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Related Clinical Coverage Policies

Refer to http://dma.ncdhhs.gov/ for the related coverage policies listed below:

1.0 Description of the Procedure, Product, or Service

Peer Support Services (PSS) is an evidenced-based mental health model of care that provides community-based recovery services directly to Medicaid eligible adult beneficiaries that are diagnosed with a mental illness or substance use disorder. PSS provides structured, scheduled activities that promote recovery, self-determination, self-advocacy, engagement in self-care and wellness and enhancement of community living skills of beneficiaries. PSS activities are directly provided by Certified Peer Support Specialists(CPSS) who have self-identified as a person(s) in recovery from mental illness or substance use disorders. PSS can be provided in combination with other approved mental health or substance use services or as an independent service. Due to the high prevalence of beneficiaries with co-occurring disorders (mental illness, substance use or medical disorders) it is a priority that integrated treatment be available to these beneficiaries.

PSS is based on the belief that beneficiaries with serious mental or substance use disorders can and do recover. Focus is on the person, rather than the identified mental illness or substance use disorder and emphasizes the acquisition; development; expansion of rehabilitative skills needed to move forward in recovery. The service promotes skills for coping with and managing symptoms while utilizing natural resources and the preservation and enhancement of community living skills.

Peer Support Services (PSS) activities are provided one-on-one to the beneficiary or in a group setting, with most activities being provided one-on-one by CPSS. Providing one-on-one support builds on the relationship of mutuality between the beneficiary and CPSS; supports the beneficiary in accomplishing self-identified goals; and may further support the beneficiary's engagement in treatment. Peer support services provided in a group setting allows beneficiaries the opportunity to engage in structured activities with others that share similar recovery challenges or interest; improve or develop recovery skills; and explore community resources that will assist beneficiaries in his or her recovery. PSS activities must be based on the beneficiary's needs and coordinated within the context of the beneficiary's Person-Centered Plan. Structured activities provided by PSS may include:

a. **Peer mentoring or coaching (one-on-one)** - to encourage, motivate, and support beneficiary moving forward in recovery. Assist beneficiary with setting self-identified recovery goals, developing recovery action plans, and solving problems directly related to recovery, including finding housing, developing natural support system, finding new uses of spare time, and improving job skills. Assist with issues that arise in connection with collateral problems such as legal issues or co-existing physical or mental challenges.
b. **Recovery resource connecting** – connecting beneficiaries to professional and nonprofessional services and resources available in the community that can assist beneficiary in meeting recovery goals.
c. **Skill Building Recovery groups**– structured skill development groups that focus on job skills, budgeting and managing credit, relapse prevention, and conflict resolution skills and support recovery.
d. **Building community** – assist beneficiary in enhancing their social networks that promote and help sustain mental health and substance use disorder recovery. Organization of recovery-oriented activities that provide a sense of acceptance and belonging to the

community, promote learning of social skills and the opportunity to practice newly learned skills.

1.1 Definitions

a. **Recovery** – a process of change through which a beneficiary improves their health and wellness, lives a self-directed life and strives to reach their full potential; to live, work, learn, and participate fully in their communities.
b. **Self-Determination** - the right of a beneficiary to direct their own services, to make decisions concerning their health and well-being, and to have help to make decisions from whomever they choose.
c. **Self-Advocacy** – identifying and purposefully asking for what one needs.
d. **Health** – learning to overcome, manage or more successfully live with the symptoms and making healthy choices that support one's physical and emotional wellbeing:
e. **Community –** relationships and social networks that provide support, friendship, love and hope.

2.0 Eligibility Requirements

2.1 Provisions

2.1.1 General

(***The term "General" found throughout this policy applies to all Medicaid and NCHC policies***)

a. An eligible beneficiary shall be enrolled in either:
   1. the NC Medicaid Program *(Medicaid is NC Medicaid program, unless context clearly indicates otherwise*); or
   2. the NC Health Choice (*NCHC is NC Health Choice program, unless context clearly indicates otherwise)* Program on the date of service and shall meet the criteria in **Section 3.0 of this policy**.
b. Provider(s) shall verify each Medicaid or NCHC beneficiary's eligibility each time a service is rendered.
c. The Medicaid beneficiary may have service restrictions due to their eligibility category that would make them ineligible for this service.
d. Following is only one of the eligibility and other requirements for participation in the NCHC Program under GS 108A-70.21(a): Children must be between the ages of 6 through 18.

2.1.2 Specific

(***The term "Specific" found throughout this policy only applies to this policy***)

a. <u>Medicaid</u>

An applicant may be approved for Medicaid if the applicant meets all eligibility requirements. A beneficiary may become retroactively eligible for Medicaid while receiving covered services.

Retroactively eligible beneficiaries are entitled to receive Medicaid covered services and to be reimbursed by the provider for all money paid during the retroactive period except for any third-party payments or cost-sharing

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amounts. The qualified provider may file for reimbursement with Medicaid for these services.

Medicaid shall cover Peer Support Services for an eligible beneficiary 18 years of age and older who meets the criteria in **Section 3.0** of this policy.

b. **NCHC**
NCHC shall cover Peer Support Services for an eligible beneficiary 18 years of age who meets the criteria in Section 3.0 of this policy.

Retroactive eligibility does not apply to the NCHC program.

2.2 Special Provisions

2.2.1 EPSDT Special Provision: Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age

a. **42 U.S.C. § 1396d(r) [1905(r) of the Social Security Act]**

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or procedures for Medicaid beneficiary under 21 years of age **if** the service is **medically necessary health care** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination (includes any evaluation by a physician or other licensed practitioner).

This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his or her health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

Medically necessary services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the beneficiary's physician, therapist, or other licensed practitioner; the determination process does not delay the delivery of the needed service; and the determination does not limit the beneficiary's right to a free choice of providers.

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

1. that is unsafe, ineffective, or experimental or investigational.
2. that is not medical in nature or not generally recognized as an accepted method of medical practice or treatment.

Service limitations on scope, amount, duration, frequency, location of service, and other specific criteria described in clinical coverage policies may be exceeded or may not apply as long as the provider's documentation shows that the requested service is medically necessary "to correct or ameliorate a defect, physical or mental illness, or a condition" [health problem]; that is, provider documentation shows how the service, product, or procedure meets all EPSDT criteria, including to correct or improve or maintain the

beneficiary's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

b. **EPSDT and Prior Approval Requirements**

1. If the service, product, or procedure requires prior approval, the fact that the beneficiary is under 21 years of age does **NOT** eliminate the requirement for prior approval.
2. **IMPORTANT ADDITIONAL INFORMATION** about EPSDT and prior approval is found in the *NCTracks Provider Claims and Billing Assistance Guide,* and on the EPSDT provider page. The Web addresses are specified below.

   NCTracks Provider Claims and Billing Assistance Guide: https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html

   EPSDT provider page: http://dma.ncdhhs.gov/

2.2.2 EPSDT does not apply to NCHC beneficiaries

2.2.3 Health Choice Special Provision for a Health Choice Beneficiary age 6 through 18 years of age

The Division of Medical Assistance (DMA) shall deny the claim for coverage for an NCHC beneficiary who does not meet the criteria within **Section 3.0** of this policy. Only services included under the NCHC State Plan and the DMA clinical coverage policies, service definitions, or billing codes are covered for an NCHC beneficiary.

3.0 When the Procedure, Product, or Service Is Covered

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.

3.1 General Criteria Covered

Medicaid and NCHC shall cover the procedure, product, or service related to this policy when medically necessary, and:

a. the procedure, product, or service is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the beneficiary's needs;
b. the procedure, product, or service can be safely furnished, and no equally effective and more conservative or less costly treatment is available statewide; and
c. the procedure, product, or service is furnished in a manner not primarily intended for the convenience of the beneficiary, the beneficiary's caretaker, or the provider.

3.2 Specific Criteria Covered

3.2.1 Specific criteria covered by both Medicaid and NCHC

Medicaid and NCHC shall cover Peer Support Services when the beneficiary meets the following specific criteria:

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A. A mental health or substance use diagnosis as defined by the DSM-5, or any subsequent editions of this reference material, other than a sole diagnosis of intellectual and developmental disability;

AND

B. The beneficiary has documented identified needs due to his or her mental health or substance use diagnosis in at least three of the following areas:

1. Limited ability to integrate recovery and wellness practices into daily activities; OR
2. Has recently experienced a crisis episode requiring intervention through Mobile Crisis Management, Facility Based Crisis, hospitalization [related to his or her mental health or substance use disorder], or detoxification services; OR
3. History of difficulty using traditional services (missing office appointments, difficulty maintaining medication schedules, etc.); OR
4. Limited ability to identify and utilize community services and supports without assistance; OR
5. Limited ability to develop and maintain relationships, including natural supports; OR
6. Limited ability to maintain housing, physical health, in the community, school, job, or volunteer activity.

C. There is no evidence to support that alternative interventions would be equally or more effective based on North Carolina community practice standards (for example, American Society for Addiction Medicine, American Psychiatric Association) as available.

Entrance Criteria

A comprehensive clinical assessment (CCA) that demonstrates medical necessity must be completed prior to the provision of this service. If a substantially equivalent assessment is available, reflects the current level of functioning, and contains all the required elements as outlined in community practice standards as well as in all applicable federal and state requirements, it may be used as part of the current CCA. Relevant clinical information must be obtained and included in the beneficiary's Person-Centered Plan (PCP).

Continued Stay Criteria

The beneficiary is eligible to continue this service if:

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

AND

b. Continuation of service is supported by documentation of beneficiary's progress toward goals within the beneficiary's PCP.

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Transition and Discharge Criteria

The beneficiary meets the criteria for discharge if any one of the following applies:

a. The beneficiary's level of functioning has improved with respect to the goals outlined in the PCP, inclusive of a transition plan to step down to a lower level of care;

b. The beneficiary has achieved positive life outcomes that support stable and ongoing recovery and is no longer in need of Peer Support Services;

c. The beneficiary is not making progress or is regressing and all reasonable strategies and interventions have been exhausted, indicating a need for more intensive services;

d. The beneficiary or legally responsible person no longer wishes to receive Peer Support Services.

3.2.2 Medicaid Additional Criteria Covered

None Apply.

3.2.3 NCHC Additional Criteria Covered

None Apply.

4.0 When the Procedure, Product, or Service Is Not Covered

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.

4.1 General Criteria Not Covered

Medicaid and NCHC shall not cover the procedure, product, or service related to this policy when:

a. the beneficiary does not meet the eligibility requirements listed in **Section 2.0;**
b. the beneficiary does not meet the criteria listed in **Section 3.0;**
c. the procedure, product, or service duplicates another provider's procedure, product, or service; or
d. the procedure, product, or service is experimental, investigational, or part of a clinical trial.

4.2 Specific Criteria Not Covered

4.2.1 Specific Criteria Not Covered by both Medicaid and NCHC

Medicaid and NCHC shall not cover the following activities or considered the activity covered by Peer Support Services:

a. Transportation for the beneficiary or family;
b. Any habilitation activities;
c. Time spent doing, attending or participating in recreational activities unless tied to specific planned social skill assistance;
d. Clinical and administrative supervision of Peer Support Specialist is covered as an indirect cost and included in the rate and must not be billed separately;
e. Covered services that have not been rendered;

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f. Childcare services or services provided as a substitute for the parent or other beneficiaries responsible for providing care and supervision;
g. Services provided to teach academic subjects or as a substitute for education personnel:
h. Interventions not identified on the beneficiary's Person-Centered Plan;
i. Services provided without prior authorization by the PHIP;
j. Services provided to children, spouse, parents or siblings of the eligible beneficiary under treatment or others in the eligible beneficiary's life to address problems not directly related to the eligible beneficiary's needs and not listed on the Person-Centered Plan; OR
k. Payment for room and board.

4.2.2 Medicaid Additional Criteria Not Covered

None Apply.

4.2.3 NCHC Additional Criteria Not Covered

a. In addition to the specific criteria not covered in **Subsection 4.2.1** of this policy, NCHC shall not cover…
b. NCGS § 108A-70.21(b) "Except as otherwise provided for eligibility, fees, deductibles, copayments, and other cost sharing charges, health benefits coverage provided to children eligible under the Program shall be equivalent to coverage provided for dependents under [the] North Carolina Medicaid Program except for the following:
   1. No services for long-term care.
   2. No nonemergency medical transportation.
   3. No EPSDT.
   4. Dental services shall be provided on a restricted basis in accordance with criteria adopted by the Department to implement this subsection."

   Note: **Subsection 4.2.3(b)** applies to NCHC only.

5.0 Requirements for and Limitations on Coverage

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.

5.1 Prior Approval

Medicaid shall require prior approval for Peer Support Services (PSS). The provider shall obtain prior approval before rendering PSS.

5.2 Prior Approval Requirements

5.2.1 General

The provider(s) shall submit to the Department of Health and Human Services (DHHS) Utilization Review Contractor the following:

a. the prior approval request; and
b. all health records and any other records that support the beneficiary has met the specific criteria in **Subsection 3.2** of this policy.

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5.2.2 Specific

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

Initial Authorization

Services are based upon a finding of medical necessity, must be directly related to the beneficiary's diagnostic and clinical needs, and are expected to achieve the specific rehabilitative goals detailed in the beneficiary's Person-Centered Plan (PCP) Medical necessity is determined by North Carolina community practice standards, as verified by the DHHS Utilization Management Review Contractor which will evaluate the request to determine if medical necessity supports intensive services. Medically necessary services are authorized in the most cost-effective modes, if the treatment that is made available is similarly efficacious as services requested by the beneficiary's physician, therapist, or another licensed practitioner. The medically necessary service must be recognized as an accepted method of medical practice or treatment.

To request an initial authorization, the CCA, service order for medical necessity, PCP, and the required DMA authorization request form must be submitted to the DHHS approved Utilization Management Review Contractor at least 10-days prior to the first day of service. Medicaid may cover up to 90 days for the initial authorization period.

Reauthorization

Reauthorization requests shall be submitted to the Utilization Management Review Contractor 10-days prior to the end date of the beneficiary's active authorization. Medicaid may cover up to 90 days for the reauthorization based on medical necessity documented in the PCP, the authorization request form, and supporting documentation. The duration and frequency at which PSS is provided shall be based on medical necessity and progress made by the beneficiary toward goals outlined in the PCP.

5.3 Additional Limitations or Requirements

a. A beneficiary can receive PSS from only one provider organization during an active authorization period.
b. Family members or legally responsible beneficiary(s) of the beneficiary are not eligible to provide this service to the beneficiary.
c. Beneficiaries receiving Innovations Waiver services are not eligible for PSS funded by Medicaid.
d. PSS must not be provided in conjunction with Assertive Community Treatment Team (ACTT) or Community Support Team (CST) services.
e. PSS may only be authorized during the last 30-days of an authorization of ACTT or CST if member is being transitioned to PSS but it must not be provided or billed at the same time of day.

f. Only the time during which the beneficiary receives PSS may service be billed to Medicaid. Service may not be billed during the same time as another mental health or substance use service or physical health service is being billed.

5.4 Service Orders

Service orders are a mechanism to demonstrate medical necessity for a service and are based upon an assessment of the beneficiary's needs. A signed service order must be completed by a physician, licensed psychologist, physician assistant, or nurse practitioner, per his or her scope of practice. Service orders are valid for one year. Medical necessity must be revisited and service must be ordered at least annually, based on the date of the original service order.

All the following applies to a service order:
a. backdating of the service order is not allowed.
b. each service order must be signed and dated by the authorizing professional and must indicate the date on which the service was ordered.
c. A service order must be in place prior to or on the first day that the service is initially provided to bill Medicaid for the service. Even if the beneficiary is retroactively eligible for Medicaid the provider cannot bill Medicaid without a valid service order.

5.5 Documentation Requirements

The service record documents the nature and course of a beneficiary's progress in treatment. To bill Medicaid, providers must ensure that their documentation is consistent with the requirements contained in this policy. The staff member who provides the service is responsible for accurately documenting the services billed to and reimbursed by Medicaid. The staff person who provides the service must sign and date the written entry. The signature must include credentials for professionals or job title for associate professionals. A qualified professional shall countersign service notes written by staff who do not have QP status. The PCP and a documented discharge plan must be discussed with the beneficiary and included in the service record.

5.5.1 Contents of a Service Note

For this service, a full service note for each contact or intervention for each date of service, written and signed by the person who provided the service is required. More than one intervention, activity, or goal may be reported in one service note, if applicable. A service note must include all the following elements:

a. Beneficiary's name;
b. Medicaid identification number;
c. Date of the service provision;
d. Name of service provided;
e. Type of contact;
f. Place of service;
g. Purpose of contact as it relates to the PCP goals:
h. Description of the intervention provided. Documentation of the intervention must accurately reflect treatment for the duration of time indicated;
i. Duration of service, amount of time spent preforming the intervention;
j. Assessment of the effectiveness of the intervention and the beneficiary's progress towards the beneficiary's goals;
k. Date and signature and credentials or job title of the staff member who

provided the service.

6.0 Provider(s) Eligible to Bill for the Procedure, Product, or Service

To be eligible to bill for the procedure, product, or service related to this policy, the provider(s) shall:

a. meet Medicaid or NCHC qualifications for participation;
b. have a current and signed Department of Health and Human Services (DHHS) Provider Administrative Participation Agreement; and
c. bill only for procedures, products, and services that are within the scope of their clinical practice, as defined by the appropriate licensing entity.

6.1 Provider Qualifications and Occupational Licensing Entity Regulations

Peer Support Services shall be delivered by practitioners employed by mental health or substance abuse provider organizations that:

a. meet the provider qualification policies, procedures, and standards established by the DMA;
b. fulfill the requirements of 10A NCAC 27G;
c. demonstrate that they meet these standards by being credentialed and contracted by the Prepaid Inpatient Health Plans;
d. within one year of enrollment as a provider with DMA, the organization shall achieve national accreditation with at least one of the designated accrediting agencies;
e. become established as a legally constituted entity capable of meeting all the requirements of the Provider Certification Medicaid Enrollment Agreement, Medicaid Bulletins and service implementation standards; and
f. complies with all applicable federal and state requirements. This includes the NC DHHS state rules, policies, and other published instructions.

6.2 Provider Certifications

None apply.

6.2.1 Staff Requirements

The Peer Support Services (PSS) program is provided by qualified providers with the capacity and adequate workforce to offer this service to eligible Medicaid beneficiaries. The PSS program must have the ability to offer this service at any time of the day, including evening times or weekends, as needed by the beneficiary and specified in the beneficiary’s PCP.

The PSS program shall be under the direction of a Qualified Professional (QP) who meets the requirements according to 10A NCAC 27G .0104.

PSS shall be directly provided by peer support specialist certified by North Carolina’s Peer Support Specialist Program.

The PSS program must have designated qualified staff to provide supervision to CPSS at any time; 24 hours a day; 7 days a week.

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The maximum program staff ratios are as follows: QP-to-CPSS is 1:6; CPSS-to-beneficiary is 1:25; and group ratio for CPSS Group Facilitator-to-beneficiaries is 1:12.

The PSS program shall follow the NC Peer Support Specialist Code of Ethics and Values and principles when rendering PSS services. All ethical issues shall be governed by policies and procedures established by the hiring provider agency.

The following charts provide required activities of the PSS Program Supervisor and core competencies of relationship building and peer support interaction for CPSS (identified by NC's Certified Peer Support Specialist Program). Activities provided by CPSS should be based on a relationship of mutuality with the beneficiary; the beneficiary's self-identified needs for recovery; and should demonstrate the CPSS's understanding of core competencies identified and supported by NC's Certified Peer Support Specialist Program.

Peer Support Specialist Program Supervisor
• Possesses knowledge of the CPSS role and work, as well as, understand the principles and philosophy of recovery and the code of ethics of the NC Peer Support Specialist Certification Program. • Coordinate assessments needed for the beneficiary. If appropriately licensed, the QP may conduct the assessments. • Collaborate with beneficiary(s) and CPSS to develop recovery-oriented person-centered treatment plan(s) for the beneficiary that demonstrates consideration for integrated care. • Conduct at least one face-to-face contact with the beneficiary within 30 days of PSS being initiated and no less that every 60 days thereafter to monitor the beneficiary's progress and effectiveness of the program. • Plan work assignments, monitors, reviews and evaluates work performance of program staff and facilitates staff meetings. • Provide administrative and supportive supervision to program staff individually at least once per month or more if needed. Provision of supervision should be based on the experience of the individual staff. • Collaborate with program staff to assess strengths and areas of growth and develop an individual supervision plan. • Collaborate and foster collegial roles with program staff. • Determine team caseload size based on the level of acuity and needs of the beneficiary(s). • Facilitate or co-facilitate skill building recovery groups based on the needs or request of beneficiaries. • Ensure referrals for community resources requested by beneficiary(s) are completed.

Certified Peer Support Specialist
• Knowledge of peer support principles, values and ethics. • Ability to share lived experience to support, encourage and enhance beneficiary(s) treatment and recovery.

- Possess recovery-oriented skills and knowledge to provide peer support services.
- Ability to collaborate with the program QP to assess their own strengths and areas of growth and develop a supervision plan.
- Ability to collaborate with beneficiary(s) to explore and identify barriers to accessing community resources or treatment providers.
- Ability to model and mentor recovery values, attitudes, beliefs, and personal actions in order to encourage wellness and resilience for beneficiaries served and to promote a recovery environment in the community, home and workplace.
- Ability to explore with beneficiaries served, the importance and creation of a wellness identity through open sharing and challenging viewpoints.
- Ability to promote a beneficiary's opportunity for personal growth by identifying teachable moments for building relationship skills in order to empower the beneficiary and enhance personal responsibility.
- Ability to model and share decisions-making tools to enhance a beneficiary's healthy decision-making process.
- Ability to provide examples of healthy social interactions and facilitate familiarity with, and connection to, the local community.
- Ability to recognize and appropriately respond to conditions that constitute an emergency situation to include both physical and behavioral health crisis utilizing the emergency response procedure of employer.
- Ability to provide support to the beneficiary in navigating systems (medical, social services, legal, etc).
- Ability to promote self-advocacy by facilitating each beneficiary's learning about his or her human and legal rights and supporting the beneficiary while exercising those rights in order to support the empowerment of the beneficiary.

6.2.2 Training Requirements

To provide effective peer support services, all PSS program staff shall possess the knowledge and competencies of peer support principles, values and ethics and participate in additional trainings required to provide the service. Required trainings for PSS program staff are as follows:

Timeframe	Training Required	Who	Total Minimum Hours Required
30 days of hire to provide this service	• 3 hours of Peer Support Services Policy components review • 3 hours of PCP Instructional Elements • 3 hours of Comprehensive Prevention and Intervention Crisis Plan Training (PCP) • 3 hours of Documentation Training	• All staff	12hours

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90 days of hire to provide this service	• 12 hours of Person Centered Thinking • 6 hours of Crisis Response • 13 hours of Motivational Interviewing (MINT)	• All staff	31 hours
	• 3 hours of Peer Support Supervisor Training	• Peer Support Staff Supervisor	3 hours
Annually	• 10 hours of continuing education	• All staff	10 hours

Peer support program staff shall successfully complete initial requirements of training identified above within identified timeframes. The initial training requirements may be waived by the hiring agency if the employee can produce written documentation certifying that training was successfully completed no more than 24 months prior to hire date.

Peer support program staff shall participate in additional hours of training that is appropriate for the population being served. Additional training options for all PSS program staff may include:

- Trauma Informed Care
- Wellness and Recovery Action Plan (WRAP)
- Whole Health Action Management (WHAM)
- Basic Mental Health and Substance Use 101
- Mental Health First Aid
- Housing First, Permanent Supportive Housing, Tenancy Support Training

6.3 Expected Outcomes

The expected outcomes for this service are specific to recommendations resulting from clinical assessments and meeting the identified goals in the beneficiary's PCP.

Expected outcomes include the following:

a. increased engagement in self-directed recovery process;
b. increased natural and social support networks;
c. increased ability to engage in community activities;
d. increased ability to live independently as possible and use recovery skills to maintain a stable living arrangement;
e. higher levels of empowerment and hopefulness in recovery;
f. improved emotional, behavioral and physical health;
g. improved quality of life;
h. improved vocational skills
i. decreased substance use
j. decreased frequency or intensity of crisis episodes; or
k. decreased use of crisis services or hospitalizations

7.0 Additional Requirements

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.

7.1 Compliance

Provider(s) shall comply with the following in effect at the time the service is rendered:

a. All applicable agreements, federal, state and local laws and regulations including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements; and
b. All DMA's clinical (medical) coverage policies, guidelines, policies, provider manuals, implementation updates, and bulletins published by the Centers for Medicare and Medicaid Services (CMS), DHHS, DHHS division(s) or fiscal contractor(s).

8.0 Policy Implementation and History

Original Effective Date: Month Day, Year

History:

Date	Section or Subsection Amended	Change
	All Sections and Attachment(s)	

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Attachment A: Claims-Related Information

Provider(s) shall comply with the, *NCTracks Provider Claims and Billing Assistance Guide*, Medicaid bulletins, fee schedules, DMA's clinical coverage policies and any other relevant documents for specific coverage and reimbursement for Medicaid and NCHC:

A. Claim Type

Professional (CMS-1500/837P transaction)

Institutional (UB-04/837I transaction)

B. International Classification of Diseases, Tenth Revisions, Clinical Modification (ICD-10-CM) and Procedural Coding System (PCS)

Provider(s) shall report the ICD-10-CM and Procedural Coding System (PCS) to the highest level of specificity that supports medical necessity. Provider(s) shall use the current ICD-10 edition and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for code description, as it is no longer documented in the policy.

C. Code(s)

Provider(s) shall report the most specific billing code that accurately and completely describes the procedure, product or service provided. Provider(s) shall use the Current Procedural Terminology (CPT), Health Care Procedure Coding System (HCPCS), and UB-04 Data Specifications Manual (for a complete listing of valid revenue codes) and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for the code description, as it is no longer documented in the policy.

If no such specific CPT or HCPCS code exists, then the provider(s) shall report the procedure, product or service using the appropriate unlisted procedure or service code.

HCPCS Code(s)	Billing Unit
H0038 – Individual	1 unit = 15 minutes
H0038 HQ - Group	1 unit = 15 minutes

Unlisted Procedure or Service
CPT: The provider(s) shall refer to and comply with the Instructions for Use of the CPT Codebook, Unlisted Procedure or Service, and Special Report as documented in the current CPT in effect at the time of service.

HCPCS: The provider(s) shall refer to and comply with the Instructions For Use of HCPCS National Level II codes, Unlisted Procedure or Service and Special Report as documented in the current HCPCS edition in effect at the time of service.

D. Modifiers

Provider(s) shall follow applicable modifier guidelines.

E. Billing Units

Provider(s) shall report the appropriate code(s) used which determines the billing unit(s). Units are billed in 15-increments.

F. Place of Service

PSS may be provided in the beneficiary's place of residence, community or in a office setting.

G. Co-payments

For Medicaid refer to Medicaid State Plan, Attachment 4.18-A, page 1, located at http://dma.ncdhhs.gov/.
For NCHC refer to G.S. 108A-70.21(d), located at http://www.ncleg.net/EnactedLegislation/Statutes/HTML/BySection/Chapter_108A/GS_108A-70.21.html

H. Reimbursement

Provider(s) shall bill their usual and customary charges.
For a schedule of rates, refer to: http://dma.ncdhhs.gov/

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