 6.1	The staff definition for qualified client record manager was deleted.
7/1/06	Section 7.1	Information pertaining to annual audits was updated. This section pertaining to the Certification of Need for Institutional Care was deleted from the policy.
7/1/06	Section 7.2	This section pertaining to therapeutic leave was deleted from the policy.
7/1/06	Section 7.4	This section pertaining to the F2 stamp requirement was deleted from the policy.
7/1/06	Section 7.5	This section pertaining to Criterion #5 was deleted from the policy.
7/1/06	Section 7.6	This section pertaining to staffing for residential treatment services was deleted from the policy.
7/1/06	Section 7.7	Information from Section 8.3 pertaining to appeal of service denials for non medically necessary services was added to this section, which was renumbered to Section 7.2.
7/1/06	Section 7.7.3	The portion of this section pertaining to the appeal of a service denial from an area mental health program by DMH/DD/SAS was deleted from the policy. The remainder of the information in this section (OAH hearings) was renumbered to Section 7.2.3
7/1/06	Section 8.1	This section pertaining to who can bill CPT codes was deleted from the policy.
7/1/06	Section 8.2	This section pertaining to what services can be billed was deleted from the policy.
7/1/06	Section 8.3	Information pertaining to appeal of service denial for non medically necessary services was moved to Section 7.7 and the section was renumbered to Section 8.1.
7/1/06	Section 8.4	This section pertaining to billing for therapeutic leave was deleted from the policy.
7/1/06	Attachment C	This attachment pertaining to CPT codes and billable services was deleted from the policy.
7/1/06	Attachment D	The attachment pertaining to HCPCS codes was updated and renumbered to Attachment C.
7/1/06	Attachment E	The service definitions listed were revised effective with date of approval by CMS and the attachment was renumbered to Attachment D.
12/1/06	Section 2.2	The special provision related to EPSDT was revised.
12/1/06	Sections 3.0 and 4.0	A note regarding EPSDT was added to these sections.
4/1/07	Attachment D, Medicaid Billable Service	A section on Utilization Management and the first sentence under Service Exclusions/Limitations were added after having been inadvertently omitted.

Date	Section Revised	Change
4/1/07	Attachment D, Partial Hospitalization	The minimum provision was corrected from 3 to 4 hours per day. This is a correction to an error, not a change in coverage.
4/1/07	Sections 2.2, 3.0, and 4.0	EPSDT information was revised to clarify exceptions to policy limitations for recipients under 21 years of age.
6/11/07	Section 6.2	Corrected title of Licensed Clinical Supervisor to Certified Clinical Supervisor.
6/11/07	Attachment D	Revised service definitions for community supports (children and adults).
2/1/08	Attachment D	Revised service definitions for community supports (children and adults).

Attachment A: Goal Writing

“A usefully stated objective [goal] is one that succeeds in communicating an intended result.” [Mager, *Preparing Instructional Objectives*].

A strong, well-written goal will communicate three pieces of information: what the person will do (behavior); under what conditions the performance will occur (condition); and the acceptable level of performance (criteria).

What the Person Will Do refers to the **behavior, performance, or action** of the person for whom the goal is written. In services for people with disabilities, especially in the context of person-centered services, behavioral objectives/goals should be stated in positive, affirmative language.

Under What Conditions the Performance Will Occur is the part of the goal that describes the **action of the staff person or staff intervention**. Specifically address what assistance the staff person will provide, and/or what the staff person will do (if anything) to see that the behavior, performance, or action of the individual occurs. Here are some examples of conditions and interventions:

- With assistance from a staff person...
- When asked...
- With suggestions from a team member...
- With physical assistance...
- Given that Ellen has received instruction...
- Given that Jeremy has the phone book in front of him...
- Without any verbal suggestions...
- Given that a staff person has shown Jose where the detergent is...
- With no suggestions or demonstrations...

Acceptable Level of Performance refers to **criteria**. This means the goal must include a description of how “achievement” will be defined. In writing this part of the goal, always consider how the person or the people who know the person well define success. Performance may be overt, which can be observed directly, or it may be covert, which means it cannot be observed directly, but is mental, invisible, cognitive, or internal. [Mager, *Preparing Instructional Objectives*].

Measurable Goals are most easily written by using words that are open to *fewer interpretations*, rather than words that are open to *many interpretations*. Consider the following examples:

a. Words open to many interpretations (TRY NOT TO USE THESE WORDS) are:

- to know
- to understand
- to really understand
- to appreciate
- to fully appreciate
- to grasp the significance of

- to enjoy
- to believe
- to have faith in
- to internalize

b. Words open to fewer interpretations (USE THESE TYPES OF WORDS) are:

- to write
- to recite
- to identify
- to sort
- to solve
- to construct
- to build
- to compare
- to contrast
- to smile

Here are some **examples of goals** that are written using positive language and that include the elements above:

- With staff assistance [*condition*], Marsha will choose her clothing, based on the weather [*performance*], five out of seven days for the next three months [*criteria*].
- Adam will identify places he can go in his free time [*performance*], without any suggestions from staff [*condition*], each Saturday morning for the next three months [*criteria*].
- With gentle, verbal encouragement from staff [*condition*], Charles will not scream while eating [*performance*], two out of three meals, for five minutes each time, for the next two months [*criteria*].
- Given that Rosa has received instructions [*condition*], she will call her therapist to make her own appointments [*performance*], as needed during the next four months [*criteria*].
- With suggestions from a support team member [*condition*], Henry will write a letter to his father [*performance*], once a month for the next six months [*criteria*].

Attachment B: Documentation – Best Practice Guidelines

Services that are billed to Medicaid must comply with Medicaid reimbursement guidelines, and all documentation must relate to goals in the individual's person-centered plan. To assist in assuring that these guidelines are met, the *Service Records Resource Manual for Area Programs and Contract Agencies, APSM 45-2A* recommends that documentation be:

- a. **Accurate** - describing the facts as observed or reported;
- b. **Timely** - recording significant information at the time of the event, to avoid inaccurate or incomplete information;
- c. **Objective** - recording facts and avoiding drawing conclusions. Professional opinion must be phrased to clearly indicate that it is the view of the recorder;
- d. **Specific, concise, and descriptive** - recording in detail rather than in general terms, being brief and meaningful without sacrificing essential facts, and thoroughly describing observation and other pertinent information;
- e. **Consistent** - explaining any contradictions and giving the reasons for the contradictions;
- f. **Comprehensive, logical, and reflective of thought processes** - recording significant information relative to an individual's condition and course of treatment/habilitation. Document pertinent findings, services rendered, changes in the person's condition and/or response to treatment/habilitation. Include justification for initial services as well as continued treatment/ habilitation needs. Document reasons for any atypical treatment/ habilitation utilized.
- g. **Clear** - recording meaningful information, particularly for other staff involved in the care/treatment of the individual. **Write in non-technical terms** to the extent possible.

Attachment C: HCPCS Codes

Community Support - Adults

HCPCS Procedure Code	Description	Bill with Modifier	Billing Unit
H0036	Community psychiatric supportive treatment, face-to-face, per 15 minutes	HB – denotes individual HQ – denotes group	1 unit =15 minutes

Community Support - Children

HCPCS Procedure Code	Description	Bill with Modifier	Billing Unit
H0036	Community psychiatric supportive treatment, face-to-face, per 15 minutes	HA – denotes individual HQ – denotes group	1 unit =15 minutes

Mobile Crisis Management

HCPCS Procedure Code	Description	Billing Unit
H2011	Crisis intervention service, per 15 minutes	1 unit =15 minutes

Diagnostic/Assessment

HCPCS Procedure Code	Description	Billing Unit
T1023	Screening to determine the appropriateness of consideration of an individual for participation in a specified program, project or treatment protocol, per encounter	1 unit =1 event

Intensive In-Home Services

HCPCS Procedure Code	Description	Billing Unit
H2022	Community-based wrap-around services, per diem (intensive in-home services)	1 unit =1 day

Multisystemic Therapy

HCPCS Procedure Code	Description	Billing Unit
H2033	Multisystemic therapy for juveniles, per 15 minutes	1 unit =15 minutes

Community Support Team - Adults

HCPCS Procedure Code	Description	Bill with Modifier	Billing Unit
H2015	Community psychiatric supportive treatment, face-to-face, per 15 minutes	HT – denotes individual	1 unit =15 minutes

Assertive Community Treatment Team

HCPCS Procedure Code	Description	Billing Unit
H0040	Assertive community treatment program, per diem	1 unit =1 event

Psychosocial Rehabilitation

HCPCS Procedure Code	Description	Billing Unit
H2017	Psychosocial rehabilitation services, per 15 minutes	1 unit =15 minutes

Child and Adolescent Day Treatment

HCPCS Procedure Code	Description	Bill with Modifier	Billing Unit
H2012	Behavioral health day treatment, per hour	HA	1 unit =1 hour

Partial Hospitalization

HCPCS Procedure Code	Description	Bill with Modifier	Billing Unit
H0035	Mental health partial hospitalization, treatment, less than 24 hours		1 unit =1 event

Professional Treatment Services in Facility-Based Programs – Adult

HCPCS Procedure Code	Description	Billing Unit
S9484	Crisis intervention mental health services, per hour (facility based crisis services)	1 unit = 1 hour

Substance Abuse Intensive Outpatient Program

HCPCS Procedure Code	Description	Billing Unit
H0015	Alcohol and/or drug services; intensive outpatient (treatment program that operates at least 3 hours/day and at least 3 days/week and is based on an individualized treatment plan), including assessment, counseling; crisis intervention and activity therapies or education	1 unit = 1 event per day (3 hours minimum)

Substance Abuse Comprehensive Outpatient Treatment

HCPCS Procedure Code	Description	Billing Unit
H2035	Alcohol and/or other drug treatment program, per hour (substance abuse comprehensive outpatient treatment)	1 unit = 1 hour

Substance Abuse Non-Medical Community Residential Treatment - Adult

HCPCS Procedure Code	Description	Bill with Modifier	Billing Unit
H0012	Alcohol and/or drug services; sub-acute detoxification (substance abuse non-medical community residential addiction program outpatient)	HB	1 unit = 1 day not to exceed more than 30 days in a 12-month period

Substance Abuse Medically Monitored Community Residential Treatment

HCPCS Procedure Code	Description	Billing Unit
H0013	Alcohol and/or drug services; acute detoxification (substance abuse medically monitored community residential addiction program outpatient)	1 unit = 1 day not to exceed more than 30 days in a 12-month period

Ambulatory Detoxification

HCPCS Procedure Code	Description	Billing Unit
H0014	Alcohol and/or drug services; ambulatory detoxification	1 unit = 15 minutes

Non-Hospital Medical Detoxification

HCPCS Procedure Code	Description	Billing Unit
H0010	Alcohol and/or drug services; sub-acute detoxification (non-hospital medical detox residential addiction program inpatient)	1 unit = 1 day not to exceed more than 30 days in a 12-month period

Medically Supervised Detoxification/Crisis Stabilization

HCPCS Procedure Code	Description	Billing Unit
H2036	Alcohol and/or other drug treatment program, per hour (medically supervised detox/crisis stabilization)	1 unit = 1 day not to exceed more than 30 days in a 12-month period

Opioid Treatment

HCPCS Procedure Code	Description	Billing Unit
H0020	Alcohol and/or drug services; methadone administration and/or service (provision of the drug by a licensed program)	1 unit = 1 event

Attachment D: Service Definitions

Community Support – Adults (MH/SA) Medicaid Billable Service

Service Definition and Required Components

Community Support consists of mental health and substance abuse rehabilitation services and supports necessary to assist the recipient in achieving and maintaining rehabilitative, sobriety, and recovery goals. This medically necessary service directly addresses the recipient's diagnostic and clinical needs. These diagnostic and clinical needs are evidenced by the presence of a diagnosable mental illness and/or substance related disorder (as defined by the DSM-IV-TR and its successors), with symptoms and effects documented in the Person Centered Plan.

Community Support services, which are psychoeducational and supportive in nature, are intended to meet the mental health or substance abuse needs of adults who have significant functional impairments that seriously interfere with or impede their roles or functioning in family, school, or community.

The service is designed to

- increase skills to address the complex mental health and/or substance abuse needs of adults who have significant functional deficits in order to promote symptom reduction;
- assist recipients in acquiring mental health/substance abuse recovery skills necessary to successfully address vocational, housing, and educational needs; and
- assist recipients in gaining access to and coordinating necessary services to promote clinical stability and meet their mental health/substance abuse treatment, social, and other treatment support needs.

The rehabilitative service activities of Community Support consist of a variety of interventions that must directly relate to the recipient's diagnostic and clinical needs as reflected in a comprehensive clinical assessment and outlined in the Person Centered Plan.

These shall include the following, as clinically indicated:

- Identification of strengths that will aid the individual in his or her recovery, as well as barriers that impede the development of skills necessary for independent functioning in the community
- One-on-one interventions with the recipient, unless a group intervention is deemed more efficacious, to develop interpersonal, relational, and coping skills in the community, including adaptation to home, school, and work environments
- Therapeutic mentoring that directly increases the acquisition of skills needed to accomplish the goals of the Person Centered Plan
- Symptom monitoring
- Medication monitoring, with documented communication to prescribing physician(s)
- Self-management of symptoms
- Direct preventive and therapeutic interventions that will assist with skill building
- Assistance with skill enhancement or acquisition
- Relapse prevention and disease management strategies
- Psychoeducation and training of family, unpaid caregivers, and others who have a legitimate role in addressing the needs identified in the Person Centered Plan

- Support for ongoing treatment and encouraging the achievement of functional gains
- Case management for the effective coordination of clinical services, natural and community supports for the recipient and his or her family

The service includes providing “first responder” crisis response on a 24/7/365 basis to recipients experiencing a crisis.

The Community Support Qualified Professional in partnership with the recipient initiates, develops, and revises the Person Centered Plan. The Community Support Qualified Professional provides coordination of movement across levels of care by interacting directly with the person and his or her family and by coordinating discharge planning and community re-entry following hospitalization, residential services, and other levels of care. The Community Support Qualified Professional provides and oversees case management to arrange, link, monitor, and/or integrate multiple services as well as assessment and reassessment (e.g., changes in life domains) of the recipient’s need for services.

The Community Support Qualified Professional must consult with identified providers, include their input in the Person Centered Planning process, inform all involved stakeholders, and monitor the status of the recipient in relationship to the treatment goals. Community Support staff also inform the recipient about benefits, community resources, and services; and assist the recipient in accessing benefits and services. The organization assumes the roles of advocate, broker, coordinator, and monitor of the service delivery system on behalf of the recipient.

For Medicaid-funded services, a personally signed service order for Community Support services must be completed by a physician, licensed psychologist, physician’s assistant, or nurse practitioner according to his or her scope of practice, along with other documentation requirements outlined in this policy. The service order must be based on an individualized assessment of the recipient’s needs. For State-funded services, it is recommended that a service order be completed within the first visit.

Provider Requirements

Community Support services must be delivered by practitioners employed by mental health or substance abuse provider organizations that

- meet the provider qualification policies, procedures, and standards established by the Division of Medical Assistance (DMA);
- meet the provider qualification policies, procedures, and standards established by the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (MH/DD/SAS); and
- fulfill the requirements of 10A NCAC 27G.

These policies and procedures set forth the administrative, financial, clinical, quality improvement, and information services infrastructure necessary to provide services. Provider organizations must demonstrate that they meet these standards by being endorsed by the Local Management Entity (LME). Additionally, within three years of enrollment as a provider, the organization must have achieved national accreditation with at least one of the designated accrediting agencies. The organization must be established as a legally constituted entity capable of meeting all of the requirements of the Provider Endorsement, Medicaid Enrollment Agreement, Medicaid Bulletins, and service implementation standards. This includes national accreditation within the prescribed timeframe.

The Community Support provider organization is identified in the Person Centered Plan. For Medicaid services, the organization is responsible for obtaining authorization from Medicaid's approved vendor for medically necessary services identified in the Person Centered Plan. For State-funded services, the organization is responsible for obtaining authorization from the Local Management Entity. The Community Support provider organization must comply with all applicable federal, state, and DHHS requirements. This includes, but is not limited to, DHHS Statutes, Rule, Policy, Implementation Updates, Medicaid Bulletins, and other published instruction.

Staffing Requirements

Persons who meet the requirements specified (10A NCAC 27G.0104) for Qualified Professional (QP), Associate Professional (AP), or Paraprofessional status, and who have the knowledge, skills, and abilities required by the population and age to be served, may deliver Community Support. Qualified Professionals shall develop and coordinate the Person Centered Plan. Associate Professionals and Paraprofessionals may deliver Community Support services to directly address the recipient's diagnostic and clinical needs under the direction of a Qualified Professional.

All Associate Professionals and Paraprofessionals providing Community Support must be supervised by a Qualified Professional. Supervision must be provided according to supervision requirements specified in 10A NCAC 27G.0204 and according to licensure or certification requirements of the appropriate discipline.

A Certified Clinical Supervisor (CCS) or Licensed Clinical Addiction Specialist (LCAS) may also deliver and supervise Community Support as a Qualified Professional.

The following chart sets forth the activities that may be performed by a Qualified Professional, Certified Clinical Supervisor, Licensed Clinical Addiction Specialist, Associate Professional, or Paraprofessional. These activities reflect the appropriate scope of practice for these individuals.

Community Support	
Qualified Professional Certified Clinical Supervisor Licensed Clinical Addiction Specialist	Associate Professional Paraprofessional (under the supervision of the Qualified Professional)
<ul style="list-style-type: none"> • Coordination and oversight of initial and ongoing assessment activities • Ensuring linkage to the most clinically appropriate and effective services • Facilitation of the Person Centered Planning process, including the recipient and people identified as important in the recipient's life (e.g., family, friends, providers) • Initial development and ongoing revision of Person Centered Plan • Monitoring the implementation of the Person Centered Plan, including involvement of other medical and non-medical providers, the consumer, and natural and community supports • Supportive counseling to address the diagnostic and clinical needs of the recipient • Case management functions to arrange, link, monitor, and/or integrate multiple services and referrals • Coordination with the recipient's medical home (e.g., primary care physician) • Monitoring of activities provided by Associate Professional and Paraprofessional staff providing Community Support • Provision of all activities, functions, and interventions of the Community Support service definition 	<ul style="list-style-type: none"> • Assistance with therapeutic interventions to rehabilitate <ul style="list-style-type: none"> ○ Functional skills ○ Adaptation, socialization, relational, and coping skills ○ Self-management of symptoms ○ Daily and community living skills ○ Behavior and anger management skills • Therapeutic mentoring that directly increases the acquisition of skills needed to accomplish the goals of the Person Centered Plan • Psychoeducation and training of family, unpaid caregivers, and others who have a legitimate role in addressing the needs identified in the Person Centered Plan • Direct preventive and therapeutic interventions that will assist with skill building • Relapse prevention and disease management strategies • Ongoing symptom monitoring and management • Ongoing medication monitoring, with report to medical providers • Service coordination activities within the established Person Centered Plan • Input into the Person Centered Plan modifications

All staff providing community support to adults must complete a minimum of 20 hours of training specific to the required components of the Community Support Service definition, including crisis response, within the first 90 days of employment.

Family members or legally responsible persons of the recipient may not provide these services for reimbursement.

Service Type/Setting

Community Support is a direct and indirect periodic service in which the Community Support staff provides direct clinical intervention and also arrange, coordinate, and monitor services on behalf of the

recipient. Community Support providers must have the ability to deliver services in various environments, such as homes, schools, jails (for State funds only),* homeless shelters, street locations, and other community settings.

This service includes providing “first responder” crisis response on a 24/7/365 basis to recipients experiencing a crisis.

Community Support also includes telephone time with the individual recipient and collateral contact with persons who assist the recipient in meeting his or her rehabilitation goals. Community Support includes activities and meetings for the planning, development, and revision of the recipient’s Person Centered Plan. Community Support services may be provided to an individual or a group of individuals.

***Note:** For all services, federal Medicaid regulations will deny Medicaid payment for services delivered to inmates of public correctional institutions or to patients in facilities that have more than 16 beds and that are classified as Institutions of Mental Diseases.

Program Requirements

Caseload size for a Community Support Qualified Professional may not exceed 1 Qualified Professional to 30 recipients. (Note: in computing caseload ratios, a recipient receiving fewer than 4 hours of service per week may be counted as half a recipient). When Community Support services are provided in a group, groups may not exceed 8 individuals.

For each authorization period (90 days or less, depending on authorization), a minimum of 15% of the total billable community support services provided per recipient must be provided by the Qualified Professional. This is to ensure that medically appropriate clinical interventions are provided based on implementation/revision of the required Person Centered Plan. For each endorsed provider site, a minimum of 25% of the total aggregate billable Community Support services per month will be provided by all Qualified Professionals providing the service.

Program services are primarily delivered face-to-face with the recipient and in locations outside the agency’s facility. The aggregate services that have been delivered by the endorsed provider site will be assessed and documented annually by each endorsed provider site using the following quality assurance benchmarks:

- All individuals receiving Community Support must receive a minimum of two contacts per month, with one contact occurring face-to-face with the recipient;
- a minimum of 60% of Community Support services that are delivered must be performed face-to-face with recipients; and
- a minimum of 60% of staff time must be spent working outside of the agency’s facility, with or on behalf of the recipients.

Entrance Criteria

The recipient is eligible for this service when:

- A. significant impairment is documented in at least two of the life domains related to the recipient’s diagnosis that impedes the use of the skills necessary for independent functioning in the community. These life domains are as follows: emotional, social, safety, housing, medical/health, and legal.

AND

B. there is an Axis I or II MH/SA diagnosis as defined by the DSM-IV-TR or its successors, other than a sole diagnosis of Developmental Disability

AND

C. for recipients with a substance abuse diagnosis, American Society for Addiction Medicine (ASAM) criteria are met

AND

D. the recipient is experiencing difficulties in at least **two** of the following criteria as evidenced by documentation of symptoms:

1. is at risk for institutionalization, hospitalization, or is placed outside the natural living environment
2. is receiving or needs crisis intervention services
3. has unmet identified needs, related to the MH/SA diagnosis, for services from multiple agencies related to the life domains and needs advocacy and service coordination
4. is abused or neglected as substantiated by DSS, or has established dependency as defined by DSS criteria
5. exhibits intense verbal aggression, as well as limited physical aggression, to self or others, due to symptoms associated with diagnosis, that is sufficient to create functional problems in the home, community, school, job, etc.
6. is in active recovery from substance abuse or dependency and is in need of continuing relapse prevention support

AND

E. there is no evidence to support that alternative interventions would be equally or more effective based on generally accepted North Carolina community practice standards (e.g., American Society for Addiction Medicine, American Psychiatric Association) as available.

Entrance Process

Medicaid covers up to 4 unmanaged Qualified Professional hours for the purpose of collecting information to develop and initiate the required Person Centered Plan. These unmanaged visits are only for recipients new to the service system and not new to the provider. For other recipients, prior authorization is required.

For State-funded Community Support services, prior authorization by the Local Management Entity is required.

Relevant diagnostic information must be obtained to complete the Person Centered Plan. This requirement may be fulfilled through the completion of any comprehensive clinical assessment service. If a substantially equivalent assessment is available that 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, state, and DHHS requirements, it may be utilized as a part of the current comprehensive clinical assessment.

For Medicaid, in order to facilitate a request for the initial authorization, the required Person Centered Plan with signatures and the required authorization request form must be submitted to the Medicaid-approved vendor.

For State-funded Community Support, in order to facilitate a request for the initial authorization, a required Person Centered Plan with signatures, the required authorization request form, and the Consumer Admission Form must be submitted to the Local Management Entity.

During the 4 unmanaged hours, or at any point while the person is receiving Community Support, the Qualified Professional shall link the recipient to an alternative service if an equally or more effective service is clinically indicated. The activities that led to the referral must be documented in the full daily service note.

Continued Stay Criteria

The desired outcome or level of functioning has not been restored, improved, or sustained over the time frame outlined in the recipient's Person Centered Plan; or the recipient continues to be at risk for relapse based on current clinical assessment, history, and the tenuous nature of the functional gains;

AND

one of the following applies:

- A. Recipient has achieved current Person Centered Plan goals and additional goals are indicated as evidenced by documented symptoms.
- B. Recipient is making satisfactory progress toward meeting goals and there is documentation that supports that continuation of this service will be effective in addressing the goals outlined in the Person Centered Plan.
- C. Recipient is making some progress, but the specific interventions in the Person Centered Plan need to be modified so that greater gains, which are consistent with the recipient's premorbid level of functioning, are possible or can be achieved.
- D. Recipient fails to make progress and/or demonstrates regression in meeting goals through the strategies outlined in the Person Centered Plan. The recipient's diagnosis should be reassessed to identify any unrecognized co-occurring disorders, with treatment recommendations revised based on findings.

Discharge Criteria

Any one of the following applies:

- A. Recipient's level of functioning has improved with respect to the goals outlined in the Person Centered Plan, inclusive of a transition plan to step down.
- B. Recipient has achieved positive life outcomes that support stable and ongoing recovery and is no longer in need of Community Support services.
- C. Recipient is not making progress or is regressing and all reasonable strategies and interventions have been exhausted, indicating a need for more intensive services.
- D. Recipient or legally responsible person no longer wishes to receive Community Support services.
- E. Recipient, based on presentation and failure to show improvement despite modifications in the Person Centered Plan, requires a more appropriate best practice treatment modality based on North Carolina community practice standards (e.g., National Institute of Drug Abuse, American Psychiatric Association).

Note: Any denial, reduction, suspension, or termination of service requires notification to the recipient and/or legally responsible person about their appeal rights in accordance with the Department's recipient notices procedure.

Expected Clinical Outcomes

The expected clinical outcomes for this service are specific to recommendations resulting from clinical assessments and meeting the identified goals in the recipient's Person Centered Plan.

Expected clinical outcomes may include:

- Maintain recovery
- Reduce symptoms
- Increase coping skills and social skills that mediate life stresses resulting from the recipient's diagnostic and clinical needs
- Minimize the negative effects of psychiatric symptoms and/or substance dependence that interfere with the recipient's daily living
- Use natural and social supports
- Utilize functional skills to live independently
- Develop and utilize strategies and supportive interventions to maintain a stable living arrangement and avoid of out-of-home placement

Documentation Requirements

The minimum standard is a daily full service note written and signed by the person who provided the service that includes:

- Recipient's name
- Medicaid identification number
- Service provided (e.g., Community Support – Individual or Group)
- Date of service
- Place of service
- Type of contact (face-to-face, phone call, collateral)
- Purpose of the contact
- Description of the provider's interventions
- Amount of time spent performing the interventions
- Description of the effectiveness of the interventions
- Signature and credentials of the staff member(s) providing the service (for paraprofessionals, position is required in lieu of credentials with staff signature)

Refer to DMA Clinical Policies and the DMH/DD/SAS *Records Management and Documentation Manual* for a complete listing of documentation requirements.

Utilization Management

Services are based upon a finding of medical necessity, must be directly related to the recipient's diagnostic and clinical needs, and are expected to achieve the specific rehabilitative goals specified in the individual's Person Centered Plan. Medical necessity is determined by generally accepted North Carolina community practice standards as verified by independent Medicaid consultants, or the Local Management Entity for State-funded services.

If the needed medical information is not yet completed when the initial prior authorization request is submitted, the appointment date(s) and historical clinical information should be included. Interim prior authorizations with variable timelines for resubmission will be given to ensure the delivery of needed services.

Medically necessary service is authorized in the most economic mode, as long as the treatment that is made available is similarly efficacious to services requested by the recipient's physician, therapist, or other licensed practitioner.

For Medicaid, authorization by the Medicaid-approved vendor is required according to published policy.

For State-funded Community Support services, authorization is required by the Local Management Entity prior to the first visit. The Medicaid-approved vendor or the Local Management Entity will evaluate the request to determine if medical necessity supports more or less intensive services.

Medicaid covers up to 780 units for a 90-day period, based on the medical necessity documented in the required Person Centered Plan and supporting documentation. Community Support services are not intended to remain at this level of intensity long term. If the initial benefit of 780 units is expended before the end of the 90-day period, the required Person Centered Plan and a new request for authorization must be submitted to the Medicaid-approved vendor to request additional units and/or equally or more effective clinically alternative services.

For State-funded services, the Local Management Entity will determine the initial authorization period. The required Person Centered Plan, a request for authorization, and supporting documentation reflecting the appropriate level of care and service must be submitted to the Local Management Entity.

Additional units may be authorized on a time-limited basis to allow time for the Qualified Professional to coordinate these alternative services.

If continued Community Support services are needed at the end of the initial authorization period, the required Person Centered Plan and a new request for authorization reflecting the appropriate level of care and service must be submitted to the Medicaid-approved vendor for Medicaid services, or to the Local Management Entity for State-funded services. This should occur prior to the expiration of the authorization.

Units are billed in 15-minute increments, with the required modifier designating the level of the staff providing the service.

Service Exclusions/Limitations

An individual may receive Community Support services from only one Community Support provider organization at a time.

Community Support services may be provided for individuals residing in adult mental health residential facilities: independent living; supervised living low or moderate; and group living low, moderate, or high.

Community Support–Individual services may be billed in accordance with the authorization for services during the same authorization period for Psychosocial Rehabilitation services based on medical necessity.

For the purposes of transitioning a recipient to and from a service (e.g., facilitating an admission to a service and/or discharge planning) and ensuring that the service provider works directly with the Community Support Qualified Professional, Community Support–Individual services may be provided by

the Qualified Professional and billed for a maximum of 8 units for the first and last 30-day periods for individuals who are authorized to receive one of the following services:

- Assertive Community Team Treatment
- Community Support Team

For the purposes of transitioning a recipient to and from a service (e.g., facilitating an admission to a service and/or discharge planning), providing coordination during the provision of a service, and ensuring that the service provider works directly with the Community Support Qualified Professional, Community Support–Individual services may be provided by the Qualified Professional and billed for a maximum of 8 units for each 30-day period for individuals who are authorized to receive one of the following services:

- Substance Abuse Intensive Outpatient Program*
- Substance Abuse Comprehensive Outpatient Program*

For the purposes of transitioning a recipient to and from a service (e.g., facilitating an admission to a service and/or discharge planning), providing coordination during the provision of a service, and ensuring that the service provider works directly with the Community Support Qualified Professional, Community Support–Individual services may be provided by the Qualified Professional and billed in accordance with the authorization for services during the same authorization period for the following services based on medical necessity:

- All detoxification services
- Opioid treatment
- Professional Treatment Services in Facility-Based Crisis Programs
- Partial Hospitalization
- Substance Abuse Medically Monitored Community Residential Treatment
- Substance Abuse Non-Medically Monitored Community Residential Treatment

Note: For recipients under the age of 21, additional products, services, or procedures may be requested even if they do not appear in the N.C. State Plan or when coverage is limited to those over 21 years of age. Service limitations on scope, amount, or frequency described in the coverage policy may not apply if the product, service, or procedure is medically necessary.

***Provider of these services is responsible for the Person Centered Plan and all other clinical home responsibilities.**

Community Support – Children/Adolescents (MH/SA) Medicaid Billable Service

Service Definition and Required Components

Community Support services are services and supports necessary to assist youth 3 through 17 years of age (20 years old or younger for children enrolled in Medicaid) and their caregivers in the youth's mental health and/or substance abuse rehabilitative and recovery goals. This medically necessary service directly addresses the recipient's diagnostic and clinical needs, which are evidenced by the presence of a diagnosable mental, behavioral, and/or emotional disturbance (as defined by the DSM-IV-TR and its successors), with symptoms and effects documented in the Person Centered Plan. [See **Section 2.2., EPSDT Special Provision**, in this policy (Clinical Coverage Policy 8A, *Enhanced Mental Health and Substance Abuse Services*).]

Community Support services, which are psychoeducational and supportive in nature, are intended to meet the mental health and/or substance abuse needs of children and adolescents who have significant functional impairment that seriously interferes with or impedes their roles or functioning in family, school, or community. The service is designed to

- increase skills to address the complex mental health and/or substance abuse needs of children and adolescents who have significant functional deficits in order to promote symptom reduction and improve age-appropriate functioning in their daily environments, and
- assist the child/youth and family in gaining access to and coordinating necessary services to promote clinical stability and support the emotional and functional growth and development of the child.

The rehabilitative service activities of Community Support consist of a variety of interventions that must directly relate to the recipient's diagnostic and clinical needs as reflected in a comprehensive clinical assessment and outlined in the Person Centered Plan. These shall include the following, as clinically indicated:

- One-on-one interventions with the recipient, unless a group intervention is deemed more efficacious, to develop interpersonal and community relational skills, including adaptation to home, school, work, and other natural environments
- Therapeutic mentoring that directly increases the acquisition of skills needed to accomplish the goals of the Person Centered Plan
- Symptom monitoring
- Self-management of symptoms
- Medication monitoring, with documented communication to prescribing physician(s)
- Direct preventive and therapeutic interventions that will assist with skill building
- Assistance with skill enhancement or acquisition
- Relapse prevention and disease management strategies
- Psychoeducation and training of family, unpaid caregivers, and others who have a legitimate role in addressing the needs identified in the Person Centered Plan
- Support for ongoing treatment and encouraging the achievement of functional gains
- Case management for the effective coordination of clinical services, natural and community supports for the child/youth and his or her family

The service includes providing "first responder" crisis response on a 24/7/365 basis to recipients experiencing a crisis.

In partnership with the family and/or the legally responsible person, the Qualified Professional is responsible for convening the Child and Family Team. The Child and Family Team is the vehicle for the Person Centered Planning process. The Qualified Professional consults with identified medical and non-medical providers, and engages community and natural supports and includes their input in the Person Centered Planning process. The Qualified Professional is responsible for monitoring and documenting the status of the recipient's progress and the effectiveness of the strategies and interventions with the Child and Family Team as outlined in the Person Centered Plan.

The Community Support Qualified Professional provides and oversees case management to arrange, link, monitor, and/or integrate multiple services. Case management includes assessment and reassessment of the recipient's need for services. The Community Support Qualified Professional provides coordination of movement across levels of care, both by interacting directly with the person and his or her family and by coordinating discharge planning and community re-entry following hospitalization, residential services, and other levels of care.

Community Support staff also inform the recipient about benefits, community resources, and services; assist the recipient in accessing benefits and services; arrange for the recipient to receive benefits and services; and monitor the provision of services. The provider organization assumes the roles of advocate, broker, coordinator, and monitor of the service delivery system on behalf of the recipient.

For Medicaid-funded services, a personally signed service order for Community Support services must be completed by a physician, licensed psychologist, physician's assistant, or nurse practitioner according to his or her scope of practice, along with other documentation requirements outlined in this policy. The service order must be based on an individualized assessment of the recipient's needs. For State-funded services, it is recommended that a service order be completed within the first visit.

Provider Requirements

Community Support services must be delivered by practitioners who are employed by mental health or substance abuse provider organizations that

- meet the provider qualification policies, procedures, and standards established by the Division of Medical Assistance (DMA);
- meet the provider qualification policies, procedures, and standards established by the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (MH/DD/SAS); and
- fulfill the requirements of 10A NCAC 27G.

These policies and procedures set forth the administrative, financial, clinical, quality improvement, and information services infrastructure necessary to provide services. Provider organizations must demonstrate that they meet these standards by being endorsed by the Local Management Entity (LME). Additionally, within three years of enrollment as a provider, the organization must have achieved national accreditation with at least one of the designated accrediting agencies. The organization must be established as a legally constituted entity capable of meeting all of the requirements of the Provider Endorsement, Medicaid Enrollment Agreement, Medicaid Bulletins, and service implementation standards. This includes national accreditation within the prescribed timeframe.

The Community Support provider organization is identified in each Person Centered Plan. For Medicaid services, the organization is responsible for obtaining authorization from the Medicaid-approved vendor for medically necessary services identified in the Person Centered Plan. For State-funded services, the organization is responsible for obtaining authorization from the Local Management Entity for the

medically necessary services identified by the Person Centered Plan. The Community Support provider organization must comply with all applicable federal, state, and DHHS requirements. This includes, but is not limited to, DHHS Statutes, Rule, Policy, Implementation Updates, Medicaid Bulletins, and other published instruction.

Staffing Requirements

Persons who meet the requirements specified (10A NCAC 27G.0104) for Qualified Professional (QP), Associate Professional (AP), and Paraprofessional status, and who have the knowledge, skills, and abilities required by the population and age to be served, may deliver Community Support. Qualified Professionals shall develop and coordinate the Person Centered Plan. Associate Professionals and Paraprofessionals will deliver Community Support services to directly address the recipient's diagnostic and clinical needs under the direction of the Qualified Professional.

All Associate Professionals and Paraprofessionals providing Community Support must be supervised by a Qualified Professional. Supervision must be provided according to supervision requirements specified in 10A NCAC 27G.0204 and according to licensure or certification requirements of the appropriate discipline.

A Certified Clinical Supervisor (CCS) or Licensed Clinical Addiction Specialist (LCAS) may also deliver and supervise Community Support as a Qualified Professional.

The following chart sets forth the activities that may be performed by a Qualified Professional, Certified Clinical Supervisor, Licensed Clinical Addiction Specialist, Associate Professional, or Paraprofessional. These activities reflect the appropriate scope of practice for these individuals.

Community Support	
Qualified Professional Certified Clinical Supervisor Licensed Clinical Addiction Specialist	Associate Professional Paraprofessional (under the supervision of the Qualified Professional)
<ul style="list-style-type: none"> • Coordination and oversight of initial and ongoing assessment activities • Ensuring linkage to the most clinically appropriate and effective services • Convening the Child and Family Team, including the recipient, family, and people identified as important in the recipient's life, for Person Centered Planning • Initial development and ongoing revision of Person Centered Plan • Monitoring the implementation of the Person Centered Plan, including involvement of other medical and non-medical providers, the recipient and family, and natural and community supports • Supportive counseling to address the diagnostic and clinical needs of the recipient • Case management functions to arrange, link, monitor, and/or integrate multiple services and referrals • Coordination with the recipient's medical home (e.g., primary care physician) • Monitoring of activities provided by Associate and Paraprofessional staff providing Community Support • Provision of all activities, functions, and interventions of the Community Support service definition 	<ul style="list-style-type: none"> • Assistance with therapeutic interventions to rehabilitate <ul style="list-style-type: none"> ○ Functional skills ○ Daily and community living skills ○ Adaptation, socialization, relational, and coping skills ○ Self-management of symptoms ○ Behavior and anger management skills • Therapeutic mentoring that directly increases the acquisition of skills needed to accomplish the goals of the Person Centered Plan • Psychoeducation and training of family, unpaid caregivers, and others who have a legitimate role in addressing the needs identified in the Person Centered Plan • Direct preventive and therapeutic interventions that will assist with skill building • Relapse prevention and disease management strategies • Ongoing symptom monitoring and management • Ongoing medication monitoring with report to medical providers • Service coordination activities within the established Person Centered Plan • Input into the Person Centered Plan modifications

All staff must complete a minimum of 20 hours of training specific to the required rehabilitative service activities and all other components of the Community Support service definition, including crisis response, within the first 90 days of employment.

Family members or legally responsible persons of the recipient may not provide these services for reimbursement.

Service Type/Setting

Community Support is a direct and indirect periodic service in which the Community Support staff member provides direct intervention and also arranges, coordinates, and monitors services on behalf of the recipient. Community Support services may be provided to an individual or a group of individuals.

Community Support providers must have the ability to deliver services in various environments, such as homes, schools, detention centers and jails (State funds only),* homeless shelters, street locations, and other community settings.

Community Support also includes telephone time with the individual recipient and collateral contact with persons who assist the recipient in meeting his or her rehabilitation goals. Community Support includes activities and meetings for the planning, development, and revision of the recipient's Person Centered Plan.

When children are inpatients in an Institution for Mental Diseases (IMD), the Qualified Professional may provide 8 units per month of the case management component of this service in order to facilitate transition to community services. This component may not be duplicative of hospital discharge planning.

***Note:** For all services, federal Medicaid regulations will deny Medicaid payment for services delivered to inmates of public correctional institutions (detention centers, youth correctional facilities, jails).

Program Requirements

Caseload size for a Community Support Qualified Professional may not exceed 1 Qualified Professional to 15 recipients. (Note: in computing caseload ratios, a recipient receiving fewer than 4 hours of service per week may be counted as half a recipient). Community Support services may be provided to groups of individuals, but groups may not exceed 8 individuals.

For each authorization period (90 days or less, depending on authorization), a minimum of 15% of the total billable community support services provided per recipient must be provided by the Qualified Professional. This is to ensure that medically appropriate clinical interventions are provided based on implementation/revision of the required Person Centered Plan. For each endorsed provider site, a minimum of 25% of the total aggregate billable Community Support services per month will be provided by all Qualified Professionals providing the service.

Program services are primarily delivered face-to-face with the recipient and in locations outside the agency's facility. The aggregate services that have been delivered by the endorsed provider site will be assessed and documented annually by each endorsed provider site using the following quality assurance benchmarks:

- all youth receiving Community Support must receive a minimum of two contacts per month, with one contact occurring face-to-face with the recipient;
- a minimum of 60% of Community Support services that are delivered must be performed face-to-face with recipients; and
- a minimum of 60% of staff time must be spent working outside of the agency's facility, with or on behalf of recipients.

Entrance Criteria

The recipient is eligible for this service when:

- A. significant impairment is documented in at least two of the life domains related to the recipient's diagnosis that impedes the use of the skills necessary for independent functioning in the community. These life domains are as follows: emotional, social, safety, medical/health, educational/vocational, and legal.

AND

- B. there is an Axis I or II MH/SA diagnosis (as defined by the DSM-IV-TR or its successors), other than a sole diagnosis of Developmental Disability

AND

- C. for recipients with a substance abuse diagnosis, American Society for Addiction Medicine (ASAM) criteria are met

AND

- D. the recipient is experiencing difficulties in at least **two** of the following areas as evidenced by documentation of symptoms:
1. is previously or imminently at risk for institutionalization, hospitalization, or placement outside the recipient's natural living environment
 2. is receiving or needs crisis intervention services or Intensive In-Home services
 3. has unmet identified needs related to MH/SA diagnosis as reported from multiple agencies, needs advocacy, and service coordination as defined by the Child and Family Team
 4. is abused or neglected as substantiated by DSS, or is found in need of services by DSS, or meets dependency as defined by DSS criteria (GS 7B101)
 5. exhibits intense verbal aggression, as well as limited physical aggression, to self or others, due to symptoms associated with diagnosis, which is sufficient to create functional problems in the home, community, school, job, etc.
 6. is in active recovery from substance abuse or dependency and is in need of continuing relapse prevention support

AND

- E. there is no evidence to support that alternative interventions would be equally or more effective based on generally accepted North Carolina community practice standards (e.g., Best Practice Guidelines per the American Academy of Child and Adolescent Psychiatry, American Psychiatric Association, American Society of Addiction Medicine).

Entrance Process

Medicaid covers up to 8 unmanaged Qualified Professional hours to collect information, convene the Child and Family Team in partnership with the family, and develop the required Person Centered Plan. These unmanaged visits are only for recipients new to the service system and not new to the provider. If the recipient has been receiving a Medicaid-funded MH/SA service previously, prior authorization is required from point of entry. For State-funded Community Support services, prior authorization by the Local Management Entity is required. When authorization is approved, the Qualified Professional will collect information, convene the Child and Family Team in partnership with the family, and develop the required Person Centered Plan.

Relevant diagnostic information must be obtained to complete the Person Centered Plan. This requirement may be fulfilled through the completion of any comprehensive clinical assessment service. If a substantially equivalent assessment is available that 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, state, and DHHS requirements, it may be utilized as a part of the current comprehensive clinical assessment.

For Medicaid, in order to facilitate a request for the initial authorization, the required Person Centered Plan with signatures and the required authorization request form must be submitted to the Medicaid-approved vendor.

For State-funded Community Support, in order to facilitate a request for the initial authorization, a required Person Centered Plan with signatures, the required authorization request form, and the Consumer Admission Form must be submitted to the Local Management Entity.

During the 8 unmanaged hours, or at any point while the child is receiving Community Support, the Qualified Professional shall link the recipient to an alternative service if an equally or more effective service is clinically indicated and functionally appropriate to the needs of the child. A full service note is required to document the activities that led to the referral.

Continued Stay Criteria

The desired outcome or level of functioning has not been restored, improved, or sustained over the time frame outlined in the recipient's Person Centered Plan; or the recipient continues to be at risk for relapse based on current clinical assessment, history, and the tenuous nature of the functional gains;

AND

One of the following applies:

- A. Recipient has achieved current Person Centered Plan goals and additional goals are indicated as evidenced by documented symptoms.
- B. Recipient is making satisfactory progress toward meeting goals and there is documentation that supports that continuation of this service will be effective in addressing the goals outlined in the Person Centered Plan.
- C. Recipient is making some progress, but the specific interventions in the Person Centered Plan need to be modified so that greater gains, which are consistent with the recipient's premorbid level of functioning, are possible or can be achieved.
- D. Recipient fails to make progress and/or demonstrates regression in meeting goals through the strategies outlined in the Person Centered Plan. The recipient's diagnosis should be reassessed to identify any unrecognized co-occurring disorders, with treatment recommendations revised based on findings.

Discharge Criteria

Any one of the following applies:

- A. Recipient's level of functioning has improved with respect to the goals outlined in the Person Centered Plan, inclusive of a transition plan to step down.
- B. Recipient has achieved goals and is no longer in need of Community Support services.
- C. Recipient is not making progress or is regressing and all reasonable clinical strategies and interventions have been exhausted, indicating a need for more intensive services.
- D. Recipient or family/legally responsible guardian no longer wishes to receive Community Support services.
- E. Recipient, based on presentation and failure to show improvement despite modifications in the Person Centered Plan, requires a more appropriate best practice treatment modality based on North Carolina community practice standards (e.g., the American Academy of Child and Adolescent Psychiatry and the American Psychiatric Association Practice Guidelines, American Society of Addiction Medicine).

Note: Any denial, reduction, suspension, or termination of service requires notification to the recipient and/or legal guardian about their appeal rights in accordance with the Department's recipient notices procedure.

Expected Clinical Outcomes

The expected clinical outcomes for this service are specific to recommendations resulting from clinical assessments and meeting the identified goals in the recipient's Person Centered Plan.

Expected clinical outcomes may include:

- Symptom reduction
- Maintain recovery
- Improve and sustain developmentally appropriate functioning in specified life domains
- Increase coping skills and social skills that mediate life stresses resulting from the recipient's diagnostic and clinical needs
- Minimize the negative effects of psychiatric symptoms and/or substance dependence that interfere with the recipient's daily living
- Uses natural and social supports
- Utilize functional skills to live independently
- Develop and utilize strategies and supportive interventions to maintain a stable living arrangement and avoid of out-of-home placement

Documentation Requirements

The minimum standard is a daily full service note written and signed by the person who provided the service that includes:

- Recipient's name
- Medicaid identification number
- Service provided (e.g., Community Support–Individual or Community Support–Group)
- Date of service
- Place of service
- Type of contact (face-to-face, phone call, collateral)
- Purpose of the contact
- Description of the provider's interventions
- Amount of time spent performing the interventions
- Description of the effectiveness of the interventions
- Signature and credentials of the staff member(s) providing the service (for paraprofessionals, position is required in lieu of credentials with staff signature)

Refer to DMA Clinical Policies and the DMH/DD/SAS *Records Management and Documentation Manual* for a complete listing of documentation requirements.

Utilization Management

Services are based upon a finding of medical necessity, must be directly related to the recipient's diagnostic and clinical needs, and are expected to achieve the specific rehabilitative goals specified in the individual's Person Centered Plan. Medical necessity is determined by generally accepted North Carolina community practice standards as verified by independent Medicaid consultants, or the Local Management Entity for State-funded services.

If the needed medical information is not yet completed when the initial prior authorization request is submitted, the appointment date(s) and historical clinical information should be included. Interim prior authorizations with variable timelines for resubmission will occur to ensure the delivery of needed services.

Typically, the medically necessary service must be generally recognized as an accepted method of medical practice or treatment. Each case is reviewed individually to determine if the requested service meets the criteria outlined under EPSDT.

Medically necessary service is authorized in the most economic mode, as long as the treatment that is made available is similarly efficacious to services requested by the recipient's physician, therapist or other licensed practitioner.

For Medicaid, authorization by the Medicaid-approved vendor is required.

For State-funded Community Support services, authorization by the Local Management Entity is required prior to the first visit. The Medicaid-approved vendor or the Local Management Entity will evaluate the request to determine if medical necessity supports more or less intensive services.

Units are billed in 15-minute increments and must include the modifier to denote level of staff providing the service.

Medicaid covers up to 780 units for a 90-day period, based on the medical necessity documented in the required Person Centered Plan, the Medicaid vendor's authorization request form, and supporting documentation. Community Support services are not intended to remain at this level of intensity long term. If the initial benefit of 780 units is expended before the end of the 90-day period, a required Person Centered Plan and a new request for authorization must be submitted to the Medicaid-approved vendor to request additional units and/or equally or more effective clinically and developmentally appropriate alternative services.

For State-funded services, the Local Management Entity will determine the initial authorization period. A required Person Centered Plan, a request for authorization, and supporting documentation reflecting the appropriate level of care and service must be submitted to the Local Management Entity.

Additional units may be authorized on a time-limited basis to allow time for the Qualified Professional to coordinate for alternative services.

If continued Community Support services are needed at the end of the initial authorization period, the required Person Centered Plan and a new request for authorization reflecting the appropriate level of care and service must be submitted to the Medicaid-approved vendor for Medicaid services, or to the Local Management Entity for State-funded services. This should occur prior to the expiration of the initial authorization.

No additional Community Support services may be requested without a required Person Centered Plan with signatures and the Medicaid vendor's authorization form.

Service Exclusions/Limitations

An individual may receive Community Support services from only one Community Support provider organization at a time.

For the purposes of facilitating an admission to a service, making a transition to or from a service, ensuring that the service provider works directly with the Community Support Qualified Professional, and/or discharge planning, Community Support–Individual services may be billed for a maximum of 8 units per 30-day period for individuals who are authorized to receive one of the following services during the same authorization period:

- Child and adolescent day treatment
- Intensive in-home services*
- Multisystemic therapy*
- Partial hospitalization
- Substance abuse intensive outpatient treatment*
- Levels II through IV child residential treatment
- Substance abuse residential services
- PRTF
- Inpatient services

Note: For recipients under the age of 21, additional products, services, or procedures may be requested even if they do not appear in the N.C. State Plan or when coverage is limited to those over 21 years of age. Service limitations on scope, amount, or frequency described in the coverage policy may not apply if the product, service, or procedure is medically necessary.

***Provider of these services is responsible for the Person Centered Plan and all other clinical home responsibilities.**

Mobile Crisis Management (MH/DD/SA)

Medicaid Billable Service

Service Definition and Required Components

Mobile Crisis Management involves all support, services and treatments necessary to provide integrated crisis response, crisis stabilization interventions, and crisis prevention activities. Mobile Crisis Management services are available at all times, 24/7/365. Crisis response provides an immediate evaluation, triage and access to acute mental health, developmental disabilities, and/or substance abuse services, treatment, and supports to effect symptom reduction, harm reduction, and/or to safely transition persons in acute crises to appropriate crisis stabilization and detoxification supports/services. These services include immediate telephonic response to assess the crisis and determine the risk, mental status, medical stability, and appropriate response.

Mobile Crisis Management also includes crisis prevention and supports that are designed to reduce the incidence of recurring crises. These supports and services should be specified in a recipient's Crisis Plan, which is a component of all Person Centered Plans.

Provider Requirements

Mobile Crisis Management services must be delivered by a team of practitioners employed by a mental health/substance abuse/developmental disability provider organization that meets the provider qualification policies and procedures established by DMH and the requirements of 10A NCAC 27I.0208 (Endorsement of Providers). These policies and procedures set forth the administrative, financial, clinical, quality improvement, and information services infrastructure necessary to provide services. Provider organizations must demonstrate that they meet these standards by being endorsed by the LME. Within three years of enrollment as a provider, the organization must have achieved national accreditation. The organization must be established as a legally recognized entity in the United States and qualified/registered to do business as a corporate entity in the State of North Carolina.

Staffing Requirements

Mobile Crisis Management services must be provided by a team of individuals that includes a QP according to 10A NCAC 27G.0104 and who must either be a nurse, clinical social worker or psychologist as defined in this administrative code. One of the team members must be a CCAS, CCS or a Certified Substance Abuse Counselor (CSAC). Each organization providing crisis management must have 24/7/365 access to a board certified or eligible psychiatrist. The psychiatrist **must** be available for face to face or phone consultation to crisis staff. A QP or AP with experience in Developmental Disabilities must be available to the team as well. Paraprofessionals with competency in crisis management may also be members of the crisis management team when supervised by the QP. A supervising professional must be available for consultation when a Paraprofessional is providing services.

All staff providing crisis management services must demonstrate competencies in crisis response and crisis prevention. At a minimum, these staff must have:

- a minimum of one (1) year's experience in providing crisis management services in the following settings: assertive outreach, assertive community treatment, emergency department or other service providing 24/7 response in emergent or urgent situations

AND

- twenty (20) hours of training in appropriate crisis intervention strategies within the first 90 days of employment

Professional staff must have appropriate licenses, certification, training and experience and non-licensed staff must have appropriate training and experience.

Service Type/Setting

Mobile Crisis Management is a direct and periodic service that is available at all times, 24/7/365. It is a "second level" service, in that other services should be billed before Crisis Management, as appropriate and if there is a choice. For example, if the recipient's outpatient clinician stabilized his/her crisis, the outpatient billing code should be used, not crisis management. If a Community Support worker responds and stabilizes his/her crisis, the Community Support billing code should be used.

Units will be billed in fifteen (15) minute increments.

Mobile Crisis Management services are primarily delivered face-to-face with the consumer and in locations outside the agency's facility. Annually the aggregate services that have been delivered by the agency will be assessed for each provider agency using the following quality assurance benchmarks:

Team providing this service must provide at least eighty percent (80%) of their units on a face-to-face with recipients of this service.

If a face-to-face assessment is required, this assessment must be delivered in the least restrictive environment and provided in or as close as possible to a person's home, in the individual's natural setting, school, work, local emergency room, etc. This response must be mobile. The result of this assessment should identify the appropriate crisis stabilization intervention.

Note: For all services, federal Medicaid regulations will deny Medicaid payment for services delivered to inmates of public correctional institutions or for patients in facilities with more than 16 beds that are classified as Institutions of Mental Diseases.

Program Requirements

Mobile Crisis Management services should be delivered in the least restrictive environment and provided in or as close as possible to a person's home.

Mobile Crisis Management services must be capable of addressing all psychiatric, substance abuse, and developmental disability crises for all ages to help restore (at a minimum) an individual to his/her previous level of functioning.

Mobile Crisis Management services may be delivered by one (1) or more individual practitioners on the team.

For recipients new to the public system, Mobile Crisis Management must develop a Crisis Plan before discharge. This Crisis Plan should be provided to the individual, caregivers (if appropriate), and any agencies that may provide ongoing treatment and supports after the crisis has been stabilized. For recipients who are already receiving services, Mobile Crisis Management should recommend revisions to existing crisis plan components in Person Centered Plans, as appropriate.

Utilization Management

There is no prior authorization for the first 32 units of crisis services per episode. The maximum length of service is 24 hours per episode. Additional authorization must occur after 32 units of services have been rendered. For individuals enrolled with the LME, the crisis management provider must contact the LME to determine if the individual is enrolled with a provider that should and can provide or be involved with the response. Mobile Crisis Management should be used to divert individuals from inpatient psychiatric and detoxification services. These services are not used as “step down” services from inpatient hospitalization.

If it is a Medicaid covered service, utilization management will be done by the statewide vendor. If it is a non-covered Medicaid service or non-Medicaid client, then the utilization review will be done by the LME.

The maximum length of service is 24 hours per episode.

Entrance Criteria

The recipient is eligible for this service when:

- A. the person and/or family are experiencing an acute, immediate crisis as determined by a crisis rating scale specified by DMH

AND

- B. the person and/or family has insufficient or severely limited resources or skills necessary to cope with the immediate crisis

OR

- C. the person and/or family members evidences impairment of judgment and/or impulse control and/or cognitive/perceptual disabilities

OR

- D. the person is intoxicated or in withdrawal and in need of substance abuse treatment and unable to access services without immediate assistance

Priority should be given to individuals with a history of multiple crisis episodes and/or who are at substantial risk of future crises.

Continued Stay Criteria

The recipient’s crisis has not been resolved or their crisis situation has not been stabilized, which may include placement in a facility-based crisis unit or other appropriate residential placement.

Discharge Criteria

Recipient’s crisis has been stabilized and his/her need for ongoing treatment/supports has been assessed. If the recipient has continuing treatment/support needs, a linkage to ongoing treatment or supports has been made.

Note: Any denial, reduction, suspension or termination of service requires notification to the recipient and/or legal guardian about their appeal rights.

Expected Outcomes

This service includes a broad array of crisis prevention and intervention strategies which assist the recipient in managing, stabilizing or minimizing clinical crisis or situations. This service is designed to rapidly assess crisis situations and a recipient's clinical condition, to triage the severity of the crisis, and to provide immediate, focused crisis intervention services which are mobilized based on the type and severity of crisis.

Documentation Requirements

Minimum standard is a daily full service note that includes the recipient's name, Medicaid identification number, date of service, purpose of contact, describes the provider's interventions, includes the time spent performing the interventions, effectiveness of the intervention, and the signature of the staff providing the service. Treatment logs or preprinted check sheets will not be sufficient to provide the necessary documentation. For recipients new to the public system, Mobile Crisis Management must develop a crisis plan before discharge.

Service Exclusions

Assertive Community Treatment, Intensive In-Home Services, Multisystemic Therapy, Medical Community Substance Abuse Residential Treatment, Non-Medical Community Substance Abuse Residential Treatment, Detoxification Services, Inpatient Substance Abuse Treatment, Inpatient Psychiatric Treatment, and Psychiatric Residential Treatment Facility except for the day of admission. Mobile Crisis Management services may be provided to an individual who receives inpatient psychiatric services on the same day of service.

Note: For recipients under the age of 21, additional products, services, or procedures may be requested even if they do not appear in the N.C. State Plan or when coverage is limited to those over 21 years of age. Service limitations on scope, amount, or frequency described in the coverage policy may not apply if the product, service, or procedure is medically necessary.

Diagnostic/Assessment (MH/DD/SA)

Medicaid Billable Service

Service Definition and Required Components

A Diagnostic/Assessment is an intensive clinical and functional face to face evaluation of a recipient's mental health, developmental disability, or substance abuse condition that results in the issuance of a Diagnostic/Assessment report with a recommendation regarding whether the recipient meets target population criteria, and includes an order for Enhanced Benefit services that provides the basis for the development of an initial Person Centered Plan. For substance abuse-focused Diagnostic/Assessment, the designated Diagnostic Tool specified by DMH (e.g., SUDDS IV, ASI, SASSI) for specific substance abuse target populations (i.e., Work First, DWI, etc.) must be used. In addition, any elements included in this service definition that are not covered by the tool must be completed.

The Diagnostic/Assessment must include the following elements:

- A. a chronological general health and behavioral health history (includes both mental health and substance abuse) of the recipient's symptoms, treatment, treatment response and attitudes about treatment over time, emphasizing factors that have contributed to or inhibited previous recovery efforts;
- B. biological, psychological, familial, social, developmental and environmental dimensions and identified strengths and weaknesses in each area;
- C. a description of the presenting problems, including source of distress, precipitating events, associated problems or symptoms, recent progressions; and current medications
- D. a strengths/problem summary which addresses risk of harm, functional status, co-morbidity, recovery environment, and treatment and recovery history;
- E. diagnoses on all five (5) axes of DSM-IV;
- F. evidence of an interdisciplinary team progress note that documents the team's review and discussion of the assessment;
- G. a recommendation regarding target population eligibility; and
- H. evidence of recipient participation including families, or when applicable, guardians or other caregivers

This assessment will be signed and dated by the MD, DO, PA, NP, licensed psychologist and will serve as the initial order for services included in the PCP. Upon completion, the PCP will be sent to the LME for administrative review and authorization of services under the purview of the LME.

For additional services added after the development of the initial PCP, the order requirement for each service is included in the service definition.

Provider Requirements

Diagnostic/Assessments must be conducted by practitioners employed by a mental health/substance abuse/developmental disability provider meet the provider qualification policies, procedures, and standards established by DMH and the requirements of 10A NCAC 27G These policies and procedures set forth the administrative, financial, clinical, quality improvement, and information services infrastructure necessary to provide services. Provider organizations must demonstrate that they meet these standards by being endorsed by the LME. Within three years of enrollment as a provider, the organization must have achieved national accreditation. The organization must be established as a legally recognized entity in the United States and qualified/registered to do business as a corporate entity in the State of North Carolina.

Staffing Requirements

The Diagnostic/Assessment team must include at least two (2) QPs, according to 10A NCAC 27G.0104, both of whom are licensed or certified clinicians; one (1) of the team members must be a qualified practitioner whose professional licensure or certification authorizes the practitioner to diagnose mental illnesses and/or addictive disorders. One of which must be an MD, DO, Nurse Practitioner, Physician Assistant, or licensed psychologists. For substance abuse-focused Diagnostic/Assessment, the team must include a CCS or CCAS. For developmental disabilities, the team must include a Master's level qualified professional with at least two years experience with the developmentally disabled.

Service Type/Setting

Diagnostic/Assessment is a direct periodic service that can be provided in any location.*

***Note:** For Medicaid recipients this service cannot be provided in an IMD (for adults) or in a public institution, (jail, detention center.)

Program Requirements

An initial Diagnostic/Assessment shall be performed by a Diagnostic/Assessment team for each recipient being considered for receipt of services in the mental health, developmental disabilities, and/or substance abuse Enhanced Benefit package.

Utilization Management

A recipient may receive one Diagnostic/Assessment per year. An assessment equals one (1) event. For individuals eligible for Enhanced Benefit services, referral by the LME for Diagnostic/Assessment is required. Additional events require prior authorization from the statewide vendor or LME.

If it is Medicaid-covered service, utilization management will be done by the state vendor or the DHHS-approved LME contracted with the Medicaid agency. If it is a non-covered Medicaid service or non-Medicaid client, then the utilization review will be done by the LME.

Entrance Criteria

The recipient is eligible for this service when:

A. there is a known or suspected mental health, substance abuse diagnosis, or developmental disability diagnosis

OR

B. initial screening/triage information indicates a need for additional mental health/substance abuse/developmental disabilities treatment/supports.

Continued Stay Criteria

Not applicable.

Discharge Criteria

Not applicable.

Note: Any denial, reduction, suspension or termination of service requires notification to the recipient and/or legal guardian about their appeal rights.

Expected Outcomes

A Diagnostic/Assessment determines whether the recipient is appropriate for and can benefit from mental health, developmental disabilities, and/or substance abuse services based on the recipient's diagnosis, presenting problems, and treatment/recovery goals. It also evaluates the recipient's level of readiness and motivation to engage in treatment. Results from a Diagnostic/Assessment include an interpretation of the assessment information, appropriate case formulation and an order for immediate needs and the development of Person Centered Plan. For substance abusers, a Diagnostic/Assessment recommends a level of placement using N.C. Modified A/ASAM criteria. This assessment will include signing the order for the initial PCP. That order will constitute the order for the services in the PCP.

Documentation Requirements

The Diagnostic/Assessment must include the following elements:

- A. a chronological general health and behavioral health history (includes both mental health and substance abuse) of the recipient's symptoms, treatment, treatment response and attitudes about treatment over time, emphasizing factors that
- B. have contributed to or inhibited previous recovery efforts; biological, psychological, familial, social, developmental and environmental dimensions and identified strengths and weaknesses in each area;
- C. a description of the presenting problems, including source of distress, precipitating events, associated problems or symptoms, recent progressions, and current medications
- D. strengths/problem summary which addresses risk of harm, functional status, co-morbidity, recovery environment, and treatment and recovery history;
- E. diagnoses on all five (5) axes of DSM-IV;
- F. evidence of an interdisciplinary team progress note that documents the team's review and discussion of the assessment;
- G. a recommendation regarding target population eligibility; and
- H. evidence of recipient participation including families, or when applicable, guardians or other caregivers.

Service Exclusions/Limitations

A recipient may receive one (1) Diagnostic/Assessment per year. Any additional Diagnostic/Assessment within a one (1)-year period must be authorized by the DHHS-approved LME or the statewide vendor prior to the devlivery of the service. Diagnostic/Assessment shall not be billed on the same day as Assertive Community Treatment, Intensive In-Home, Multisystemic Therapy or Community Support Team. If psychological testing or specialized assessments are indicated, they are billed separately using appropriate CPT codes for psychological, developmental, or neuropsychological testing.

Note: For recipients under the age of 21, additional products, services, or procedures may be requested even if they do not appear in the N.C. State Plan or when coverage is limited to those over 21 years of age. Service limitations on scope, amount, or frequency described in the coverage policy may not apply if the product, service, or procedure is medically necessary.

Intensive In-Home Services Medicaid Billable Service

Service Definition and Required Components

This is a time-limited intensive family preservation intervention intended to stabilize the living arrangement, promote reunification or prevent the utilization of out-of-home therapeutic resources (i.e., psychiatric hospital, therapeutic foster care, residential treatment facility) for the identified youth through the age of 20. These services are delivered primarily to children in their family's home with a family focus to:

1. Defuse the current crisis, evaluate its nature, and intervene to reduce the likelihood of a recurrence;
2. Ensure linkage to needed community services and resources;
3. Provide self help and living skills training for youth;
4. Provide parenting skills training to help the family build skills for coping with the youth's disorder;
5. Monitor and manage the presenting psychiatric and/or addiction symptoms; and
6. Work with caregivers in the implementation of home-based behavioral supports. Services may include crisis management, intensive case management, individual and/or family therapy, substance abuse intervention, skills training, and other rehabilitative supports to prevent the need for an out-of-home, more restrictive services.

This intervention uses a team approach designed to address the identified needs of children and adolescents who are transitioning from out of home placements or are at risk of out-of-home placement and need intensive interventions to remain stable in the community. This population has access to a variety of interventions twenty four (24) hours a day, seven (7) days per week by staff that will maintain contact and intervene as one (1) organizational unit.

Team services are individually designed for each family, in full partnership with the family, to minimize intrusion, and maximize independence. Services are generally more intensive at the beginning of treatment and decrease over time as the youth and family's coping skills develop.

The team services are structured and delivered face-to-face to provide support and guidance in all areas of functional domains: adaptive, communication, psychosocial, problem solving, behavior management, etc. This service is **not** delivered in a group setting.

A service order for Intensive In-Home services must be completed by a physician, licensed psychologist, physician's assistant or nurse practitioner according to their scope of practice prior to or on the day that the services are to be provided.

Provider Requirements

Intensive In-Home services must be delivered by practitioners employed by a mental health/substance abuse provider organization that meets the provider qualification policies, procedures, and standards established by DMH and the requirements of 10A NCAC 27G. These policies and procedures set forth the administrative, financial, clinical, quality improvement, and information services infrastructure necessary to provide services. Provider organizations must demonstrate that they meet these standards by being

endorsed by the LME. Within three years of enrollment as a provider, the organization must have achieved national accreditation. The organization must be established as a legally recognized entity in the United States and qualified/registered to do business as a corporate entity in the State of North Carolina.

Intensive In-Home Service providers must have the ability to deliver services in various environments, such as homes, schools, detention centers and jails (state funds only), homeless shelters, street locations, etc.

Organizations that provide Intensive In-Home Services must provide “first responder” crisis response on a 24/7/365 basis to recipients who are receiving this service.

Staffing Requirements

This service model includes both a licensed professional and a minimum of two (2) staff who are APs or provisional licensed and who have the knowledge, skills, and abilities required by the population and age to be served. The team leader must be a licensed professional and is responsible for coordinating the initial assessment and developing the youth’s Person Centered Plan (PCP). The service model requires that in-home staff provide 24 hour coverage, 7 days per week. The licensed professional is also responsible for providing or coordinating (with another licensed professional) treatment for the youth or other family members. All treatment must be directed toward the eligible recipient of in-home services. Team to family ratio shall not exceed one to eight (1 to 8) for each three-person team. Intensive In-Home Services focused on substance abuse intervention must include a CCS, CCAS, or CSAC on the team.

Persons who meet the requirements specified for qualified professional or AP status according to 10A NCAC 27G.0104 and who have the knowledge, skills, and abilities required by the population and age to be served may deliver Intensive In-Home Services within the requirements of the staff definition specified in the above rule. Supervision is provided according to supervision requirements specified in 10A NCAC 27G.0104 and according to licensure and certification requirements of the appropriate discipline.

All staff providing Intensive In-Home Services to children and families must have a minimum of one (1) year documented experience with this population. In addition, all staff must complete the intensive in-home services training within the first 90 days of employment.

Service Type/Setting

Intensive In-Home services are direct and indirect periodic services where the team provides direct intervention and also arranges, coordinates, and monitors services on behalf of the recipient. This service is provided in any location. Intensive In-Home services are primarily provided in a range of community settings such as recipient’s home, school, homeless shelters, libraries, etc. Intensive In-Home services also include telephone time with the individual recipient and collateral contact with persons who assist the recipient in meeting their goals specified in their Person Centered Plan.

Note: For all services, federal Medicaid regulations will deny Medicaid payment for services delivered to inmates of public correctional institutions, jails, or detention centers, or for patients in facilities with more than 16 beds that are classified as Institutions of Mental Diseases.

Clinical Requirements

For Intensive In-Home recipients, a minimum of twelve (12) contacts must occur within the first month. One contact will equal all visits occurring in a 24 (twenty-four) hour period of time starting at 7a.m. For

the second and third months of Intensive In-Home services, an average of six (6) contacts per month must occur. It is the expectation that service frequency will be titrated over the last two (2) months.

Units will be billed on a per diem basis with a minimum of 2 hours per day

Services are primarily delivered face-to-face with the consumer and/or family and in locations outside the agency's facility. The aggregate services that have been delivered by the agency will be assessed annually for each provider agency using the following quality assurance benchmarks:

- A minimum of sixty percent (60%) of the contacts occur face-to-face with the youth and/or family. The remaining units may either be phone or collateral contacts; and
- A minimum of sixty percent (60%) or more of staff time must be spent working outside of the agency's facility, with or on behalf of the recipients.

Utilization Management

Authorization by the statewide vendor is required. The amount, duration, and frequency of the service must be included in a recipient's Person-Centered Plan. Initial authorization for services may not exceed thirty (30) days. Reauthorization will occur within a minimum of sixty (60) days thereafter and is so documented in the Person Centered Plan and service record.

If it is a Medicaid covered service, utilization management will be done by the statewide vendor. If it is a non-covered Medicaid service or non-Medicaid client, then the utilization review will be done by the LME.

Entrance Criteria

A recipient is eligible for this service when:

- A. There is an Axis I or II diagnosis present, other than a sole diagnosis of Developmental Disability.

AND

- B. Treatment in a less intensive service (e.g., community support) was attempted or evaluated during the assessment but was found to be inappropriate or not effective.

AND

- C. The youth and/or family have insufficient or severely limited resources or skills necessary to cope with an immediate crisis.

AND

- D. The youth and/or family issues are unmanageable in school based or behavioral program settings and require intensive coordinated clinical and positive behavioral interventions.

AND

- E. The youth is at risk of out-of-home placement or is currently in an out-of-home placement and reunification is imminent.

Continued Stay Criteria

The desired outcome or level of functioning has not been restored, improved or sustained over the time frame outlined in the youth's Person Centered Plan or the youth continues to be at risk for out-of-home placement:

- A. Recipient has achieved initial Person Centered Plan goals and additional goals are indicated.
AND
- B. Recipient is making satisfactory progress toward meeting goals.
AND
- C. Recipient is making some progress, but the Person Centered Plan (specific interventions) needs to be modified so that greater gains, which are consistent with the recipient's premorbid level of functioning, are possible or can be achieved.
OR
- D. Recipient is not making progress; the Person Centered Plan must be modified to identify more effective interventions.
OR
- E. Recipient is regressing; the Person Centered Plan must be modified to identify more effective interventions.

Discharge Criteria

Service recipient's level of functioning has improved with respect to the goals outlined in the Person Centered Plan, inclusive of a transition plan to step down, or no longer benefits, or has the ability to function at this level of care and any of the following apply:

- A. Recipient has achieved goals; discharge to a lower level of care is indicated, or recipient has entered a Substance Abuse Intensive Out-Patient Program.
- B. The youth and families/caregivers have skills and resources needed to step down to a less intensive service.
- C. There is a significant reduction in the youth's problem behavior and/or increase in pro-social behaviors.
- D. The youth's or parent/guardian requests discharge (and is not imminently dangerous to self or others).
- E. An adequate continuing care plan has been established.
- F. The youth requires a higher level of care (i.e., inpatient hospitalization or PRTF).

Note: Any denial, reduction, suspension or termination of service requires notification to the recipient and/or legal guardian about their appeal rights.

Documentation Requirements

Minimum standard is a daily note for services provided that includes the recipient's name, Medicaid identification number, date of service, purpose of contact, describes the provider's interventions, the time spent performing the intervention, the effectiveness of interventions and the signature of the staff providing the service.

Expected Outcomes

The individual's living arrangement has been stabilized, crisis needs have been resolved, linkage has been made with needed community service/resources; youth has gained living skills; parenting skills have been increased; need for out of home placements has been reduced/eliminated

Service Exclusions/Limitations

An individual can receive Intensive In-Home Services from only one Intensive In-Home provider organization at a time.

Intensive in-home services cannot be provided during the same authorization period with the following services except as specified below: Community Support, Multisystemic Therapy, Day Treatment, Hourly Respite, Individual, group or family therapy, SAIOP, or living in a Level II-IV child residential or substance abuse residential facility

Service Limitation: CS can be billed for a maximum of 8 units per month in accordance with the person centered plan for individuals who are receiving intensive in-home services for the purpose of facilitating transition to the service, admission to the service, meeting with the person as soon as possible upon admission, providing coordination during the provision of service, ensuring that the service provider works directly with the CS professional and discharge planning.

Note: For recipients under the age of 21, additional products, services, or procedures may be requested even if they do not appear in the N.C. State Plan or when coverage is limited to those over 21 years of age. Service limitations on scope, amount, or frequency described in the coverage policy may not apply if the product, service, or procedure is medically necessary.

Multisystemic Therapy (MST)

Medicaid Billable Service

Service Definition and Required Components

Multisystemic Therapy (MST) is a program designed for youth generally between the ages 7 through 17 who have antisocial, aggressive/violent behaviors, are at risk of out-of-home placement due to delinquency and/or; adjudicated youth returning from out-of-home placement and/or; chronic or violent juvenile offenders, and/or youth with serious emotional disturbances or abusing substances and their families—MST provides an intensive model of treatment based on empirical data and evidence-based interventions that target specific behaviors with individualized behavioral interventions. The purpose of this program is to keep youth in the home by delivering an intensive therapy to the family within the home. Services are provided through a team approach to youth and their families. Services include: an initial assessment to identify the focus of the MST intervention; individual therapeutic interventions with the youth and family; peer intervention; case management; and crisis stabilization. Specialized therapeutic and rehabilitative interventions are available to address special areas such as substance abuse, sexual abuse, sex offending, and domestic violence. Services are available in-home, at school, and in other community settings. The duration of MST intervention is three to five (3 to 5) months. MST involves families and other systems such as the school, probation officers, extended families, and community connections.

MST services are delivered in a team approach designed to address the identified needs of children and adolescents with significant behavioral problems who are transitioning from out of home placements or are at risk of out-of-home placement and need intensive interventions to remain stable in the community. This population has access to a variety of interventions twenty four (24/7) hours a day by staff that will maintain contact and intervene as one organizational unit.

This team approach is structured face-to-face therapeutic interventions to provide support and guidance in all areas of functional domains: adaptive, communication, psychosocial, problem solving, behavior management, etc. The service promotes the family's capacity to monitor and manage the youth's behavior.

A service order for MST must be completed by a physician, licensed psychologist, physician's assistant or nurse practitioner according to their scope of practice prior to or on the day that the services are to be provided.

Provider Requirements

MST services must be delivered by practitioners employed by a mental health/substance abuse provider organization that meets the provider qualification policies, procedures, and standards established by DMH and the requirements of 10A NCAC 27G. These policies and procedures set forth the administrative, financial, clinical, quality improvement, and information services infrastructure necessary to provide services. Provider organizations must demonstrate that they meet these standards by being endorsed by the LME. Within three years of enrollment as a provider, the organization must have achieved national accreditation. The organization must be established as a legally recognized entity in the United States and qualified/registered to do business as a corporate entity in the State of North Carolina.

MST providers must have the ability to deliver services in various environments, such as homes, schools, detention centers and jails (state funds only), homeless shelters, street locations, etc. Organizations that provide MST must provide “first responder” crisis response on a 24/7/365 basis to consumers who are receiving this service

Staffing Requirements

This service model includes at a minimum a master’s level QP who is the team supervisor and three (3) QP staff who provide available 24-hour coverage, 7 days per week. Staff is required to participate in MST introductory training and quarterly training on topics directly related to the needs of MST youth and their family on an ongoing basis. All staff on the MST team shall receive a minimum of one (1) hour of group supervision and one (1) hour of telephone consultation per week. MST team member to family ratio shall not exceed one to five (1 to 5) for each member.

Service Type/Setting

MST is a direct and indirect periodic service where the MST worker provides direct intervention and also arranges, coordinates, and monitors services on behalf of the recipient. This service is provided in any location. MST services are provided in a range of community settings such as recipient’s home, school, homeless shelters, libraries, etc. MST also includes telephone time with the individual recipient and collateral contact with persons who assist the recipient in meeting their goals specified in their Person Centered Plan.

Note: For all services, federal Medicaid regulations will deny Medicaid payment for services delivered to inmates of public correctional institutions or for patients in facilities with more than 16 beds that are classified as Institutions of Mental Diseases.

Clinical Requirements

For registered recipients, a minimum of twelve (12) contacts must occur within the first month. For the second and third months of MST, an average of six (6) contacts per month must occur. It is the expectation that service frequency will be titrated over the last two (2) months.

Units will be billed in fifteen (15) minute increments.

Program services are primarily delivered face-to-face with the consumer and/or their family and in locations outside the agency’s facility. The aggregate services that have been delivered by the agency will be assessed annually for each provider agency using the following quality assurance benchmarks:

- A minimum of fifty percent (50%) of the contacts occur face-to-face with the youth and/or family. The remaining units may either be phone or collateral contacts; and
- A minimum of sixty percent (60%) or more of staff time must be spent working outside of the agency’s facility, with or on behalf of consumers.

Utilization Management

Authorization by the statewide vendor is required. The amount, duration, and frequency of the service must be included in an individual’s Person Centered Plan. The initial authorization for services may not exceed thirty (30) days. Reauthorization will occur within a minimum sixty (60) days thereafter and is so documented in the Person Centered Plan and service record.

If it is a Medicaid covered service, utilization management will be done by the statewide vendor. If it is a non-covered Medicaid service or non-Medicaid client, then the utilization review will be done by the LME.

A maximum of thirty-two (32) units of MST services can be provided in a twenty-four (24) hour period. No more than 480 units of services can be provided to an individual in a three (3) month period unless specific authorization for exceeding this limit is approved.

Entrance Criteria

- A. There is an Axis I or II diagnosis present, other than a sole diagnosis of Developmental Disability.
AND
- B. The youth should be between the ages of 7 through 17.
AND
- C. The youth displays willful behavioral misconduct (e.g., theft, property destruction, assault, truancy or substance use/abuse or juvenile sex offense), when in conjunction with other adjudicated delinquent behaviors
AND
- D. The youth is at imminent risk of out-of-home placement or is currently in out-of-home placement due to delinquency and reunification is imminent within thirty (30) days of referral.
AND
- E. The youth has a caregiver that is willing to assume long term parenting role and caregiver who is willing to participate with service providers for the duration of the treatment.

Continued Stay Criteria

The desired outcome or level of functioning has not been restored, improved or sustained over the time frame outlined in the youth's Person Centered Plan or the youth continues to be at risk for relapse based on history or the tenuous nature of the functional gains or any one of the following apply:

- A. Youth continues to exhibit willful behavioral misconduct.
AND
- B. There is a reasonable expectation that the youth will continue to make progress in reaching overarching goals identified in MST in the first four (4) weeks.
OR
- C. Youth is not making progress; the Person Centered Plan must be modified to identify more effective interventions.
OR
- D. Youth is regressing; the Person Centered Plan must be modified to identify more effective interventions.

Discharge Criteria

Youth's level of functioning has improved with respect to the goals outlined in the Person Centered Plan, or no longer benefits from this service. The decision should be based on one of the following:

- A. Youth has achieved seventy-five percent (75%) of the Person Centered Plan goals, discharge to a lower level of care is indicated.
- B. Youth is not making progress or is regressing, and all realistic treatment options within this modality have been exhausted.

- C. The youth/family requests discharge and is not imminently dangerous to self or others
- D. The youth requires a higher level of care (i.e., inpatient hospitalization or PRTF).

Note: Any denial, reduction, suspension, or termination of service requires notification to the recipient and/or legal guardian about their appeal rights.

Documentation Requirements

Minimum standard is a daily full service note that includes the recipient's name, Medicaid identification number, date of service, purpose of contact, describes the provider's intervention, the time spent performing the intervention, the effectiveness of interventions and the signature of the staff providing the service.

Expected Outcomes

The youth has improved in domains such as: adaptive, communication, psychosocial, problem solving and behavior, willful behavioral misconduct has been reduced/eliminated (e.g. theft, property destruction, assault, truancy or substance abuse/use, or juvenile sex offense, when in conjunction with other delinquent behaviors) The family has increased capacity to monitor and manage the youth's behavior; need for out of home placement has been reduced/eliminated.

Service Exclusions/Limitations

An individual can receive MST services from only one MST provider organization at a time.

MST services can not be billed for individuals who are receiving Community Support, Intensive In-Home Services, Day Treatment, Hourly Respite, individual, group or family therapy, SAIOP, living in Level II-IV Child residential, or substance abuse residential placements except as specified below:

Service Limitation: CS can be billed for a maximum of 8 units per month in accordance with the person centered plan for individuals who are receiving MST services for the purpose of facilitating transition to the service, admission to the service, meeting with the person as soon as possible upon admission, providing coordination during the provision of service, ensuring that the service provider works directly with the CS profession and discharge planning.

Note: For recipients under the age of 21, additional products, services, or procedures may be requested even if they do not appear in the N.C. State Plan or when coverage is limited to those over 21 years of age. Service limitations on scope, amount, or frequency described in the coverage policy may not apply if the product, service, or procedure is medically necessary.

Community Support Team (CST) (MH/SA)

Medicaid Billable Service

Service Definition and Required Components

Community Support Team (CST) services consist of mental health and substance abuse rehabilitation services and supports necessary to assist adults (age 18 and older) in achieving rehabilitative and recovery goals. This is an intensive community rehabilitation service that provides treatment and restorative interventions to: assist individuals to gain access to necessary services; reduce psychiatric and addiction symptoms; and develop optimal community living skills. Services offered by the CST shall be documented in a Person Centered Plan and must include: assistance and support for the individuals in crisis situations; service coordination; psycho-education and support for individuals and their families; individual restorative interventions for the development of interpersonal, community coping and independent living skills; development of symptom monitoring and management skills; monitoring medication; and self medication.

Individuals will experience decreased crisis episodes, and increased community tenure, time working, in school or with social contacts, and personal satisfaction and independence. Through supports based on the individuals' needs, consumers will reside in independent or semi-independent living arrangements, and be engaged in the recovery process.

The CST must consult with identified professionals, family members and others, include their input into the Person Centered Planning process, inform all involved stakeholders, and monitor the status of the recipient in relationship to the treatment goals. The CST provider assumes the roles of advocate, broker, coordinator, and monitor of the service delivery system on behalf of the recipient. The community Support Professional provides coordination of movement across levels of care, directly to the person and their family, and coordinates discharge planning and community re-entry following hospitalization, residential services and other levels of care.

A service order for CST must be completed by a physician, licensed psychologist, physician's assistant or nurse practitioner according to their scope of practice prior to or on the day that the services are to be provided.

Provider Requirements

Community Support services provided by a team must be delivered by practitioners employed by a mental health/substance abuse provider organization that meet the provider qualification policies. These policies and procedures set forth the administrative, financial, clinical, quality improvement, and information services infrastructure necessary to provide services. Provider organizations must demonstrate that they meet these standards by being endorsed by the LME. Within three (3) years of enrollment as a provider, the organization must have achieved national accreditation. The organization must be established as a legally recognized entity in the United States and qualified/registered to do business in the State of North Carolina.

The CST must have the ability to deliver services in various environments, such as homes, schools, jails (state funds only), homeless shelters, street locations, etc.

Organizations that provide CST services must provide “first responder” crisis response on a 24/7/365 basis to consumers who are receiving this service.

Staffing Requirements

Community Support teams must be comprised of three (3) staff persons meeting the requirements above. Each team must have a team leader who must meet QP status according to 10A NCAC 27G.0104. The team must have a least a .5 FTE team leader that provides clinical and administrative supervision of the team and also function as a practicing clinician on the team.

AND

Persons who meet the requirements specified for QP or AP status according to 10A NCAC 27G.0104 and who have the knowledge, skills and abilities required by the population and age to be served may deliver Community Support Team services. A QP must be the team leader (supervisor). Supervision is provided according to supervision requirements specified in 10A NCAC 27G.0203 and according to licensure requirements of the appropriate discipline.

AND

The team may include a paraprofessional who meet the requirements specified for Paraprofessional status according to 10A NCAC 27G.0104 and who have the knowledge, skills and abilities required by the population and age to be served may deliver Community Support Team services within the requirements of the staff definition specific in the above role. Supervision of Paraprofessionals is also to be carried out according to 10A NCAC 27G.0204.

OR

A Certified Peer Support Specialist is an individual who is or has been a recipient or is a recipient of mental health or substance abuse services with mental illness or addiction. A Certified Peer Specialist is a fully integrated team member who provides highly individualized services in the community and promotes individual self-determination and decision making.

The Community Support Team maintains a consumer-to-practitioner ratio of no more than fifteen (15) consumers per staff person. Staff-to-consumer ratio takes into consideration evening and weekend hours, needs of special populations, and geographical areas to be served. (For example, a team of three staff can have a caseload of 45 consumers.)

All staff providing community support team services must have a minimum of one year documented experience with the adult population and completion of a minimum of twenty hours of crisis management and community support team service definition required components within the first 90 days of employment.

Service Type/Setting

Community Support Team is a direct and indirect periodic service in which the team provides direct intervention and also arranges, coordinates, and monitors services on behalf of the recipient. This service is provided in any location. Community Support Team services are provided in a range of community settings such as recipient’s home, homeless shelters, libraries, etc. Community Support Team services also include telephone time with the individual recipient and collateral contact with persons who assist the recipient in meeting his/her rehabilitation goals.

This service is billable to Medicaid except when provided to a consumer who is an inmate of a public correctional institution or a resident in an Institution for Mental Diseases (IMD).

**Division of Medical Assistance
Enhanced Mental Health
and Substance Abuse Services**

**Clinical Coverage Policy No.: 8A
Original Effective Date: July 1, 1989
Revised Date: February 1, 2008
Effective March 1, 2008**

Clinical Requirements

For registered recipients, a minimum of eight (8) contacts must occur within the first month. Units will be billed in fifteen (15) minute increments.

Program services are primarily delivered face-to-face with the consumer and in locations outside the agency's facility. The aggregate services that have been delivered by the agency will be assessed annually for each provider agency using the following quality assurance benchmarks:

- A minimum of sixty percent (60%) or more of CST services that are delivered face-to-face with the recipient. The remaining units may either by phone or collateral contacts; and
- A minimum of ninety percent (90%) or more of staff time must be spent working outside of the agency's facility, with or on behalf of consumers.

Utilization Management

Authorization by the statewide vendor is required. The amount, duration and frequency of the service must be included in an individual's Person Centered Plan and a QP must obtain service orders prior to the delivery of services. The initial authorization for services may not exceed 30 days. Reauthorization will occur within a minimum of 60 days thereafter and is to be documented in the Person Centered Plan and service record.

If it is a Medicaid covered service, utilization management will be done by the statewide vendor. If it is a non-covered Medicaid service or non-Medicaid client, then the utilization review will be done by the LME.

A maximum of 32 units of CST services can be provided in a 24-hour period, unless specific authorization for exceeding this limit is appropriate. No more than 140 units of services per week can be provided to an individual unless specific authorization for exceeding this limit is required based on medical necessity.

Entrance Criteria

The recipient is eligible for this service when:

- A. There are two (2) identified needs in the appropriate documented domains,

AND

- B. There is an Axis I or II diagnosis present, other than a sole diagnosis of a Developmental Disability

AND/OR

- C. Adult of Care Criteria or level A/ASAM (American Society for Addiction Medicine)

AND

- D. And four or more of the following conditions:

1. High use of acute psychiatric hospitals or crisis/emergency services including mobile, in-clinic or crisis residential (e.g., two or more admissions per year) or extended hospital stay (30 days within the past year) or psychiatric emergency services.
2. History of inadequate follow-through with elements of a Person Centered Plan related to risk factors (including lack of follow through taking medications, following a crisis plan or maintaining housing).

3. Intermittently medication refractory.
4. Co-diagnosis of substance abuse (ASAM – any level of care) and mental illness.
5. Legal issues (conditional release for non-violent offense; history of failures to show in court, etc.).
6. Homeless or at high risk of homelessness due to residential instability.
7. Clinical evidence of suicidal gestures and/or ideation in past 3 months.
8. Ongoing inappropriate public behavior in the community within the last three months.
9. Self-harm or threats of harm to others within last year.
10. Evidence of significant complications such as cognitive impairment, behavioral problems, or medical conditions.
11. A lower level of care has been tried or considered and found to be inappropriate for the consumer at the time that authorization is requested.

Continued Stay Criteria

The desired outcome or level of functioning has not been restored, improved, or sustained over the time frame outlined in the recipient's Person Centered Plan or the recipient continues to be at risk for relapse based on history or the tenuous nature of the functional gains or any one of the following apply:

- A. Recipient has achieved initial Person Centered Plan goals and these services are necessary to meet additional goals.
- B. Recipient is making satisfactory progress toward meeting goals.
- C. Recipient is making some progress, but the Person Centered Plan (specific interventions) need to be modified so that greater gains, which are consistent with the recipient's premorbid level of functioning, are possible or can be achieved.
- D. Recipient is not making progress; the Person Centered Plan must be modified to identify more effective interventions.
- E. Recipient is regressing; the Person Centered Plan must be modified to identify more effective interventions.

AND

Utilization review must be conducted every 60 days (after the initial 30 day UR) and is so documented in the Person Centered Plan and service record.

Discharge Criteria

Recipient's level of functioning has improved with respect to the goals outlined in the Person Centered Plan, inclusive of a transition plan to step down, or no longer benefits, or has the ability to function at this level of care and any of the following apply:

- A. Recipient has positive life outcomes that supports stable and ongoing recovery.
- B. Recipient is not making progress, or is regressing and all realistic treatment options have been exhausted indicating a need for more intensive services.
- C. Recipient/family no longer wants Community Support Team services.

Note: Any denial, reduction, suspension, or termination of service requires notification to the recipient and/or legal guardian about their appeal rights.

Documentation Requirements

Minimum standard is a daily full service note that includes the recipient's name, Medicaid identification number, date of service, purpose of contact, describes the provider's interventions, includes the time spent performing the interventions, effectiveness of the intervention, and the signature and credentials of the staff providing the service.

Expected Outcomes

Individuals will experience decreased crisis episodes and increased community tenure, time working in school or with social contact, and personal satisfaction and independence. Through supports based on the individuals' needs, consumers will reside in independent or semi-independent living arrangements, and be engaged in the recovery process

Service Exclusions/Limitations

An individual can receive Community Support Team services from only one Community Support Team provider at a time.

Community Support Team services can not be billed for individuals who are receiving Community Support, ACTT, SA Intensive Outpatient Program (SAIOP), SA Comprehensive Outpatient Treatment (SACOT) or SA residential services except as specified below.

Community Support Team services can be billed for a maximum of eight (8) units per month in accordance with the PCP for individuals who are receiving Community Support, ACTT, Partial Hospitalization, SAIOP, SACOT, or residential services for the purpose of facilitating a transition for the service, admission to the service, meeting with the person as soon as possible upon admission, providing coordination during the provision of service, and ensuring that the service provider works directly with the CST professional and discharge planning.

Community Support Team services can be provided for individuals residing in adult MH residential programs (e.g., Supervised Living Low or Moderate, Group Living Low, Moderate or High).

Note: For recipients under the age of 21, additional products, services, or procedures may be requested even if they do not appear in the N.C. State Plan or when coverage is limited to those over 21 years of age. Service limitations on scope, amount, or frequency described in the coverage policy may not apply if the product, service, or procedure is medically necessary.

Assertive Community Treatment Team (ACTT) Medicaid Billable Service

Service Definition and Required Components

The Assertive Community Treatment Team is a service provided by an interdisciplinary team that ensures service availability 24 hours a day, 7 days per week and is prepared to carry out a full range of treatment functions wherever and whenever needed. A service recipient is referred to the Assertive Community Treatment Team service when it has been determined that his/her needs are so pervasive and/or unpredictable that they can not be met effectively by any other combination of available community services. Typically this service should be targeted to the ten percent (10%) of MH/DD/SA service recipients who have serious and persistent mental illness or co-occurring disorders, dual and triply diagnosed and the most complex and expensive treatment needs. The service objectives are addressed by activities designed to: promote symptom stability and appropriate use of medication; restore personal, community living and social skills; promote and maintain physical health; establish access to entitlements, housing, work and social opportunities; and promote and maintain the highest possible level of functioning in the community. ACT Teams should make every effort to meet critical standards contained in the most current edition of the National Program Standards for ACT Teams as established by the National Alliance for the Mentally Ill or US Department of Health and Human Services, Center for Mental Health Services.

This service is delivered in a team approach designed to address the identified needs of specialized populations and/or the long term support of those with persistent MH/DD/SA issues that require intensive interventions to remain stable in the community. These service recipients would tend to be high cost, receive multiple services, decompensate to the point of requiring hospitalization before seeking treatment, seek treatment only during a crisis, or unable to benefit from traditional forms of clinic based services. This population has access to a variety of interventions twenty four (24) hours, seven days per week by staff that will maintain contact and intervene as one organizational unit.

This team approach involves structured face-to-face scheduled therapeutic interventions to provide support and guidance in all areas of functional domains: adaptive, communication, personal care, domestic, psychosocial, problem solving, etc. in preventing, overcoming, or managing the recipient's level of functioning and enhancing his/her ability to remain in the community.

This service includes interventions that address the functional problems associated with the most complex and/or pervasive conditions of the identified population. These interventions are strength based and focused on promoting symptom stability, increasing the recipient's ability to cope and relate to others and enhancing the highest level of functioning in the community.

ACTT provides ongoing assertive outreach and treatment necessary to address the service recipient's needs effectively. Consideration of geographical locale may impact on the effectiveness of this service model. This model is primary a mobile unit, but includes some clinic based services.

A service order for ACTT must be completed by a physician, licensed psychologist, physician's assistant or nurse practitioner according to their scope of practice prior to or on the day that the services are to be provided.

Provider Requirements

Assertive Community Treatment services must be delivered by practitioners employed by a mental health/substance abuse provider organization that meet the provider qualification policies, procedures, and standards established by DMH and the requirements of 10A NCAC 27G . These policies and procedures set forth the administrative, financial, clinical, quality improvement, and information services infrastructure necessary to provide services. Provider organizations must demonstrate that they meet these standards by being endorsed by the LME. Within three years of enrollment as a provider, the organization must have achieved national accreditation. The organization must be established as a legally recognized entity in the United States and qualified/registered to do business in the State of North Carolina.

ACTT services may be provided to an individual by only one organization at a time. This organization is identified in the Person Centered Plan and is responsible for obtaining authorization from the LME for the PCP. ACTT providers must have the ability to deliver services in various environments, such as homes, schools, homeless shelters, street locations, etc.

***Note:** For all services, federal Medicaid regulations will deny Medicaid payment for services delivered to inmates of public correctional institutions. For ACTT, the case management component may be billed when provided thirty (30) days prior to discharge when a recipient resides in a general hospital or a psychiatric inpatient setting and retains Medicaid eligibility.

Organizations that provide ACTT services must ensure service availability 24 hours per day, 7 days per week, 365 days per year and be capable of providing a full range of treatment functions including crisis response wherever and whenever needed to recipients who are receiving ACTT services.

Staffing Requirements

Assertive Community Treatment services must be provided by a team of individuals. Individuals on this team shall have sufficient individual competence, professional qualifications and experience to provide service coordination; crisis assessment and intervention; symptom assessment and management; individual counseling and psychotherapy; medication prescription, administration, monitoring and documentation; substance abuse treatment; work-related services; activities of daily living services; social, interpersonal relationship and leisure-time activity services; support services or direct assistance to ensure that individuals obtain the basic necessities of daily life; and education, support, and consultation to individuals' families and other major supports. Each ACT team staff member must successfully participate in the DMH approved ACTT training. The DMH approved training will focus on developing staff's competencies for delivering ACTT services according to the most recent evidenced based practices. Each ACT team shall have sufficient numbers of staff to provide treatment, rehabilitation, and support services 24 hours a day, seven days per week.

Each ACT team shall have a staff-to-individual ratio that does not exceed one full-time equivalent (FTE) staff person for every 10 individuals (not including the psychiatrist and the program assistant ACT teams **that serve approximately 100 individuals** shall employ a minimum of 10 FTE multidisciplinary clinical staff persons including:

Team Leader: A full-time team leader/supervisor that is the clinical and administrative supervisor of the team and who also functions as a practicing clinician on the ACTT team. The team leader at a minimum must have a master's level QP status according to 10A NCAC 27G.0104.

Psychiatrist: A psychiatrist, who works on a full-time or part-time basis for a minimum of 16 hours per week for every 50 individuals. The psychiatrist provides clinical services to all ACTT individuals; works with the team leader to monitor each individual's clinical status and response to treatment; supervises staff delivery of services; and directs psychopharmacologic and medical services.

Registered Nurses: A minimum of two FTE registered nurses. At least one nurse must have a QP status according to 10A NCAC 27G.0104 or be an Advanced Practice Nurse (APN) according to NCGS Chapter 90 Article I, Subchapter 32M. The other nurse must have at minimum an AP status according to 10A NCAC 27G.0104. By July 1, 2005 it is expected that all team nurses will be have QP Status or be an APN.

Other Mental Health Professionals: A minimum of 4 FTE QP or AP (in addition to the team leader), with at least one designated for the role of vocational specialist, preferably with a master's degree in rehabilitation counseling. At least one-half of these other mental health staff shall be master's level professionals.

Substance Abuse Specialist: One FTE who has a QP status according to 10A NCAC 27G.0104. and is one of the following: CCS, CCAS, or CSAC.

Certified Peer Support Specialist: A minimum of one FTE Certified Peer Support Specialist. A Certified Peer Support Specialist is an individual who is or has been a recipient of mental health services. Because of life experience with mental illness and mental health services, the Certified Peer Support Specialist provides expertise that professional training cannot replicate. Certified Peer Support Specialists are fully integrated team members who provide highly individualized services in the community and promote individual self-determination and decision-making.

Certified Peer Support Specialists also provide essential expertise and consultation to the entire team to promote a culture in which each individual's point of view and preferences are recognized, understood, respected and integrated into treatment, rehabilitation, and community self-help activities.

Remaining Clinical Staff: The additional clinical staff may be bachelor's level and Paraprofessional mental health workers who carry out rehabilitation and support functions. A bachelor's level mental health worker has a bachelor's degree in social work or a behavioral science and work experience with adults with severe and persistent mental illness. A Paraprofessional mental health worker may have a bachelor's degree in a field other than behavioral sciences or have a high school degree and work experience with adults with severe and persistent mental illness or with individuals with similar human-services needs. These Paraprofessionals may have related training (e.g., certified occupational therapy assistant, home health care aide) or work experience (e.g., teaching) and life experience.

Program/Administrative Assistant: One FTE program/administrative assistant who is responsible for organizing, coordinating, and monitoring all non-clinical operations of ACTT, including managing medical records; operating and coordinating the management information system; maintaining accounting and budget records for individual and program expenditures; and providing receptionist activities, including triaging calls and coordinating communication between the team and individuals.

Smaller teams **servicing no more than 50 individuals** shall employ a minimum of 6 to 8 FTE multidisciplinary clinical staff persons, including one team leader (MHP), one registered nurse, one FTE peer specialist, one FTE program assistant, and 16 hours of psychiatrist time for every 50 individuals on the team. One of the multidisciplinary clinical staff persons should be a CCS or CCAS, CSAC.

Service Type/Setting

ACTT is a direct and indirect periodic service where the ACTT staff provides direct intervention and also arranges, coordinates, and monitors services on behalf of the recipient. This service is provided in any location. ACTT are intended to be provided on an individualized basis.

ACTT services are primarily provided in a range of community settings such as recipient's home, school, homeless shelters, libraries, etc.

***Note:** For all services, federal Medicaid regulations will deny Medicaid payment for services delivered to inmates of public correctional institutions. For ACTT, the case management component may be billed when provided thirty (30) days prior to discharge when a recipient resides in a general hospital or a psychiatric inpatient setting and retains Medicaid eligibility.

ACTT may include telephone time with the individual recipient and collateral contact with persons who assist the recipient in meeting his/her rehabilitation goals. ACTT activities include person-centered planning meetings and meetings for treatment/Person Centered Plan development.

Program Requirements

The ACT team shall have the capacity to provide multiple contacts a week with individuals experiencing severe symptoms, trying a new medication, experiencing a health problem or serious life event, trying to go back to school or starting a new job, making changes in living situation or employment or having significant ongoing problems in daily living. These multiple contacts may be as frequent as two to three times per day, seven days per week and depend on individual need and a mutually agreed upon plan between individuals and program staff. Many, if not all, staff shall share responsibility for addressing the needs of all individuals requiring frequent contact. The ACT team shall provide an average of three contacts per week for all individuals.

Program services are primarily delivered face-to-face with the consumer and in locations outside the agency's facility. The aggregate services that have been delivered by the agency will be assessed annually for each provider agency using the following quality assurance benchmarks:

- A minimum of eighty percent (80%) or more of staff time must be face-to-face with the recipient. The remaining units may either be phone or collateral contacts; and
- Each team shall set a goal of providing seventy-five percent (75%) of service contacts in the community in non office-based or non facility-based settings.

To ensure appropriate ACT team development, each new ACT team is recommended to titrate ACTT intake (e.g., 4-6 individuals per month) to gradually build up capacity to serve no more than 100-120 individuals (with 10-12 staff) and no more than 42-50 individuals (with 6-8 staff) for smaller teams.

The ACT team shall be available to provide treatment, rehabilitation, and support activities seven days per week. It is recommended that ACT team schedules should follow the standards established in the National Program Standards for ACT Teams.

Utilization Management

Authorization by the statewide vendor is required. Utilization review must be conducted every thirty (30) days and is so documented in the Person Centered Plan and service record.

If it is a Medicaid covered service, utilization management will be done by the statewide vendor. If it is a non-covered Medicaid service or non-Medicaid client, then the utilization review will be done by the LME.

Entrance Criteria

The recipient is eligible for ACTT services when:

- A. They have a severe and persistent mental illness listed in the diagnostic nomenclature (currently the Diagnostic and Statistical Manual, Fourth Edition, or DSM IV, of the American Psychiatric Association) that seriously impair their functioning in community living. Priority is given to people with schizophrenia, other psychotic disorders (e.g., schizoaffective disorder), and bipolar disorder because these illnesses more often cause long-term psychiatric disability. (Individuals with a primary diagnosis of a substance abuse disorder or mental retardation are not the intended recipient group.)
- B. They have a significant functional impairments as demonstrated by at least one of the following conditions:
 1. Significant difficulty consistently performing the range of practical daily living tasks required for basic adult functioning in the community (e.g., caring for personal business affairs; obtaining medical, legal, and housing services; recognizing and avoiding common dangers or hazards to self and possessions; meeting nutritional needs; maintaining personal hygiene) or persistent or recurrent difficulty performing daily living tasks except with significant support or assistance from others such as friends, family, or relatives.
 2. Significant difficulty maintaining consistent employment at a self-sustaining level or significant difficulty consistently carrying out the homemaker role (e.g., household meal preparation, washing clothes, budgeting, or child-care tasks and responsibilities).
 3. Significant difficulty maintaining a safe living situation (e.g., repeated evictions or loss of housing).
- C. Have one or more of the following problems, which are indicators of a need for continuous high level of services (i.e., greater than eight hours per month):
 1. High use of acute psychiatric hospitals (e.g., two or more admissions per year) or psychiatric emergency services.
 2. Intractable (i.e., persistent or very recurrent) severe major psychiatric symptoms (e.g., affective, psychotic, suicidal).
 3. Coexisting mental health and substance abuse disorder of significant duration (e.g., greater than 6 months).
 4. High risk or recent history of criminal justice involvement (e.g., arrest, incarceration).
 5. Significant difficulty meeting basic survival needs, residing in substandard housing, homelessness or imminent risk of becoming homeless.
 6. Residing in an inpatient or supervised community residence, but clinically assessed to be able to live in a more independent living situation if intensive services are provided, or requiring a residential or institutional placement if more intensive services are not available.
 7. Difficulty effectively utilizing traditional office-based outpatient services.

Priority is given to people with schizophrenia, other psychotic disorders (e.g., schizoaffective disorder), and bipolar disorder. Individuals with other major psychiatric disorders may be eligible when other services have not been effective in meeting their needs.

Continued Stay Criteria

The desired outcome or level of functioning has not been restored, improved, or sustained over the time frame outlined in the recipient's Person Centered Plan or the recipient continues to be at risk for relapse based on attempts to reduce ACTT services in a planful way; or the tenuous nature of the functional gains; or any one of the following apply:

- A. Recipient has achieved positive life outcomes that supports stable and ongoing recovery and these services are needed to meet additional goals.
- B. Recipient is making satisfactory progress toward meeting goals.
- C. Recipient is making some progress, but the Person Centered Plan (specific interventions) needs to be modified so that greater gains, which are consistent with the recipient's premorbid level of functioning, are possible or can be achieved.
- D. Recipient is not making progress; the Person Centered Plan must be modified to identify more effective interventions or indicating a need for more intensive services.
- E. Recipient is regressing; the Person Centered Plan must be modified to identify more effective interventions.

If the recipient is functioning effectively with this service and discharge would otherwise be indicated, ACTT services should be maintained when it can be reasonably anticipated that regression is likely to occur if the service is withdrawn. The decision should be based on any one of the following:

- A. Past history of regression in the absence of ACTT is documented in the service record or attempts to titrate ACTT downward have resulted in regression,

OR

- B. In the event there is an epidemiologically sound expectation that symptoms will persist and that ongoing outreach treatment interventions are needed to sustain functional gains. The presence of a DSM IV diagnosis would necessitate a disability management approach.

Discharge Criteria

- A. Discharges from the ACT team occur when recipients and program staff mutually agree to the termination of services. This shall occur when recipients:
 - 1. Have successfully reached individually established goals for discharge, and when the recipient and program staff mutually agree to the termination of services.
 - 2. Have successfully demonstrated an ability to function in all major role areas (i.e., work, social, self-care) without ongoing assistance from the program, without significant relapse when services are withdrawn, and when the recipient requests discharge, and the program staff mutually agree to the termination of services.
 - 3. Move outside the geographic area of ACTT's responsibility. In such cases, the ACT team shall arrange for transfer of mental health service responsibility to an ACTT program or another provider wherever the recipient is moving. The ACT team shall maintain contact with the recipient until this service transfer is implemented.

4. Decline or refuse ACTT services and request discharge, despite the team's best efforts to develop an acceptable treatment plan with the recipient.
- B. Documentation of discharge shall include:
1. The reasons for discharge as stated by both the recipient and the ACT team.
 2. The recipient's biopsychosocial status at discharge.
 3. A written final evaluation summary of the recipient's progress toward the goals set forth in the treatment plan.
 4. A plan developed in conjunction with the recipient for follow-up treatment after discharge.
 5. The signature of the recipient, the recipient's service coordinator, the team leader, and the psychiatrist.

Note: Any denial, reduction, suspension, or termination of service requires notification to the recipient and/or legal guardian about their appeal rights.

Documentation Requirements

Minimum standard is a daily full service note that includes the consumer's name, Medicaid identification number, date of service, purpose of contact, describes the provider's interventions, includes the time spent performing the interventions, effectiveness of the intervention, and the signature of the staff providing the service.

Expected Outcomes

The individual will have increased ability to function in all major role areas (i.e., work, social, self-care) without ongoing assistance from the program, without significant relapse when services are withdrawn, need for emergency and inpatient psychiatric services will be reduced; severe psychiatric symptoms will be reduced, criminal justice involvement will be decreased, ability to meet basic needs such as food, clothing, housing will be increased.

Service Exclusions/Limitations

An individual can receive ACTT services from only one ACTT provider at a time. ACTT is a comprehensive team intervention and most other services are excluded. Opioid Treatment can be provided concurrently with ACTT.

ACTT services can be billed for a limited period of time in accordance with the PCP for individuals who are receiving Community Support, CST, Partial Hospitalization, SAIOP, SACOT, PSR, or SA residential services for the purpose of facilitating transition to the service admission to the service, meeting with the person as soon as possible upon admission, providing coordination during the provision of service, ensuring that the service provider works directly with the ACTT professional and discharge planning.

ACTT services can be provided for individuals residing in adult MH residential programs (e.g. Supervised Living Low or Moderate, Group Living Low, Moderate or High).

Note: For recipients under the age of 21, additional products, services, or procedures may be requested even if they do not appear in the N.C. State Plan or when coverage is limited to those over 21 years of age. Service limitations on scope, amount, or frequency described in the coverage policy may not apply if the product, service, or procedure is medically necessary.

Psychosocial Rehabilitation Medicaid Billable Service

Service Definition and Required Components

A Psychosocial Rehabilitation (PSR) service is designed to help adults with psychiatric disabilities increase their functioning so that they can be successful and satisfied in the environments of their choice with the least amount of ongoing professional intervention. PSR focuses on skill and resource development related to life in the community and to increasing the participant's ability to live as independently as possible, to manage their illness and their lives with as little professional intervention as possible, and to participate in community opportunities related to functional, social, educational and vocational goals.

The service is based on the principles of recovery, including equipping consumers with skills, emphasizing self-determination, using natural and community supports, providing individualized intervention, emphasizing employment, emphasizing the "here and now", providing early intervention, providing a caring environment, practicing dignity and respect, promoting consumer choice and involvement in the process, emphasizing functioning and support in real world environments, and allowing time for interventions to have an effect over the long term.

There should be a supportive, therapeutic relationship between the providers, recipient, and family which addresses and/or implements interventions outlined in the Person Centered Plan in any of the following skills development, educational, and pre-vocational activities:

- A. community living, such as housekeeping, shopping, cooking, use of transportation facilities, money management;
- B. personal care such as health care, medication self-management, grooming;
- C. social relationships;
- D. use of leisure time
- E. educational activities which include assisting the client in securing needed education services such as adult basic education and special interest courses; and
- F. prevocational activities which focus on the development of positive work habits and participation in activities that would increase the participant's self worth, purpose and confidence; these activities are not to be job specific training.

A service order for Psychosocial Rehabilitation must be completed by a physician, licensed psychologist, physician's assistant or nurse practitioner according to their scope of practice prior to or on the day that the services are to be provided.

Provider Requirements

Psychosocial Rehabilitation services must be delivered by a mental health provider organization that meet the provider qualification policies, procedures, and standards established by DMH and the requirements of 10A NCAC 27G These policies and procedures set forth the administrative, financial, quality improvement, and information services infrastructure necessary to provide services. Provider organizations must demonstrate that they meet these standards by being endorsed by the LME. Within three years of enrollment as a provider, the organization must have achieved national accreditation. The

organization must be established as a legally recognized entity in the United States and qualified/registered to do business as a corporate entity in the State of North Carolina.

Staffing Requirements

The program shall be under the direction of a person who meets the requirements specified for QP status according to 10A NCAC 27G.0104. The QP is responsible for supervision of other program staff which may include APs and Paraprofessionals who meet the requirements according to 10A NCAC 27G.0104 and who have the knowledge, skills and abilities required by the population and age to be served.

Service Type/Setting

Psychosocial Rehabilitation is a service that shall be available five hours a day minimally and the setting shall meet the licensure requirements of 10A NCAC 27G.1200.

Program Requirements

This service is to be available for a period of five or more hours per day at least five days per week and it may be provided on weekends or in the evening. The number of hours that participant receives PSR services are to be specified in his/her Person Centered Plan.

If the PSR provider organization also provides Supported Employment or Transitional Employment, these services are to be costed and reported separately.

Only the time during which the participant receives PSR services may be billed to Medicaid.

Utilization Management

Authorization by the statewide vendor is required. The amount, duration, and frequency of services must be included in an individual's Person Centered Plan, and authorized on or before the day services are to be provided. Initial authorization for services would not exceed a six (6) month period. Utilization review must be conducted every 6 months and be so documented in the service record.

If it is a Medicaid covered service, utilization management will be done by the statewide vendor. If it is a non-covered Medicaid service or non-Medicaid client, then the utilization review will be done by the LME.

Entrance Criteria:

The recipient is eligible for this service when:

A. There is an Axis I or II diagnosis present,

AND

B. Level of Care Criteria

AND

C. The recipient has impaired role functioning that adversely affects at least two of the following:

1. employment,
2. management of financial affairs,
3. ability to procure needed public support services,
4. appropriateness of social behavior, or
5. activities of daily living.

**Division of Medical Assistance
Enhanced Mental Health
and Substance Abuse Services**

**Clinical Coverage Policy No.: 8A
Original Effective Date: July 1, 1989
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Effective March 1, 2008**

AND

- D. The recipient's level of functioning may indicate a need for psychosocial rehabilitation if the recipient has unmet needs related to recovery and regaining the skills and experience needed to maintain personal care, meal preparation, housing, or to access social, vocational and recreational opportunities in the community.

Continued Stay Criteria

The desired outcome or level of functioning has not been restored, improved, or sustained over the time frame outlined in the recipient's person centered plan or the recipient continues to be at risk for relapse based on history or the tenuous nature of the functional gains or any one of the following apply:

- A. Recipient has achieved initial rehabilitation goals in the person centered plan goals and continued services are needed in order to achieve additional goals.
- B. Recipient is making satisfactory progress toward meeting rehabilitation goals.
- C. Recipient is making some progress, but the specific interventions need to be modified so that greater gains, which are consistent with the recipient's rehabilitation goals are possible or can be achieved.
- D. Recipient is not making progress; the rehabilitation goals must be modified to identify more effective interventions.
- E. Recipient is regressing; the person centered plan must be modified to identify more effective interventions.

Discharge Criteria

Recipient's level of functioning has improved with respect to the rehabilitation goals outlined in the person centered plan, inclusive of a transition plan to step down, or no longer benefits, or has the ability to function at this level of care and any of the following apply:

- A. Recipient has achieved rehabilitation goals, discharge to a lower level of care is indicated.
- B. Recipient is not making progress, or is regressing and all realistic treatment options with this modality have been exhausted.
- C. Recipient requires a more intensive level of care or service.

Note: Any denial, reduction, suspension, or termination of service requires notification to the recipient and/or legal guardian about their appeal rights.

Expected Outcomes

This service includes interventions that address the functional problems associated with complex and/or complicated conditions related to mental illness. These interventions are strength-based and focused on promoting recovery, symptom stability, increased coping skills and achievement of the highest level of functioning in the community. The focus of interventions is the individualized goals related to addressing the recipient's daily living, financial management and personal development; developing strategies and supportive interventions that will maintain stability; assisting recipients to increase social support skills that ameliorate life stresses resulting from the recipient's mental illness.

Documentation Requirements

Minimum standard is a full daily service note that includes the recipient's name, Medicaid identification number, date of service, purpose of contact, describes the provider's intervention, the time spent performing the intervention, the effectiveness of interventions and the signature of the staff providing the service.

Service Exclusions

PSR cannot be provided during the same authorization period with the following services: Partial hospitalization and ACTT.

Note: For recipients under the age of 21, additional products, services, or procedures may be requested even if they do not appear in the N.C. State Plan or when coverage is limited to those over 21 years of age. Service limitations on scope, amount, or frequency described in the coverage policy may not apply if the product, service, or procedure is medically necessary.

Child and Adolescent Day Treatment (MH/SA)

Medicaid Billable Service

Service Definition and Required Components

Day Treatment includes a structured treatment service program that builds on the strengths and addresses the identified functional problems associated with the complex conditions of each individual child or adolescent and family. These interventions are designed to support symptom reduction and/or sustain symptom stability at lowest possible levels, increase the individual's ability to cope and relate to others, support and sustain recovery, and enhance the child's capacity to function in an inclusive setting or to be maintained in community based services. It is available for children 3 to 17 years of age (20 or younger for those who are eligible for Medicaid).

Day Treatment provides mental health and/or substance abuse interventions in the context of a treatment milieu. This service should be focused on achieving functional gains, be developmentally appropriate, culturally relevant and sensitive, child and family centered and focus on reintegrating the individual back into the school or transitioning into employment. The outcomes and therapeutic or rehabilitation goals of this service are defined in individual treatment goals outlined in the PCP/Child and Family Plan. The Child and Family Team, are those persons relevant to the child's successful achievement of service goals including, but not limited to, family members, mentors, school personnel and members of the community who may provide support, structure, and services for the child.

Intensive services are designed to reduce symptoms and improve functional skills. Functional skills shall include, but are not limited to:

- Functioning in a mainstream educational setting;
- Maintaining residence with a family or community based non-institutional setting (foster home, therapeutic home, residential treatment, etc.); and
- Maintaining appropriate role functioning in community settings.

In addition to traditional therapeutic interventions, day treatment may also include time spent off site in places that are related to achieving service goals including, but not limited to, normalizing community activities, such as visiting a local place of business to file an application for part time employment. For younger children, relationship and play-based therapies should be delivered in a natural setting.

Best practices include a supportive, therapeutic relationship between the providers and consumer and family/caregiver that addresses and/or implements specific interventions outlined in the PCP/Child and Family Plan. These shall include, but are not limited to, any of the following:

- Behavioral/symptom interventions/management,
- Social and other therapeutically relevant skill development,
- Adaptive skill training,
- Enhancement of communication and problem-solving skills,
- Anger management,
- Family support, including training of family/caregivers and others who have a legitimate role in addressing the needs identified in the Person Centered Plan
- Monitoring of psychiatric symptoms and self management of symptoms/behaviors,
- Relapse prevention and disease management strategies, and
- Related positive behavior support activities and reinforcements.

In addition, Day Treatment provides case management services including, but not limited to, the following:

- Assessing the child's needs for comprehensive services
- Linking the child and/or family to needed services and supports
- Monitoring the provision of services and supports
- Assessing the outcomes of services and supports
- Convening Child and Family Team meetings to coordinate the provision of multiple services and ensure appropriate modification of the PCP over time.

Children and adolescents may be residents of their own home or a substitute home. However, the day treatment shall be provided in a setting separate from the consumer's residence.

A service order for child and adolescent Day Treatment must be completed by a physician, licensed psychologist, physician's assistant or nurse practitioner according to their scope of practice prior to or on the day that the services are to be provided.

Provider Requirements

Day Treatment shall be delivered by a provider organization that meet the provider qualification policies, procedures and standards established by DMH and the requirements of 10A NCAC 27G. These policies and procedures set forth the administrative, financial, clinical, quality improvement and information services infrastructure necessary to provide services. Provider organizations shall demonstrate that they meet these standards by being endorsed by the LME. Within three years of enrollment as a provider, the organization must have achieved national accreditation. The provider organization shall be established as a legally recognized entity in the United States and qualified/registered to do business in the State of North Carolina.

Staffing Requirements

A program director who meets the requirements specified for a QP and has a minimum of two years experience in child and adolescent mental health/substance abuse treatment services must be present in developing and implementing services. Minimum ratio of one QP staff to every six consumers is required to be present. The minimum staff to consumer ratio shall be present with the consumers at all times and staffing configuration must be adequate to anticipate and meet consumer needs. Psychiatric consultation shall be available for each consumer.

Day Treatment includes professional services on an individual and group basis in a structured community based setting. Persons who meet the requirements specified for QP or AP status according to 10A NCAC 27G.0104 may deliver Day Treatment. Supervision is provided according to supervision requirements specified in 10A NCAC 27G.0203 and according to licensure requirements of the appropriate discipline. Paraprofessional level providers who meet the requirements specified for Paraprofessional status and who have the knowledge, skills and abilities required by the population and age to be served may deliver Day Treatment within the requirements of the staff definition specific in the above role. When a Paraprofessional provides Day Treatment services, a QP or AP is responsible for overseeing the development of the recipient's Person Centered Plan/Child and Family Plan. When Paraprofessionals provide Day Treatment services, they shall be under the supervision of a QP or AP. Supervision of Paraprofessionals is to be carried out according to 10A NCAC 27G.0204.

For programs providing services to children with primary substance abuse or dependence diagnoses: Persons who meet the requirements specified for CCS, CCAS, and CSAC under Article 5C may deliver Day Treatment services. Services may also be provided by staff who meet the requirements specified for QP or AP status according to 10A NCAC 27G.0104, under the supervision of a CCAS or CCS. Paraprofessional level providers who meet the requirements for Paraprofessional status according to 10A NCAC 27G and who have the knowledge, skills and abilities required by the population and age to be served may deliver Day Treatment services, under the supervision of a CCAS or CCS.

Service Type/Setting

This is a day/night service that shall be available a minimum of three hours a day during all days of operation. Must be in operation a minimum of two days per week.

This is a facility based service and is provided in a licensed and structured program setting appropriate for the developmental age of children and adolescents. At least 50% of the treatment services shall be provided in the on-site licensed setting.

Utilization Management

In order for day treatment service to be reimbursable, all of the following shall apply:

1. The child shall meet clinical necessity criteria for Day Treatment services as outlined below.
2. The service shall be reflected in the child's Person Centered Plan.

Authorization by the statewide vendor. Utilization review shall be conducted 30 days after the first date of service or on the first business day thereafter. Subsequently, utilization review shall be provided a minimum of 30 days or more frequently as needed. All utilization review activity shall be documented in the Provider's Service Plan.

If it is a Medicaid covered service, utilization management will be done by the statewide vendor. If it is a non-covered Medicaid service or non-Medicaid client, then the utilization review will be done by the LME.

Entrance Criteria

- A. Shall have an Axis I or II diagnosis based on DSM IV-TR criteria.

AND

- B. The client's treatment needs meets Level of Care criteria.

AND

- C. The client is experiencing symptoms/behaviors related to his/her diagnosis that severely impair functional ability in academic, social, vocational, community, or family domains.

AND

- D. Any one of the following shall apply:

1. The child is living in a family setting and is at risk of being removed from that setting for reasons related to items 1-3, immediately above.

OR

2. The child is at risk of or has already experienced significant preschool/school disruption (multiple suspensions, long term suspensions, expulsion, impaired or destructive peer relationships, etc.) for reasons related to items 1 through 3 above.

AND

E. Any of the following apply:

1. Client requires a Day Treatment to acquire any of the following: improved coping skills and strategies, disability management strategies, or strategies for managing behaviors associated with functional impairments.

OR

2. The child is 3 to 5 years of age with atypical social and emotional development and manifest behaviors of a diagnosable mental disorder without therapeutic intervention.

Continued Stay Criteria

Any one of the following apply:

- A. Recipient has achieved initial PCP/Child and Family Plan goals and additional goals are indicated.
- B. Recipient is making satisfactory progress toward meeting goals but goals have not yet been fully met.
- C. Recipient is making some progress, but the PCP/Child and Family Plan (specific interventions) need to be modified so that greater gains can be achieved.
- D. Recipient is not making progress; the PCP/Child and Family Plan must be modified to identify more effective interventions.
- E. Recipient is regressing; the PCP/Child and Family Plan must be modified to identify more effective interventions.

AND

Utilization review shall be conducted 30 days after the first date of service or on the first business day thereafter. Subsequently, utilization review shall be provided every 30 days thereafter or more frequently as needed. All utilization review activity shall be documented in the provider's service plan.

Discharge Criteria

Any of the following apply:

- A. Consumer has achieved goals, discharge and transition plan to a lower level of care is indicated.
- B. Consumer is not making progress, or is regressing and all realistic treatment options with this modality have been exhausted indicating a need for more intensive services.
- C. Consumer and family determine this service is no longer needed in consultation with a QP.

Note: Any denial, reduction, suspension, or termination of service requires notification to the consumer and/or legal guardian about their appeal rights.

Expected Outcomes

- Child is able to remain in their home.
- Child is making satisfactory school progress and with interactions with staff and peers.
- Child will acquire behavioral/coping skills/symptom and behavior management needed to enhance functioning and resiliency.

- Child will acquire strategies to minimize the ongoing impact of mental health or substance related disabilities on their level of functioning and quality of life.
- Child will be reintegrated into school settings or transition into employment.

Documentation Requirements

Minimum documentation is a daily service note that includes the recipient's name, Medicaid identification number, date of service, purpose of contact, describes the provider's intervention, the time spent performing the intervention, the effectiveness of interventions and the signature of the staff providing the service.

The PCP shall include a Crisis Plan and a Transition Plan. The service record shall reflect outcomes sustained and progress toward implementing the Transition Plan. These shall be noted, minimally, at Utilization Review intervals and/or service team meetings. Transition planning should be coordinated through the Child and Family Team and with the local system of care (as necessary) including the local education agency, other involved individuals and community providers such as social services, juvenile justice and vocational rehabilitation.

Service Exclusions

Day Treatment can only be provided by one Day Treatment provider at a time.

- Educational skills that are usually taught in primary or secondary school settings; e.g., reading, math, writing, etc. are not reimbursable. Such skills and educational advancement should be coordinated with and provided by the local education agency.
- This service may not be provided in the consumer's place of residence.
- This service is only to be provided in a community based setting.
- This service may not be provided during the same authorization period with the following services: Residential treatment, psychiatric residential treatment facility (PRTF), inpatient hospital setting, Substance Abuse Intensive Out-patient Services, SA residential facilities, Multisystemic Therapy, Community Support (except as noted below), or Intensive In-Home Services.
- Community support services can be billed for a maximum of 8 units per month in accordance with the person centered plan for the individuals who are receiving day treatment services for the purpose of facilitating transition to the service, admission to the service, meeting with the person as soon as possible upon admission, providing coordination during the provision of service, ensuring that the service provider works directly with the CS professional and discharge planning.

Note: For recipients under the age of 21, additional products, services, or procedures may be requested even if they do not appear in the N.C. State Plan or when coverage is limited to those over 21 years of age. Service limitations on scope, amount, or frequency described in the coverage policy may not apply if the product, service, or procedure is medically necessary.

Partial Hospitalization

Partial Hospitalization is a short-term service for acutely mentally ill children or adults, which provides a broad range of intensive therapeutic approaches which may include: group activities/therapy, individual therapy, recreational therapy, community living skills/training, increases the individual's ability to relate to others and to function appropriately, coping skills, medical services. This service is designed to prevent hospitalization or to serve as an interim step for those leaving an inpatient facility. A physician shall participate in diagnosis, treatment planning, and admission/discharge decisions. Physician involvement shall be one factor that distinguishes Partial Hospitalization from Day Treatment Services.

Therapeutic Relationship and Interventions

This service is designed to offer face-to-face therapeutic interventions to provide support and guidance in preventing, overcoming, or managing identified needs on the service plan to aid with improving the client's level of functioning in all domains, increasing coping abilities or skills, or sustaining the achieved level of functioning.

Structure of Daily Living

This service offers a variety of structured therapeutic activities including medication monitoring designed to support a client remaining in the community that are provided under the direction of a physician, although the program does not have to be hospital based. Other identified providers shall carry out the identified individual or group interventions (under the direction of the physician). This service offers support and structure to assist the individual client with coping and functioning on a day-to-day basis to prevent hospitalization or to step down into a lower level of care from inpatient setting.

Cognitive and Behavioral Skill Acquisition

This service includes interventions that address functional deficits associated with affective or cognitive problems and/or the client's diagnostic conditions. This may include training in community living, and specific coping skills, and medication management. This assistance allows clients to develop their strengths and establish peer and community relationships.

Service Type

This is day/night service that shall be provided a minimum of (4) four hours per day, (5) five days per week, and (12) twelve months per year. Service standards and licensure requirements are outlined in 10A NCAC 27G.1100. If it is a Medicaid covered service, utilization management will be done by the statewide vendor. If it is a non-covered Medicaid service or non-Medicaid client, then the utilization review will be done by the LME.

Resiliency/Environmental Intervention

This service assists the client in transitioning from one service to another (an inpatient setting to a community-based service) or preventing hospitalization. This service provides a broad array of intensive approaches, which may include group and individual activities.

Service Delivery Setting

This service is provided in a licensed facility that offers a structured, therapeutic program under the direction of a physician that may or may not be hospital based.

Utilization Management

Authorization by the statewide vendor is required. The amount, duration, and frequency of the service must be included in a recipient's Person-Centered Plan. Initial authorization for services may not exceed thirty (30) days. Reauthorization will occur within a minimum of sixty (60) days thereafter and is so documented in the Person Centered Plan and service record.

If it is a Medicaid covered service, utilization management will be done by the statewide vendor. If it is a non-covered Medicaid service or non-Medicaid client, then the utilization review will be done by the LME.

Medical Necessity

Must have Axis I or II diagnosis

AND

Level of Care Criteria, Level C/NCSNAP

AND

The consumer is experiencing difficulties in at least one of the following areas:

- A. Functional impairment, crisis intervention/diversion/aftercare needs, and/or at risk for placement outside the natural home setting,

AND

- B. The consumer's level of functioning has not been restored or improved and may indicate a need for clinical interventions in a natural setting if any on of the following apply:
1. Being unable to remain in family or community setting due to symptoms associated with diagnosis, therefore being at risk for out of home placement, hospitalizations, and/or institutionalization.
 2. Presenting with intensive, verbal and limited physical aggression due to symptoms associated with diagnosis, which are sufficient to create functional problems in a community setting.
 3. Being at risk of exclusion from services, placement or significant community support system as a result of functional behavioral problems associated with diagnosis.
 4. Requires a structured setting to monitor mental stability and symptomology, and foster successful integration into the community through individualized interventions and activities.
 5. Service is a part of an aftercare planning process (time limited or transitioning) and is required to avoid returning to a higher, or more restrictive level of service.

Service Order Requirement

A Physician, PhD, Psychiatric Nurse Practitioners, Psychiatric Clinical Nurse Specialist within their scope of practice can order this service. The service must be ordered prior to or on the day the service is initiated.

Continuation/Utilization Review Criteria

The desired outcome or level of functioning has not been restored, improved, or sustained over the time frame outlined in the consumer's service plan or the consumer continues to be at risk for relapse based on history or the tenuous nature of the functional gains or any one of the following apply:

- A. Consumer has achieved initial service plan goals and additional goals are indicated,
- B. Consumer is making satisfactory progress toward meeting goals.
- C. Consumer is making some progress, but the service plan (specific interventions) need to be modified so that greater gains which are consistent with the consumer's premorbid level of functioning are possible or can be achieved.
- D. Consumer is not making progress; the service plan must be modified to identify more effective interventions.
- E. Consumer is regressing; the service plan must be modified to identify more effective interventions.

Discharge Criteria

Consumer's level of functioning has improved with respect to the goals outlined in the service plan, inclusive of a transition plan to step down, or no longer benefits, or has the ability to function at this level of care and any of the following apply:

- A. Consumer has achieved goals, discharged to a lower level of care is indicated.
- B. Consumer is not making progress, or is regressing and all realistic treatment options with this modality have been exhausted.

***Note:** Any denial, reduction, suspension or termination of service requires notification to the recipient and/or legal guardian about their appeal rights.

Service Maintenance Criteria

If the consumer is functioning effectively with this service and discharge would otherwise be indicated, PH should be maintained when it can be reasonably anticipated that regression is likely to occur if the service is withdrawn. The decision should be based on any one of the following:

- A. Past history of regression in the absence of PH is documented in the consumer record,

OR

- B. The presence of a DSM-IV diagnosis that would necessitate a disability management approach. In the event, there is epidemiological sound expectations that symptoms will persist and that on Going treatment interventions are needed to sustain functional gains.

***Note:** Any denial, reduction, suspension or termination of service requires notification to the recipient and/or legal guardian about their appeal rights.

Provider Requirement and Supervision

All services in the partial hospital are provided by a team, which may have the following configuration: social workers, psychologists, therapists, case managers, or other MH/SA paraprofessional staff. The partial hospital milieu is directed under the supervision of a physician. Staffing requirements are outlined in 10A NCAC 27G .1102.

Documentation Requirements

Minimum documentation is a weekly service note that includes the purpose of contact, describes the provider's interventions, and the effectiveness of the interventions.

Note: For recipients under the age of 21, additional products, services, or procedures may be requested even if they do not appear in the N.C. State Plan or when coverage is limited to those over 21 years of age. Service limitations on scope, amount, or frequency described in the coverage policy may not apply if the product, service, or procedure is medically necessary.

Professional Treatment Services in Facility-Based Crisis Program

This service provides an alternative to hospitalization for adults who have a mental illness or substance abuse disorder. This is a 24-hour residential facility with 16 beds or less that provides support and crisis services in a community setting. This can be provided in a non-hospital setting for recipients in crisis who need short-term intensive evaluation, treatment intervention or behavioral management to stabilize acute or crisis situations.

Therapeutic Relationship and Interventions

This service offers therapeutic interventions designed to support a recipient remaining in the community and alleviate acute or crisis situations that are provided under the direction of a physician, although the program does not have to be hospital based. Interventions are implemented by other staff under the direction of the physician. These supportive interventions assist the recipient with coping and functioning on a day-to-day basis to prevent hospitalization.

Structure of Daily Living

This service is an intensified short-term, medically supervised service that is provided in certain 24-hour service sites. The objectives of the service include assessment and evaluation of the condition(s) that have resulted in acute psychiatric symptoms, disruptive or dangerous behaviors, or intoxication from alcohol or drugs; to implement intensive treatment, behavioral management interventions, or detoxification protocols; to stabilize the immediate problems that have resulted in the need for crisis intervention or detoxification; to ensure the safety of the individual by closely monitoring his/her medical condition and response to the treatment protocol; and to arrange for linkage to services that will provide further treatment and/or rehabilitation upon discharge from the Facility Based Crisis Service.

Cognitive and Behavioral Skill Acquisition

This service is designed to provide support and treatment in preventing, overcoming, or managing the identified crisis or acute situations on the service plan to assist with improving the recipient's level of functioning in all documented domains, increasing coping abilities or skills, or sustaining the achieved level of functioning.

Service Type

This is a 24-hour service that is offered seven (7) days a week.

Resiliency/Environmental Intervention

This service assists the recipient with remaining in the community and receiving treatment interventions at an intensive level without the structure of an inpatient setting. This structured program assesses, monitors, and stabilizes acute symptoms twenty-four (24) hours a day.

Service Delivery Setting

This service can be provided in a licensed facility that meets 10A NCAC 27G.5000 licensure standards.

Medical Necessity

The recipient is eligible for this service when:

- A. There is an Axis I or II diagnosis present or the person has a condition that may be defined as a developmental disability as defined in GS 122C-3 (12a)

AND

- B. Level of Care Criteria, Level D/NC-SNAP (NC Supports/Needs Assessment Profile)/ASAM (American Society of Addiction Medicine)

AND

- C. The recipient is experiencing difficulties in at least one of the following areas:
1. functional impairment,
 2. crisis intervention/diversion/after-care needs, and/or
 3. at risk for placement outside of the natural home setting.

AND

- D. The recipient's level of functioning has not been restored or improved and may indicate a need for clinical interventions in a natural setting if any one of the following apply:
1. Unable to remain in family or community setting due to symptoms associated with diagnosis, therefore being at risk for out of home placement, hospitalization, and/or institutionalization.
 2. Intensive, verbal and limited physical aggression due to symptoms associated with diagnosis, which are sufficient to create functional problems in a community setting.
 3. At risk of exclusion from services, placement or significant community support systems as a result of functional behavioral problems associated with diagnosis.

Service Order Requirement

Service must be ordered by a primary care physician, psychiatrist or a licensed psychologist. All service orders must be made prior to or on the day service is initiated.

Continuation/Utilization Review

The desired outcome or level of functioning has not been restored, improved or sustained over the time frame outlined in the recipient's service plan or the recipient continues to be at risk for relapse based on history or the tenuous nature of the functional gains or any one of the following apply:

- A. Recipient has achieved initial service plan goals and additional goals are indicated.
- B. Recipient is making satisfactory progress toward meeting goals.
- C. Recipient is making some progress, but the service plan (specific interventions) need to be modified so that greater gains, which are consistent with the recipient's premorbid level of functioning, are possible or can be achieved.
- D. Recipient is not making progress; the service plan must be modified to identify more effective interventions.
- E. Recipient is regressing; the service plan must be modified to identify more effective interventions.

AND

Utilization review by the statewide vendor must be conducted after the first 16 hours and is so documented in the service record. This is a short-term service that cannot be provided for more than 30 days in a 12-month period.

Discharge Criteria

Recipient's level of functioning has improved with respect to the goals outlined in the service plan, inclusive of a transition plan to step-down or no longer benefits or has the ability to function at this level of care and any of the following apply:

- A. Recipient has achieved goals, discharge to a lower level of care is indicated.
- B. Recipient is not making progress or is regressing and all realistic treatment options with this modality have been exhausted.

Note: Any denial, reduction, suspension or termination of service requires notification to the recipient and/or legal guardian about their appeal rights.

Service Maintenance Criteria

If the recipient is functioning effectively with this service and discharge would otherwise be indicated, Facility-based crisis service should be maintained when it can be reasonably anticipated that regression is likely to occur if the service is withdrawn. The decision should be based on any one of the following:

- A. Past history of regression in the absence of facility based crisis service is documented in the service record

OR

- B. In the event there are epidemiologically sound expectations that symptoms will persist and that ongoing treatment interventions are needed to sustain functional gains, the nature of the recipient's DSM-IV diagnosis necessitates a disability management approach.

Note: Any denial, reduction, suspension or termination of service requires notification to the recipient and/or legal guardian about their appeal rights.

Provider Requirement and Supervision

This is a 24-hour service that is offered seven days a week, with a staff to recipient ratio that ensures the health and safety of clients served in the community and compliance with 10NCAC 14R.0104 Seclusion, Restraint and Isolation Time Out. At no time will staff to recipient ratio be less than 1:6 for adult mental health recipients and 1:9 for adult substance abuse recipients.

Documentation Requirements

Minimum documentation is a daily service note per shift.

SUBSTANCE ABUSE SERVICES

Medicaid Billable Service

Diagnostic Assessment

See Diagnostic/Assessment (MH/DD/SA) service.

Mobile Crisis Management

See Mobile Crisis Management (MH/DD/SA) service.

Community Support – Adult

See Community Support – Adult (MH/SA).

Community Support – Child/Adolescents

See Community Support – Child/Adolescents (MH/SA).

Community Support Team – Adult

See Community Support Team —Adult (MH/SA).

Substance Abuse Intensive Outpatient Program Medicaid Billable Service

Level II.1 Intensive Outpatient Services ASAM Patient Placement Criteria

Service Definition and Required Components

SA Intensive Outpatient Program (SAIOP) means structured individual and group addiction activities and services that are provided at an outpatient program designed to assist adult and adolescent consumers to begin recovery and learn skills for recovery maintenance. The program is offered at least three (3) hours per day at least three (3) days per week with no more than two consecutive days between offered services, and distinguishes between those individuals needing no more than 19 hours per week of structured services per week (ASAM Level II.1). The recipient must be in attendance for a minimum of three (3) hours per day in order to bill this service. SAIOP services shall include a structured program consisting of, but not limited to, the following services:

1. Individual counseling and support;
2. Group counseling and support;
3. Family counseling, training or support;
4. Biochemical assays to identify recent drug use (e.g. urine drug screens);
5. Strategies for relapse prevention to include community and social support systems in treatment;
6. Life skills;
7. Crisis contingency planning;
8. Disease Management; and
9. Treatment support activities that have been adapted or specifically designed for persons with physical disabilities, or persons with co-occurring disorders of mental illness and substance abuse/dependence or mental retardation/developmental disability and substance abuse/dependence.

SAIOP can be designed for homogenous groups of recipients e.g., pregnant women, and women and their children; individuals with co-occurring MH/SA disorders; individuals with HIV; or individuals with similar cognitive levels of functioning. Group counseling shall be provided each day SAIOP services are offered. SAIOP includes case management to arrange, link or integrate multiple services as well as assessment and reassessment of the recipient's need for services. SAIOP services also informs the recipient about benefits, community resources, and services; assists the recipient in accessing benefits and services; arranges for the recipient to receive benefits and services; and monitors the provision of services. Consumers may be residents of their own home, a substitute home, or a group care setting; however, the SAIOP must be provided in a setting separate from the consumer's residence. The program is provided over a period of several weeks or months.

A service order for SAIOP must be completed by a physician, licensed psychologist, physician's assistant or nurse practitioner according to their scope of practice prior to or on the day that the services are to be provided.

Provider Requirements

SAIOP must be delivered by practitioners employed by a substance abuse provider organization that meet the provider qualification policies, procedures, and standards established by DMH and the requirements

of 10A NCAC 27G These policies and procedures set forth the administrative, financial, clinical, quality improvement, and information services infrastructure necessary to provide services. Provider organizations must demonstrate that they meet these standards by being endorsed by LME. Within three years of enrollment as a provider, the organization must have achieved national accreditation. The organization must be established as a legally recognized entity in the United States and qualified/registered to do business as a corporate entity in the State of North Carolina.

Organizations that provide SAIOP must provide “first responder” crisis response on a 24/1/365 basis to recipients who are receiving this service

Staffing Requirements

Persons who meet the requirements specified for CCS, CCAS, and CSAC under Article 5C may deliver SAIOP. The program must be under the clinical supervision of a CCS or a CCAS who is on site a minimum of 50% of the hours the service is in operation. Services may also be provided by staff who meet the requirements specified for QP or AP status for Substance Abuse according to 10A NCAC, under the supervision of a CCAS or CCS. The maximum face-to-face staff-to-client ratio is not more than 12 adult consumers to 1 QP based on an average daily attendance. The ratio for adolescents will be 1:6. Paraprofessional level providers who meet the requirements for Paraprofessional status according to 10A NCAC 27G and who have the knowledge, skills, and abilities required for the population and age to be services may deliver SAIOP, under the supervision of a CCAS or CCS. Paraprofessional level providers may not provide services in lieu of on-site service provision by a qualified professional, CCAS, CCS, or CSAC.

Service Type/Setting

Facility licensed under 10A NCAC 27G.3700.

Program Requirements

See Service Definition and Required Components.

Utilization Management

Authorization by the statewide vendor is required. The amount, duration, and frequency of SAIOP Service must be included in an individual’s authorized Person Centered Plan. Services may not be delivered less frequently than the structured program set forth in the service description above. Initial authorization for services will not exceed a duration of 12 weeks. Under exceptional circumstances, one additional reauthorization up to 2 weeks can be approved. This service is billed with a minimum of three (3) hours per day as an event.

Entrance Criteria

The recipient is eligible for this service when:

A. There is an Axis I substance abuse disorder present;

AND

B. Level of Care Criteria, level II.1 NC Modified A/ASAM

Continued Stay Criteria

The desired outcome or level of functioning has not been restored, improved, or sustained over the time frame outlined in the recipient's Person Centered Plan or the recipient continues to be at risk for relapse based on history or the tenuous nature of the functional gains or any one of the following apply:

- A. Recipient has achieved positive life outcomes that support stable and ongoing recovery, and additional goals are indicated.
- B. Recipient is making satisfactory progress toward meeting goals.
- C. Recipient is making some progress, but the Person Centered Plan (specific interventions) needs to be modified so that greater gains, which are consistent with the recipient's premorbid level of functioning, are possible or can be achieved.
- D. Recipient is not making progress; the Person Centered Plan must be modified to identify more effective interventions
- E. Recipient is regressing; the Person Centered Plan must be modified to identify more effective interventions.

Expected Outcomes

The expected outcome of SAIOP is abstinence. Secondary outcomes (i.e., in *abstinent* patients) include: sustained improvement in health and psychosocial functioning, reduction in any psychiatric symptoms (if present), reduction in public health and/or safety concerns, and a reduction in the risk of relapse as evidenced by improvement in empirically supported modifiable relapse risk factors.

Documentation Requirements

Minimum standard is a daily full service note for each day of SAIOP that includes the recipient's name, Medicaid identification number, date of service, purpose of contact, describes the provider's interventions, the time spent performing the intervention, the effectiveness of interventions, and the signature and credentials of the staff providing the service. A documented discharge plan will be discussed with the recipient and included in the record.

Discharge Criteria

Recipient's level of functioning has improved with respect to the goals outlined in the Person Centered Plan, inclusive of a transition plan to step down, or no longer benefits, or has the ability to function at this level of care and any of the following apply:

- 1. Recipient has achieved positive life outcomes that support stable and ongoing recovery.
- 2. Recipient is not making progress, or is regressing and all realistic treatment options have been exhausted indicating a need for more intensive services.
- 3. Recipient no longer wishes to receive SAIOP services.

Service Exclusions/Limitations

SAIOP cannot be billed during the same authorization as SA Comprehensive Outpatient Treatment, all detoxification services levels, Non-Medical Community Residential Treatment or Medically Monitored Community Residential Treatment.

Service Limitations: Community support services can be billed for a maximum of 8 units per month in accordance with the person centered plan for individuals who are receiving SAIOP services for the purpose of facilitating transition to the service, admission to the service, meeting with the person as soon

as possible upon admission, providing coordination during the provision of service, ensuring that the service provider works directly with the CS professional and discharge planning.

Note: For recipients under the age of 21, additional products, services, or procedures may be requested even if they do not appear in the N.C. State Plan or when coverage is limited to those over 21 years of age. Service limitations on scope, amount, or frequency described in the coverage policy may not apply if the product, service, or procedure is medically necessary.

Substance Abuse Comprehensive Outpatient Treatment Program Medicaid Billable Service

Level II.5 Partial Hospitalization ASAM Patient Placement Criteria

Service Definition and Required Components

SA Comprehensive Outpatient Treatment (SACOT) Program means a periodic service that is a time-limited, multi-faceted approach treatment service for adults who require structure and support to achieve and sustain recovery. SACOT Program is a service emphasizing reduction in use and abuse of substances and/or continued abstinence, the negative consequences of substance abuse, development of social support network and necessary lifestyle changes, educational skills, vocational skills leading to work activity by reducing substance abuse as a barrier to employment, social and interpersonal skills, improved family functioning, the understanding of addictive disease, and the continued commitment to a recovery and maintenance program. These services are provided during day and evening hours to enable individuals to maintain residence in their community, continue to work or go to school, and to be a part of their family life. The following types of services are included in the SACOT Program:

1. Individual counseling and support;
2. Group counseling and support;
3. Family counseling, training or support;
4. Biochemical assays to identify recent drug use (e.g., urine drug screens);
5. Strategies for relapse prevention to include community and social support systems in treatment;
6. Life skills;
7. Crisis contingency planning;
8. Disease management; and
9. Treatment support activities that have been adapted or specifically designed for persons with physical disabilities or persons with co-occurring disorders of mental illness and substance abuse/dependence or mental retardation/developmental disability and substance abuse/dependence.

SACOT programs can be designed for homogenous groups of recipients e.g., individuals being detoxed on an outpatient basis; individuals with chronic relapse issues; pregnant women, and women and their children; individuals with co-occurring MH/SA disorders; individuals with HIV; or individuals with similar cognitive levels of functioning. SACOT includes case management to arrange, link or integrate multiple services as well as assessment and reassessment of the recipient's need for services. SACOT services also inform the recipient about benefits, community resources, and services; assists the recipient in accessing benefits and services; arranges for the recipient to receive benefits and services; and monitors the provision of services. Consumers may be residents of their own home, a substitute home, or a group care setting; however, the SACOT Program must be provided in a setting separate from the consumer's residence.

A service order for SACOT must be completed prior to or on the day that the services are to be provided by a physician, licensed psychologist, physician's assistant or nurse practitioner according to their scope of practice.

This service must operate at least 20 hours per week and offer a minimum of 4 hours of scheduled services per day, with availability at least 5 days per week with no more than 2 consecutive days without services available. The recipient must be in attendance for a minimum of four (4) hours per day in order to this for this service. Group counseling services must be offered each day the program operates. Services must be available during both day and evening hours. A SACOT Program may have variable lengths of stay and reduce each individual's frequency of attendance as recovery becomes established and the individual can resume more and more usual life obligations. The program conducts random drug screening and uses the results of these tests as part of a comprehensive assessment of participants' progress toward goals and for Person Centered Planning.

Provider Requirements

SACOT Program must be delivered by practitioners employed by a substance abuse provider organization that meet the provider qualification policies, procedures, and standards established by DMH and the requirements of 10A NCAC 27G. These policies and procedures set forth the administrative, financial, clinical, quality improvement, and information services infrastructure necessary to provide services. Provider organizations must demonstrate that they meet these standards by being endorsed by LME. Within three years of enrollment as a provider, the organization must have achieved national accreditation. The organization must be established as a legally recognized entity in the United States and qualified/registered to do business as a corporate entity in the State of North Carolina.

Organizations that provide SACOT must provide "first responder" crisis response on a 24/7/365 basis to recipients who are receiving this service.

Staffing Requirements

Persons who meet the requirements specified for CCS, CCAS, and CSAC under Article 5C may deliver SACOT Program. The program must be under the clinical supervision of a CCAS or CCS who is on site a minimum of 90% of the hours the service is in operation. Clinical services may also be provided by staff who meet the requirements specified for QP or AP status for Substance Abuse according to 10A NCAC 27G.0104, under the supervision of a CCS. The maximum face-to-face staff-to-client ratio is not more than 10 adult consumers to 1 QP based on an average daily attendance. Paraprofessional level providers who meet the requirements for Paraprofessional status according to 10A NCAC 27G.0104 and who have the knowledge, skills and abilities required by the population and age to be served may deliver SACOT Program, under the supervision of CCAS, CSAC or CCS. Paraprofessional level providers may not provide services in lieu of on-site service provision to recipients by a qualified CCS, CCAS or CSAC.

Consultation Services

Recipients must have ready access to psychiatric assessment and treatment services when warranted by the presence of symptoms indicating a co-occurring non-substance related Axis I or Axis II disorder (e.g. major depression, schizophrenia, borderline personality disorder). These services shall be delivered by a psychiatrists who meet requirements as specified in NCAC 27G.0104. The providers shall be familiar with the SACOT Program treatment plan for each recipient seen in consultation, shall have access to SACOT Program treatment records for the recipient, and shall be able to consult by phone or in person with the CCS, CCAS or CSAC providing SACOT Program services.

Service Type/Setting

Facility licensed in accordance with TBD.

Program Requirements

See Service Definition and Required Components.

Utilization Management

Authorization by the statewide vendor is required. The amount, duration, and frequency of the services must be included in an individual's authorized Person Centered Plan. Services may not be recommended to occur less frequently than the structured program's requirements set forth in the service description above. Utilization review will occur every 30 days. This service is billed with a minimum of four (4) hours per day billed in hourly increments

If it is a Medicaid covered service, utilization management will be done by the statewide vendor. If it is a non-covered Medicaid service or non-Medicaid client, then the utilization review will be done by the LME.

Entrance Criteria

The recipient is eligible for this service when:

- A. There is an Axis I diagnosis of a Substance Abuse disorder diagnosis.

AND

- B. Level of Care Criteria Level II.5 NC Modified A/ASAM

Continued Stay Criteria

The desired outcome or level of functioning has not been restored, improved, or sustained over the time frame outlined in the recipient's Person Centered Plan or the recipient continues to be at risk for relapse based on history or the tenuous nature of the functional gains or any one of the following apply:

1. Recipient has achieved initial Person Centered Plan goals and continued service at this level is needed to meet additional goals.
2. Recipient is making satisfactory progress toward meeting goals.
3. Recipient is making some progress, but the PCP (specific interventions) needs to be modified so that greater gains, which are consistent with the recipient's premorbid level of functioning, are possible or can be achieved.
4. Recipient is not making progress; the Person Centered Plan must be modified to identify more effective interventions.
5. Recipient is regressing; the Person Centered Plan must be modified to identify more effective interventions.

AND

Utilization review must be conducted every 30 days and is so documented in the Person Centered Plan and the service record.

Discharge Criteria

Recipient's level of functioning has improved with respect to the goals outlined in the Person Centered Plan, inclusive of a transition plan to step down, or no longer benefits, or has the ability to function at this level of care and any of the following apply:

1. Recipient has achieved positive life outcomes that support stable and ongoing recovery.
2. Recipient is not making progress, or is regressing and all realistic treatment options have been exhausted indicating a need for more intensive services.
3. Recipient/family no longer wishes to receive SACOT services.

Expected Outcomes

The expected outcome is abstinence. Secondary outcomes (i.e., in *abstinent* patients) include: sustained improvement in health and psychosocial functioning, reduction in any psychiatric symptoms (if present), reduction in public health and/or safety concerns, and a reduction in the risk of relapse as evidenced by improvement in empirically-supported modifiable relapse risk factors. For individuals with co-occurring MH/SA disorders, improved functioning is the expected outcome.

Documentation Requirements

Minimum standard is a daily full service note for each day of SACOT that includes the recipient's name, Medicaid identification number, date of service, purpose of contact, describes the provider's interventions, the time spent performing the intervention, the effectiveness of interventions, and the signature and credentials of the staff providing the service. A documented discharge plan will be discussed with the recipient and included in the record

Service Exclusions/Limitations

SACOT cannot be billed during the same authorization as SA Intensive Outpatient Program, all detoxification services levels (with the exception of Ambulatory Detoxification) or Non-Medical Community Residential Treatment or Medically Monitored Community Residential Treatment.

Service Limitation: Community Support services can be billed for a maximum of 8 units per month in accordance with the person centered plan for individuals who are receiving SACOT services for the purpose of facilitating transition to the service, admission to the service, meeting with the person as soon as possible upon admission, providing coordination during the provision of service, ensuring that the service provider works directly with the CS professional and discharge planning.

Note: For recipients under the age of 21, additional products, services, or procedures may be requested even if they do not appear in the N.C. State Plan or when coverage is limited to those over 21 years of age. Service limitations on scope, amount, or frequency described in the coverage policy may not apply if the product, service, or procedure is medically necessary.

Substance Abuse Non-Medical Community Residential Treatment Medicaid Billable Service

**(When Furnished in a Facility That Does Not Exceed 16 Beds and Is Not an Institution for
Mental Diseases for Adults)(Room and Board Are Not Included)**

Level III.5 Clinically Managed High-Intensity Residential Treatment

NC Modified ASAM Patient Placement Criteria

Service Definition and Required Components

Non-medical Community Residential Treatment is a 24-hour residential recovery program professionally supervised residential facility that provides trained staff who work intensively with adults with substance abuse disorders who provide or have the potential to provide primary care for their minor children. This is a rehabilitation facility, without twenty-four hour per day medical nursing/monitoring, where a planned program of professionally directed evaluation, care and treatment for the restoration of functioning for persons with an addiction disorder.

These programs shall include assessment/referral, individual and group therapy, family therapy, recovery skills training, disease management, symptom monitoring, monitoring medications and self management of symptoms, aftercare, follow-up and access to preventive and primary health care including psychiatric care. The facility may utilize services from another facility providing psychiatric or medical services. Services shall promote development of a social network supportive of recovery, enhance the understanding of addiction, promote successful involvement in regular productive activity (such as school or work), enhance personal responsibility and promote successful reintegration into community living. Services shall be designed to provide a safe and healthy environment for consumers and their children.

Program staff will arrange, link or integrate multiple services as well as assessment and reassessment of the recipient's need for services. Program staff will inform the recipient about benefits, community resources, and services; assist the recipient in accessing benefits and services; arrange for the recipient to receive benefits and services; and monitor the provision of services.

For programs providing services to individuals with their children in residence and/or pregnant women: Each adult shall also receive in accordance with their Person-Centered Plan: training in therapeutic parenting skills, basic independent living skills, child supervision, one-on-one interventions with the community to develop interpersonal and community coping skills, including adaptation to school and work environments and therapeutic mentoring. In addition, their children shall receive services in accordance with 10A NCAC 27G.4100.

A service order for NMCRT must be completed by a physician, licensed psychologist, physician's assistant or nurse practitioner according to their scope of practice prior to or on the day that the services are to be provided.

Provider Requirements

NMCRT must be delivered by practitioners employed by a substance abuse provider organization that meet the provider qualification policies, procedures, and standards established by DMH and the requirements of 10A NCAC 27G. These policies and procedures set forth the administrative, financial,

clinical, quality improvement, and information services infrastructure necessary to provide services. Provider organizations must demonstrate that they meet these standards by being endorsed by LME.

Within three years of enrollment as a provider, the organization must have achieved national accreditation. The organization must be established as a legally recognized entity in the United States and qualified/registered to do business as a corporate entity in the State of North Carolina.

Organizations that provide NMCRT must provide “first responder” crisis response on a 24/7/365 basis to recipients receiving this service.

Staffing Requirements

Persons who meet the requirements specified for CCS, CCAS, and CSAC under Article 5C may deliver NMCRT. Programs providing services to adolescents must have experience working with the population. The program must be under the clinical supervision of a CCAS or CCS who is on site a minimum of 8 hours per day when the service is in operation and available by phone 24 hours a day. Services may also be provided by staff who meet the requirements specified for QP or AP status for Substance Abuse according to 10A NCAC 27G.0104, under the supervision of a CCAS or CCS. Paraprofessional level providers who meet the requirements for Paraprofessional status according to 10A NCAC 27G.0104 and who have the knowledge, skills and abilities required by the population and age to be served may deliver NMCRT, under the supervision of a CCAS or CCS. Paraprofessional level providers may not provide services in lieu of on-site service provision by a qualified professional, CCS, CCAS or CSAC.

Service Type/Setting

Programs for pregnant women and/or individuals with children in residence shall be licensed under 10A NCAC 14V.4100 for residential recovery programs.

Program Requirements

See Service Definition and Required Components and 10A NCAC 27G.4100 for residential recovery programs.

See Service Definition and Required Components and 10A NCAC 27G.3400 for adolescent programs.

Utilization Management

Authorization by the statewide vendor. Service must be included in the individual’s Person Centered Plan. Initial authorization for parents with children program services must not exceed 30 days. Reauthorization for these programs will occur within a minimum of 90 days thereafter by the statewide vendor or LME.

If it is a Medicaid covered service, utilization management will be done by the statewide vendor. If it is a non-covered Medicaid service or non-Medicaid client, then the utilization review will be done by the LME.

Entrance Criteria

The recipient is eligible for this service when:

A. There is an Axis I diagnosis of a substance abuse disorder

AND

B. Level of Care Criteria Level III.5 NC Modified A/ASAM

Continued Stay Criteria

The desired outcome or level of functioning has not been restored, improved, or sustained over the time frame outlined in the recipient's Person Centered Plan or the recipient continues to be at risk for relapse based on history or the tenuous nature of the functional gains or any one of the following apply:

- Recipient has achieved initial person centered plan goals and requires this service in order to meet additional goals.
- Recipient is making satisfactory progress toward meeting goals.
- Recipient is making some progress, but the Person Centered Plan (specific interventions) needs to be modified so that greater gains, which are consistent with the recipient's pre-morbid level of functioning, are possible or can be achieved.
- Recipient is not making progress; the Person Centered Plan must be modified to identify more effective interventions.
- Recipient is regressing; the Person Centered Plan must be modified to identify more effective interventions.

AND

Utilization review must be conducted every 90 days (after the initial 30 day UR) for the parents with children programs and is so documented in the Person Centered Plan and the service record. Utilization review must be conducted every 30 days for the adolescent programs and is so documented in the Person Centered Plan and the service record.

Discharge Criteria

Recipient's level of functioning has improved with respect to the goals outlined in the Person Centered Plan, inclusive of a transition plan to step down, or no longer benefits, or has the ability to function at this level of care and any of the following apply:

1. Recipient has achieved positive life outcomes that supports stable and ongoing recovery (and parenting skills, if applicable).
2. Recipient is not making progress, or is regressing and all realistic treatment options have been exhausted indicating a need for more intensive services.
3. Recipient/family no longer wishes to receive NMCRT services.

Expected Outcomes

The expected outcome is abstinence. Secondary outcomes (i.e., in *abstinent* patients) include: sustained improvement in health and psychosocial functioning, reduction in any psychiatric symptoms (if present), reduction in public health and/or safety concerns, and a reduction in the risk of relapse as evidenced by improvement in-empirically-supported modifiable relapse risk factors. Additionally, for Residential Recovery Programs, improved parenting is an expected outcome.

Documentation Requirements

Minimum standard is a full daily note that includes the recipient's name, Medicaid identification number, date of service, purpose of contact, describes the provider's interventions, the time spent performing the intervention, the effectiveness of interventions, and the signature and credentials of the staff providing the service. Residential Recovery Programs for women and children shall also provide documentation of all

services provided to the children in the program. Goals for parent-child interaction shall be established and progress towards meeting these goals shall be documented in the parent's service record. A documented discharge plan discussed with the recipient is included in the record.

Service Exclusions/Limitations

Non-Medical Community Residential Treatment cannot be billed the same day as any other MH/SA services except group living moderate. This is a short-term service that can only be billed for 30 days in a 12 month period

Service Limitations: Community support services can be billed for a maximum of 8 units per month in accordance with the person centered plan for individuals who are receiving Non-Medical Community Residential Treatment Services for the purpose of facilitating transition to the service, admission to the service, meeting with the person as soon as possible upon admission, providing coordination during the provision of service, ensuring that the service provider works directly with the CS professional and discharge planning

Note: For recipients under the age of 21, additional products, services, or procedures may be requested even if they do not appear in the N.C. State Plan or when coverage is limited to those over 21 years of age. Service limitations on scope, amount, or frequency described in the coverage policy may not apply if the product, service, or procedure is medically necessary.

Substance Abuse Medically Monitored Community Residential Treatment Medicaid Billable Service

**(When Furnished in a Facility that Does Not Exceed 16 Beds and is Not an Institution for
Mental Diseases [IMD])(Room and Board Are Not Included)**

Level III.7 Medically Monitored Intensive Inpatient Treatment

NC Modified ASAM Patient Placement Criteria

Examples: McLeod, Swain, Hope Valley, ARCA.

Service Definition and Required Components

Medically Monitored Community Residential Treatment is a non-hospital twenty-four hour rehabilitation facility for adults, with twenty-four hour a day medical/nursing monitoring, where a planned program of professionally directed evaluation, care and treatment for the restoration of functioning for persons with alcohol and other drug problems and/or addiction occurs.

A service order for MMCRT must be completed by a physician, licensed psychologist, physician's assistant or nurse practitioner according to their scope of practice prior to or on the day that the services are to be provided.

Provider Requirements

MMCRT must be delivered by practitioners employed by a substance abuse provider organization that meet the provider qualification policies, procedures, and standards established by DMH and the requirements of 10A NCAC 27G. These policies and procedures set forth the administrative, financial, clinical, quality improvement, and information services infrastructure necessary to provide services. Provider organizations must demonstrate that they meet these standards by being endorsed by LME. Within three years of enrollment as a provider, the organization must have achieved national accreditation. The organization must be established as a legally recognized entity in the United States and qualified/registered to do business as a corporate entity in the State of North Carolina.

Organizations that provide MMCRT must provide "first responder" crisis response on a 24/7/365 basis to the recipients who are receiving this service.

Staffing Requirements

Medically Monitored Community Residential Treatment is staffed by physicians who are available 24 hours a day by telephone and who conduct assessments within 24 hours of admission. A registered nurse is available to conduct a nursing assessment on admission and oversee the monitoring of a patient's progress and medication administration on an hourly basis. Persons who meet the requirements specified for CCS, CCAS, and CSAC under Article 5C may deliver MMCRT. The program must be under the clinical supervision of a CCAS or CCS who is on site a minimum of 8 hours per day when the service is in operation and available by phone 24 hours a day. Services may also be provided by staff who meet the requirements specified for QP or AP status in Substance Abuse according to 10A NCAC 27G.0104, under the supervision of a CCAS or CCS. Paraprofessional level providers who meet the requirements for Paraprofessional status according to 10A NCAC 27G.0104 and who have the knowledge, skills and abilities required by the population and age to be served may deliver MMCRT, under the supervision of a

CCAS or CCS. Paraprofessional level providers may not provide services in lieu of no-site service provision to recipients by a qualified professional, CCS, CCAS or CSAC.

Service Type/Setting

Facility licensed under 10A NCAC 27G.3400.

Program Requirements

See Service Definition and Required Components.

Utilization Management

Authorization by the statewide vendor is required. The amount and duration of the service must be included in the individual's authorized Person Centered Plan. The initial authorization shall be no more than 14 days. In exceptional circumstances, up to an additional 7 days may be authorized following utilization review documented in the Person Centered Plan and service record. An example of such circumstances includes accomplishing an effective transition to another level of care. This is a short-term service that cannot exceed more than 30 days in a 12-month period.

Entrance Criteria

The recipient is eligible for this service when:

A. There is an Axis I diagnosis of a substance abuse disorder

AND

B. Level of Care Criteria Level III.7 NC Modified ASAM

Continued Stay Criteria

The desired outcome or level of functioning has not been restored, improved, or sustained over the time frame outlined in the recipient's Person Centered Plan or the recipient continues to be at risk for relapse based on history or the tenuous nature of the functional gains or any one of the following apply:

- Recipient has achieved positive life outcomes that supports stable and ongoing recovery and services need to be continued to meet additional goals.
- Recipient is making satisfactory progress toward meeting goals.
- Recipient is making some progress, but the Person Centered Plan (specific interventions) needs to be modified so that greater gains, which are consistent with the recipient's premorbid level of functioning, are possible or can be achieved.
- Recipient is not making progress; the Person Centered Plan must be modified to identify more effective interventions.
- Recipient is regressing; the Person Centered Plan must be modified to identify more effective interventions.

Discharge Criteria

Recipient's level of functioning has improved with respect to the goals outlined in the Person Centered Plan, inclusive of a transition plan to step down, or no longer benefits, or has the ability to function at this level of care and any of the following apply:

1. Recipient has achieved positive life outcomes that support stable and ongoing recovery.
2. Recipient is not making progress, or is regressing and all realistic treatment options have been exhausted indicating a need for more intensive services.

3. Recipient no longer wishes to receive MMCRT services. (Note that although a recipient may no longer wish to receive MMCRT services, the recipient must still be provided with discharge recommendations that are intended to help the recipient meet expected outcomes).

Expected Outcomes

The expected outcome is abstinence. Secondary outcomes (i.e., in *abstinent* patients) include: sustained improvement in health and psychosocial functioning, reduction in any psychiatric symptoms (if present), reduction in public health and/or safety concerns, and a reduction in the risk of relapse as evidenced by improvement in empirically-supported modifiable-relapse risk factors.

Upon successful completion of the treatment plan there will be successful linkage to the community of the recipient's choice for ongoing step down or support services.

Documentation Requirements

Minimum standard is a daily full service note that includes the recipient's name, Medicaid identification number, date of service, purpose of contact, describes the provider's interventions, the time spent performing the intervention, the effectiveness of interventions, and the signature and credentials of the staff providing the service. A discharge plan shall be discussed with the client and included in the record.

Service Exclusions/Limitations

This service cannot be billed the same day as any other MH/SA service except CST or ACTT.

Note: For recipients under the age of 21, additional products, services, or procedures may be requested even if they do not appear in the N.C. State Plan or when coverage is limited to those over 21 years of age. Service limitations on scope, amount, or frequency described in the coverage policy may not apply if the product, service, or procedure is medically necessary.

Substance Abuse Halfway House

Not a Medicaid Billable Service

Level III.1 Clinically Managed Low-Intensity Residential Treatment

NC Modified ASAM Patient Placement Criteria

Service Definition and Required Components

Clinically managed low intensity residential services are provided in a 24 hour facility where the primary purpose of these services is the rehabilitation of individuals who have a substance abuse disorder and who require supervision when in the residence. The consumers attend work, school, and SA treatment services. 10A NCAC 27G.5600 sets forth required service components.

Rehab Services components offered within this level of care must include the following:

1. Disease management
2. Vocational, educational, or employment training.
3. Support services for early recovery and relapse prevention
4. Linkage with the self-help and other community resources for support (e.g. 12-step meetings, faith-based programs, etc.)

A service order for substance abuse Halfway House must be completed by a physician, licensed psychologist, physician's assistant or nurse practitioner according to their scope of practice prior to or on the day that the services are to be provided.

Provider Requirements

Halfway House must be delivered by practitioners employed by a substance abuse provider organization that meet the provider qualification policies, procedures, and standards established by DMH and the requirements of 10A NCAC 27G. These policies and procedures set forth the administrative, financial, clinical, quality improvement, and information services infrastructure necessary to provide services. Provider organizations must demonstrate that they meet these standards by being endorsed by LME. Within three years of enrollment as a provider, the organization must have achieved national accreditation. The organization must be established as a legally recognized entity in the United States and qualified/registered to do business as a corporate entity in the State of North Carolina.

Staffing Requirements

Staff requirements specified in licensure rule 10A NCAC 27G.5600.

Service Type/Setting

Facility licensed under 10A NCAC 27G.5600.

Program Requirements

See Service Definition and Required Components and licensure requirements.

Utilization Management

Authorization by the statewide vendor is required. The amount and duration of this service must be included in an authorized individual's Person Centered Plan. Initial authorization for services will not exceed 180 days.

Entrance Criteria

The recipient is eligible for this service when:

A. There is an Axis I substance abuse disorder present;

AND

B. Level of Care Criteria, level III.1 OR level III.3 NC Modified A/ASAM

Continued Stay Criteria

The desired outcome or level of functioning has not been restored, improved, or sustained over the time frame outlined in the recipient's Person Centered Plan or the recipient continues to be at risk for relapse based on history or the tenuous nature of the functional gains or any one of the following apply:

- Recipient has achieved initial Person Centered Plan goals and additional goals are indicated.
- Recipient is making satisfactory progress toward meeting goals.
- Recipient is making some progress, but the Person Centered Plan (specific interventions) needs to be modified so that greater gains, which are consistent with the recipient's premorbid level of functioning, are possible or can be achieved.
- Recipient is not making progress; the person centered plan must be modified to identify more effective interventions.
- Recipient is regressing; the Person Centered Plan must be modified to identify more effective interventions.

AND

Utilization review must be conducted every 90 days and is so documented in the Person Centered Plan and the service record.

Discharge Criteria

Recipient's level of functioning has improved with respect to the goals outlined in the Person Centered Plan, inclusive of a transition plan to step down, or no longer benefits, or has the ability to function at this level of care and any of the following apply:

1. Recipient has achieved positive life outcomes that support stable and ongoing recovery.
2. Recipient is not making progress, or is regressing and all realistic treatment options have been exhausted indicating a need for more intensive services.
3. Recipient/family no longer wishes to receive Halfway House services.

Expected Outcomes

The expected outcome of Halfway House is abstinence. Secondary outcomes (i.e., in *abstinent* patients) include: sustained improvement in health and psychosocial functioning, reduction in any psychiatric symptoms (if present), reduction in public health and/or safety concerns, and a reduction in the risk of relapse as evidenced by improvement in empirically-supported modifiable relapse risk factors.

Documentation Requirements

Minimum standard is a daily full service note for each day of Halfway House that includes the recipient's name, Medicaid identification number, date of service, purpose of contact, describes the provider's interventions, the time spent performing the intervention, the effectiveness of interventions, and the signature and credentials of the staff providing the service. A documented discharge plan discussed with the recipient is included in the record.

Service Exclusions/Limitations

Halfway House may not be billed the same day as any other Residential Treatment or Inpatient Hospital service.

DETOXIFICATION SERVICES

Ambulatory Detoxification

Medicaid Billable Service

Level I-D Ambulatory Detoxification without Extended On-Site Monitoring

NC Modified ASAM Patient Placement Criteria

Service Definition and Required Components

Ambulatory Detoxification Without Extended On Site Monitoring (Outpatient Detox) is an organized outpatient service delivered by trained clinicians who provide medically supervised evaluation, detoxification and referral services according to a predetermined schedule. Such services are provided in regularly scheduled sessions. The services are designed to treat the patient's level of clinical severity and to achieve safe and comfortable withdrawal from mood-altering drugs (including alcohol) and to effectively facilitate the patient's transition into ongoing treatment and recovery.

A service order for Ambulatory Detoxification Without Extended On Site Monitoring must be completed by a physician, licensed psychologist, physician's assistant or nurse practitioner according to their scope of practice prior to or on the day that the services are to be provided.

Provider Requirements

Ambulatory Detoxification Without Extended On Site Monitoring must be delivered by practitioners employed by a substance abuse provider that meet the provider qualification policies, procedures, and standards established by DMH and the requirements of 10A NCAC 27G. These policies and procedures set forth the administrative, financial, clinical, quality improvement, and information services infrastructure necessary to provide services. Within three years of enrollment as a provider, the organization must have achieved national accreditation. The organization must be established as a legally recognized entity in the United States and qualified/registered to do business in the State of North Carolina.

Staffing Requirements

Ambulatory Detoxification Without Extended On Site Monitoring are staffed by physicians, who are available 24 hours a day by telephone and who conduct an assessment within 24 hours of admission. A registered nurse is available to conduct a nursing assessment on admission and oversee the monitoring of a patient's progress and medication. Appropriately licensed and credentialed staff are available to administer medications in accordance with physician orders and the services of counselors are available. Services must be provided by staff who meet the requirements specified for QP or AP status for Substance Abuse according to 10A NCAC 27G.0104, under the supervision of a CCAS or CCS.

Service Type/Setting

Facility licensed under 10A NCAC 27G.3300.

Entrance Criteria

- A. There is an Axis I diagnosis of substance abuse disorder present
- AND**
- B. ASAM Level of Care Criteria Level I-D (NC criteria)

Utilization Management

Authorization by the statewide vendor is required. This service must be included in an individual's Person Centered Plan. Initial authorization is limited to seven days. There is a 10-day maximum.

If it is a Medicaid covered service, utilization management will be done by the statewide vendor. If it is a non-covered Medicaid service or non-Medicaid client, then the utilization review will be done by the LME.

Continued Stay/Discharge Criteria

The patient continues in Ambulatory Detoxification Without Extended On Site Monitoring until:

- 1 withdrawal signs and symptoms are sufficiently resolved such that he or she can participate in self-directed recovery or ongoing treatment without the need for further medical or nursing detoxification monitoring; or
- 2 the signs or symptoms of withdrawal have failed to respond to treatment and have intensified such that transfer to a more intensive level of detoxification service is indicated.

Expected Outcomes

The expected outcome is abstinence and reduction in any psychiatric symptoms (if present).

Documentation Requirements

Minimum standard is a daily full service note for each day of Ambulatory Detoxification Without Extended On Site Monitoring that includes the recipient's name, Medicaid identification number, date of service, purpose of contact, describes the provider's interventions, the time spent performing the intervention, the effectiveness of interventions, and the signature and credentials of the staff providing the service. Detoxification rating scale tables e.g., Clinical Institute Withdrawal Assessment-Alcohol, Revised (CIWA-AR) and flow sheets (which include tabulation of vital signs) are used as needed, and a discharge plan which has been discussed with the recipient is also documented prior to discharge.

Service Exclusions

Cannot be billed the same day as any other service except for SA Comprehensive Outpatient Treatment and CS.

Note: For recipients under the age of 21, additional products, services, or procedures may be requested even if they do not appear in the N.C. State Plan or when coverage is limited to those over 21 years of age. Service limitations on scope, amount, or frequency described in the coverage policy may not apply if the product, service, or procedure is medically necessary.

Social Setting Detoxification Not a Medicaid Billable Service

Level III.2-D Clinically Managed Residential Detoxification

NC Modified ASAM Patient Placement Criteria

Service Definition and Required Components

Clinically Managed Residential Detoxification is an organized service that is delivered by appropriately trained staff, who provide 24-hour supervision, observation and support for patients who are intoxicated or experiencing withdrawal symptoms sufficiently severe to require 24-hour structure and support. The service is characterized by its emphasis on peer and social support. Established clinical protocols are followed by staff to identify patients who are in need of medical services beyond the capacity of the facility and to transfer such patients to the appropriate levels of care.

A service order for Social Setting Detoxification must be completed by a physician, licensed psychologist, physician's assistant or nurse practitioner according to their scope of practice prior to or on the day that the services are to be provided.

Provider Requirements

Social Setting Detoxification must be delivered by practitioners employed by a substance abuse provider organization that meet the provider qualification policies, ~~and~~ procedures, and standards established by DMH and the requirements of 10A NCAC 27G. These policies and procedures set forth the administrative, financial, clinical, quality improvement, and information services infrastructure necessary to provide services. Provider organizations must demonstrate that they meet these standards by being endorsed by LME. Within three years of enrollment as a provider, the organization must have achieved national accreditation. The organization must be established as a legally recognized entity in the United States and qualified/registered to do business as a corporate entity in the State of North Carolina.

Staffing Requirements

Persons who meet the requirements specified for CCS, CCAS, and CSAC under Article 5C may deliver Social Setting Detoxification. The program must be under the clinical supervision of a CCS or CCAS who is available 24 hours a day by telephone. All clinicians who assess and treat patients are able to obtain and interpret information regarding the needs of the patients including the signs and symptoms of alcohol and other drug intoxication and withdrawal as well as the appropriate treatment and monitoring of those conditions and how to facilitate entry into ongoing care. Back-up physician services are available by telephone 24 hours a day. Services must be provided by staff who meet the requirements specified for QP or AP status in Substance Abuse according to 10A NCAC 27G.0104, under the supervision of a CCAS or CCS. Paraprofessional level providers who meet the requirements for Paraprofessional status according to 10A NCAC 27G.0104 and Certified Peer Support Specialist and who have the knowledge, skills and abilities required by the population and age to be served may deliver Social Setting Detoxification, under the supervision of a CCAS or CCS. Paraprofessional level providers may not provide services in lieu of on-site service provision to recipients by a qualified professional, CCS, CCAS or CSAC.

Service Type/Setting

Facility licensed under 10A NCAC 14V.3200.

Entrance Criteria

- A. There is an Axis I diagnosis of substance abuse disorder present

AND

- B. ASAM Level of Care Criteria Level III.2-D (NC criteria)

Utilization Management

Authorization by the statewide vendor is required. This service must be included in an individual's Person Centered Plan. Initial authorization is limited to seven days.

Continued Stay/Discharge Criteria

The patient continues in Social Setting Detoxification until:

1. withdrawal signs and symptoms are sufficiently resolved that he or she can be safely managed at a less intensive level of care; or
2. the signs or symptoms of withdrawal have failed to respond to treatment and have intensified such that transfer to a more intensive level of detoxification service is indicated.

Expected Outcomes

The expected outcome of this service is abstinence and reduction in any psychiatric symptoms (if present).

Documentation Requirements

Minimum standard is a shift note for every 8 hours of service provided that includes the recipient's name, Medicaid identification number, date of service, purpose of contact, describes the provider's interventions, the time spent performing the intervention, the effectiveness of interventions and the signature of the staff providing the service. In addition, detoxification rating scale tables (e.g., Clinical Institute Withdrawal Assessment-Alcohol, Revised (CIWA-AR) and flow sheets (which include tabulation of vital signs) are used as needed. A documented discharge plan discussed with the recipient is included in the record.

Service Exclusions

This service cannot be billed the same day as any other MH/SA service except CS, CST, and ACTT.

Non-Hospital Medical Detoxification

Medicaid Billable Service

Level III.7-D Medically Monitored Inpatient Detoxification

NC Modified ASAM Patient Placement Criteria

Service Definition and Required Components

Medically Monitored Detoxification is an organized service delivered by medical and nursing professionals, that provides for 24-hour medically supervised evaluation and withdrawal management in a permanent facility affiliated with a hospital or in a freestanding facility of 16 beds or less. Services are delivered under a defined set of physician-approved policies and physician-monitored procedures and clinical protocols.

A service order for Medically Monitored Detoxification must be completed by a physician, licensed psychologist, physician's assistant or nurse practitioner according to their scope of practice prior to or on the day that the services are to be provided.

Provider Requirements

Medically Monitored Detoxification must be delivered by practitioners employed by a substance abuse provider organization that meet the provider qualification policies and procedures established by DMH and the requirements of 10A NCAC 27I.0208 (Endorsement of Providers). These policies and procedures set forth the administrative, financial, clinical, quality improvement, and information services infrastructure necessary to provide services. Provider organizations must demonstrate that they meet these standards by being endorsed by LME. Within three years of enrollment as a provider, the organization must have achieved national accreditation. The organization must be established as a legally recognized entity in the United States and qualified/registered to do business as a corporate entity in the State of North Carolina.

Staffing Requirements

Medically Monitored Detoxification are staffed by physicians, who are available 24 hours a day by telephone and who conducts an assessment within 24 hours of admission. A registered nurse is available to conduct a nursing assessment on admission and oversee the monitoring of a patient's progress and medication administration. The level of nursing care is appropriate to the severity of patient needs based on the clinical protocols of the program. Appropriately licensed and credentialed staff are available to administer medications in accordance with physician orders. Persons who meet the requirements specified for CCS, CCAS, and CSAC under Article 5C may deliver a planned regimen of 24-hour evaluation, care and treatment services for patients engaged in Medically Monitored Detoxification. The planned regimen of 24-hour evaluation, care and treatment services must be under the clinical supervision of a CCS or CCAS who is available by phone 24 hours a day. The planned regimen of 24-hour evaluation, care and treatment services for patients engaged in Medically Monitored Detoxification must be provided by staff who meet the requirements specified for QP or AP status in Substance Abuse according to 10A NCAC 27G.0104, under the supervision of a CCAS or CCS. Paraprofessional level providers who meet the requirements for Paraprofessional status according to 10A NCAC 27G.0104 and who have the knowledge, skills and abilities required by the population and age to be served may deliver the planned regimen of 24-hour evaluation, care and treatment services for patients engaged in Medically Monitored

Detoxification, under the supervision of a CCAS or CCS. Paraprofessional level providers may not provide services in lieu of on-site service provision to recipients by a qualified professional, CCS, CCAS or CSAC.

Service Type/Setting

Facility licensed under 10A NCAC 27G.3100.

Entrance Criteria

A. There is an Axis I diagnosis of substance abuse disorder present

AND

B. ASAM Level of Care Criteria Level III.7-D (NC criteria)

Utilization Management

Authorization by the statewide vendor is required. This service must be included in an individual's Person Centered Plan. Initial authorization is limited to seven days.

If it is a Medicaid covered service, utilization management will be done by the statewide vendor. If it is a non-covered Medicaid service or non-Medicaid client, then the utilization review will be done by the LME.

Continued Stay/Discharge Criteria

The patient continues in Medically Monitored Detoxification until:

1. withdrawal signs and symptoms are sufficiently resolved that he or she can be safely managed at a less intensive level of care; or
2. the signs or symptoms of withdrawal have failed to respond to treatment and have intensified such that transfer to a more intensive level of detoxification service is indicated.

Expected Outcomes

The expected outcome of this service is abstinence and reduction in any psychiatric symptoms if present.

Documentation Requirements

Minimum standard is a full daily note that includes number, date of service, purpose of contact, describes the provider's interventions, the time spent performing the intervention, the effectiveness of interventions, and the signature and credentials of the staff providing the service. Detoxification rating scale tables [e.g., Clinical Institute Withdrawal Assessment-Alcohol, Revised (CIWA-AR)] and flow sheets (includes tabulation of vital signs) are used as needed. A discharge plan, which has been discussed with the recipient, is also included in the record.

Service Exclusions

This service cannot be billed the same day as any other MH/SA service except CS, CST, and ACTT. This is a short-term service that cannot be billed for more than 30 days in a short-term period.

Note: For recipients under the age of 21, additional products, services, or procedures may be requested even if they do not appear in the N.C. State Plan or when coverage is limited to those over 21 years of age. Service limitations on scope, amount, or frequency described in the coverage policy may not apply if the product, service, or procedure is medically necessary.

Medically Supervised or ADATC Detoxification/Crisis Stabilization Medicaid Billable Service

(When Furnished to Adults in Facilities with Fewer than 16 Beds)

LEVEL III.9-D Medically Supervised Detoxification/Crisis Stabilization

NC Modified ASAM Patient Placement Criteria

Service Definition and Required Components

Medically Supervised or ADATC Detoxification/Crisis Stabilization is an organized service delivered by medical and nursing professionals that provides for 24-hour medically supervised evaluation and withdrawal management in a permanent facility with inpatient beds. Services are delivered under a defined set of physician-approved policies and physician-monitored procedures and clinical protocols. Recipients are often in crisis due to co-occurring severe substance-related mental disorders, such as an acutely suicidal patient, or persons with severe mental health problems that co-occur with more stabilized substance dependence who are in need short term intensive evaluation, treatment intervention, or behavioral management to stabilize the acute or crisis situation. The service has restraint and seclusion capabilities. Established clinical protocols are followed by staff to identify patients with severe biomedical conditions who are in need of medical services beyond the capacity of the facility and to transfer such patients to the appropriate level of care.

A service order for Medically Supervised or ADATC Detoxification/Crisis Stabilization must be completed by a physician, licensed psychologist, physician's assistant or nurse practitioner according to their scope of practice prior to or on the day that the services are to be provided.

Provider Requirements

Medically Supervised or ADATC Detoxification/Crisis Stabilization must be delivered by practitioners employed by a substance abuse provider organization that meet the provider qualification policies, procedures, and standards established by DMH and the requirements of 10A NCAC 27G. These policies and procedures set forth the administrative, financial, clinical, quality improvement, and information services infrastructure necessary to provide services. Provider organizations must demonstrate that they meet these standards by being endorsed by LME. Within three years of enrollment as a provider, the organization must have achieved national accreditation. The organization must be established as a legally recognized entity in the United States and qualified/registered to do business as a corporate entity in the State of North Carolina.

Staffing Requirements

Medically Supervised or ADATC Detoxification/Crisis Stabilization are staffed by physicians and psychiatrists, who are available 24 hours a day by telephone and who conduct assessments within 24 hours of admission. A registered nurse is available to conduct a nursing assessment on admission and oversee the monitoring of a patient's progress and medication administration on an hourly basis. Appropriately licensed and credentialed staff are available to administer medications in accordance with physician orders. Persons who meet the requirements specified for CCS, CCAS, and CSAC under Article 5C may deliver a planned regimen of 24-hour evaluation, care and treatment services for patients engaged in Medically Supervised or ADATC Detoxification/Crisis Stabilization. The planned regimen of 24-hour evaluation, care and treatment services must be under the clinical supervision of a CCS or CCAS who is who is available by phone 24 hours a day. The planned regimen of 24-hour evaluation, care and treatment services for patients engaged in Medically Supervised or ADATC Detoxification/Crisis Stabilization must

be provided by staff who meet the requirements specified for QP or AP status for Substance Abuse according to 10A NCAC 27G.0104, under the supervision of a CCAS or CCS. Paraprofessional level providers who meet the requirements for Paraprofessional status according to 10A NCAC 27G.0104 and who have the knowledge, skills and abilities required by the population and age to be served may deliver the planned regimen of 24-hour evaluation, care and treatment services for patients engaged in ADATC Detoxification/Crisis Stabilization, under the supervision of a CCAS or CCS.

Service Type/Setting

(Licensure TBD)

Entrance Criteria

A. There is an Axis I diagnosis of substance abuse disorder present

AND

B. ASAM Level of Care Criteria Level III.9-D (NC criteria)

Utilization Management

Authorization by the statewide vendor is required after the first eight hours of admission. This service must be included in an individual's Person Centered Plan. Initial authorization is limited to five days.

If it is a Medicaid covered service, utilization management will be done by the statewide vendor. If it is a non-covered Medicaid service or non-Medicaid client, then the utilization review will be done by the LME.

Continued Stay/Discharge Criteria

The patient continues in Medically Supervised or ADATC Detoxification/Crisis Stabilization until:

1. withdrawal signs and symptoms are sufficiently resolved that he or she can be safely managed at a less intensive level of care; or
2. the signs or symptoms of withdrawal have failed to respond to treatment and have intensified such that transfer to a more intensive level of detoxification service is indicated; or
3. the addition of other clinical services are indicated.

Expected Outcomes

The expected outcome of this service is abstinence and reduction in any psychiatric symptoms (if present).

Documentation Requirements

Minimum standard is a daily full service note that includes the recipient's name, Medicaid identification number, date of service, purpose of contact, describes the provider's interventions, the time spent performing the intervention, the effectiveness of interventions, and the signature and credentials of the staff providing the service. In addition, detoxification rating scale tables [e.g., Clinical Institute Withdrawal Assessment-Alcohol, Revised (CIWA-AR)] and flow sheets (includes tabulation of vital signs) are used as needed. A discharge plan, which as been discussed with the recipient, is also included in the record.

Service Exclusions

This service cannot be billed the same day as any other MH/SA service except CS, CST, and ACTT. This is a short-term service that cannot be billed for more than 30 days in a 12-month period.

Outpatient Opioid Treatment

Outpatient Opioid Treatment is a service designed to offer the individual an opportunity to effect constructive changes in his lifestyle by using methadone or other drug approved by the Food and Drug Administration (FDA) for the treatment of opiate addiction in conjunction with the provision of rehabilitation and medical services. It is a tool in the detoxification and rehabilitation process of an opiate-dependent individual.

Guidelines

- A. Services in this type include methadone or buprenorphine administration for:
 - 1. treatment, **OR**
 - 2. maintenance
- B. Only direct face-to-face time with client to be reported.
- C. Staff travel time to be reported separately.
- D. Preparation/documentation time NOT reported.

Payment Unit

One daily unit.

Therapeutic Relationship and Intervention

Administration of methadone or other drug approved by the FDA for the treatment of opiate addiction in a licensed opioid treatment program. Administration of methadone to patients with opiate addiction disorders for purposes of methadone maintenance or detoxification is the only activity billable to Medicaid under this service code. Medicaid patients can only be approved to receive methadone whereas self-pay and pioneer patients are eligible to receive LAAM or other FDA approved drugs as clinically indicated.

Structure of Daily Living

Not applicable.

Cognitive and Behavioral Skill Acquisition

Not applicable.

Service Type

This is a periodic service. Methadone maintenance is the only opioid treatment for opiate addiction disorders that is Medicaid billable.

Resiliency/Environment Intervention

Not applicable.

Service Delivery Setting

This service must be provided at a licensed Outpatient Treatment Program.

Medical Necessity

The recipient is eligible for this service when:

- A. An Axis I or II diagnosis is present

AND

- B. ASAM (American Society for Addiction Medicine) for Opioid Maintenance Therapy (OMT)
Level of Service is met and/or other ASAM levels as indicated

AND

- C. Service is a part of an aftercare planning process (time limited step down or transitioning) and is required to avoid returning to a higher, more restrictive level of service.

Service Order Requirement

Service orders must be completed by a physician prior to or on the day services are to be provided.

Continuation/Utilization Review Criteria

The desired outcome or level of functioning has not been restored, improved or sustained over the time frame outlined in the clients service plan or the consumer continues to be at risk for relapse based on history or the tenuous nature of the functional gains; **OR**

The client meets any of the specifications listed in the ASAM criteria for Dimension 5 Relapse, Continued Use or Continued Problem Potential for Opioid Maintenance Therapy.

Discharge Criteria

Client's level of functioning has improved with respect to the goals outlined in the service plan, inclusive of a transition plan to step down, or no longer benefits, or has the ability to function at this level of care and any of the following apply:

- A. Consumer has achieved goals, discharge to a lower level of care is indicated.
- B. Consumer is not making progress, or is regressing and all realistic treatment options with this modality have been exhausted.

Any denial, reduction, suspension, or termination of service requires notification to the consumer and/or legal guardian about their appeal rights.

Service Maintenance Criteria

If the client is functioning effectively with this service and discharge would otherwise be indicated, Opioid Treatment should be maintained when it can be reasonably anticipated that regression is likely to occur if the service is withdrawn. The decision should be based on any one of the following:

Past history of regression in the absence of Opioid Treatment is documented in the consumer record.

OR

The presence of a DSM-IV diagnosis that would necessitate a disability management approach. In the event that there is epidemiological sound expectations that symptoms will persist and that on going treatment interventions are needed to sustain functional gains.

Any denial, reduction, suspension, or termination of service requires notification to the client and/or legal guardian about their appeal rights.

Provider Requirement and Supervision

This service can only be provided by a registered nurse, licensed practical nurse, pharmacist, or physician.

**Division of Medical Assistance
Enhanced Mental Health
and Substance Abuse Services**

**Clinical Coverage Policy No.: 8A
Original Effective Date: July 1, 1989
Revised Date: February 1, 2008
Effective March 1, 2008**

Documentation Requirements

Minimum standard is a daily full service note that includes the recipient's name, Medicaid identification number, date of service, purpose of contact, describes the provider's interventions, the time spent performing the intervention, the effectiveness of interventions, and the signature and credentials of the staff providing the service. A documented discharge plan will be discussed with the recipient and included in the record.