

To all beneficiaries enrolled in a Prepaid Health Plan (PHP): for questions about benefits and services available on or after implementation, please contact your PHP.

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Related Clinical Coverage Policies

Refer to <https://medicaid.ncdhhs.gov/> for the related coverage policies listed below:
8A, Enhanced Mental Health and Substance Abuse Services

1.0 Description of the Procedure, Product, or Service

Service Definition and Required Components: An Assertive Community Treatment (ACT) team consists of a community-based group of medical, behavioral health, and rehabilitation professionals who use a team approach to meet the needs of a beneficiary with severe and persistent mental illness. A beneficiary who is appropriate for ACT does not benefit from receiving services across multiple, disconnected providers, and may become at greater risk of hospitalization, homelessness, substance use, victimization, and incarceration. An ACT team provides person-centered services addressing the breadth of a beneficiary's needs, helping him or her achieve their personal goals. Thus, a fundamental charge of ACT is to be the first-line (and generally sole provider) of all the services that an ACT beneficiary needs. Being the single point of responsibility necessitates a higher frequency and intensity of community-based contacts, and a very low beneficiary-to-staff ratio. Services are flexible; teams offer varying levels of care for all beneficiaries, and appropriately adjust service levels given an individual beneficiary's changing needs over time.

An ACT team assists a beneficiary in advancing toward personal goals with a focus on enhancing community integration and regaining valued roles (example, worker, daughter, resident, spouse, tenant, or friend). Because an ACT team often works with beneficiaries who may passively or actively resist services, an ACT team is expected to thoughtfully carry out planned assertive engagement techniques including rapport-building strategies, facilitating meeting basic needs, and motivational interviewing techniques. These techniques are used to identify and focus on the beneficiary's life goals and what he or she is motivated to change. Likewise, it is the team's responsibility to monitor the beneficiary's mental status and provide needed supports in a manner consistent with the beneficiary's level of need and functioning. The ACT team delivers all services according to a recovery-based philosophy of care. The team promotes self-determination, respects the beneficiary as an individual in his or her own right, and engages peers in promoting hope that the beneficiary can recover from mental illness and regain meaningful roles and relationships in the community.

1.1 Definitions

1.1.1 Preventive

Preventative is to anticipate the development of a disease or condition and preclude its occurrence.

1.1.2 Diagnostic

Diagnostic means to examine specific symptoms and facts to understand or explain a condition.

1.1.3 Therapeutic

Therapeutic means to treat and cure disease or disorders; it may also serve to preserve health.

1.1.4 Rehabilitative

Rehabilitative is to restore that which one has lost, to a normal or optimum state of health.

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

Medicaid

An applicant may be approved for Medicaid if the applicant meets all eligibility requirements. Occasionally, an individual become retroactively eligible for Medicaid while receiving covered services.

Retroactively eligible beneficiaries are entitled to receive Medicaid-covered service and to be reimbursed by the provider for all money paid during the retroactive period 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).

Medicaid shall cover ACT services for an eligible beneficiary 18 years of age and older who meets the criteria in **Section 3.0** of this policy

NCHC

NCHC shall cover ACT for an eligible beneficiary age 18 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 clinician).

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: <https://medicaid.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

NC Medicaid shall deny the claim for coverage for a 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 NC Medicaid clinical coverage policies, service definitions, or billing codes are covered for a 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 or NCHC shall cover procedures, products, and services related to this policy when they are 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

3.2.1 Specific criteria covered by both Medicaid and NCHC

Medicaid and NCHC shall cover ACT services for a beneficiary 18 years and older with schizophrenia, other psychotic disorders (example, schizoaffective disorder), and bipolar disorder because these illnesses more often cause long-term psychiatric disability. Beneficiaries with other psychiatric illnesses are eligible dependent on the level of the long-term disability. Beneficiaries with a primary diagnosis of a substance use disorder, ~~or~~ intellectual developmental disabilities, borderline personality disorder, traumatic brain injury, or an autism spectrum disorder are not the intended beneficiary group and should not be referred to ACT if they do not have a co-occurring psychiatric disorder. ACT teams shall document written admission criteria that reflect the following medical necessity criteria required for admission:

- a. has a current Diagnostic and Statistical Manual (DSM) 5 (or its successor) diagnosis consistent with a serious and persistent mental illness (SPMI) reflecting the need for treatment and the covered treatment must be medically necessary for meeting the specific preventive, diagnostic, therapeutic, and rehabilitative needs of the beneficiary. Refer to **Subsection 1.1** for the definitions.

AND

- b. has significant functional impairment as demonstrated by **at least one** of the following conditions:
 1. Significant difficulty consistently performing the range of routine tasks required for basic adult functioning in the community (for example, 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; attending to 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 head-of-household responsibilities (such as meal preparation, household tasks, budgeting, or child-care tasks and responsibilities);
or
 3. Significant difficulty maintaining a safe living situation (for example, repeated evictions or loss of housing or utilities);

AND

- c. has one or more of the following problems, which are indicators of continuous high-service needs:
 1. High use of acute psychiatric hospital (2 or more admissions during the past 12 months) or psychiatric emergency services;
 2. Intractable (persistent or recurrent) severe psychiatric symptoms (affective, psychotic, suicidal, etc.);
 3. Coexisting mental health and substance use disorders of significant duration (more than 6 months);
 4. High risk or recent history of criminal justice involvement (such as arrest, incarceration, probation);
 5. Significant difficulty meeting basic survival needs, residing in substandard housing, homelessness, or imminent risk of homelessness;
 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; **or**
 7. Difficulty effectively using traditional office-based outpatient services;

AND

- d. There are no indications that available alternative interventions would be equally or more effective based on North Carolina community practice standards and within the Local Management Entity-Managed Care Organization (LME-MCO) service array.

3.2.1.1 Entrance Process

A comprehensive clinical assessment (CCA) that demonstrates medical necessity must be completed prior to 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 a part of the current CCA. Relevant diagnostic information must be obtained and included in the Person-Centered Plan (PCP). Refer to **Subsection 5.0** for additional entrance process criteria.

3.2.1.2 Continued Stay Criteria

Medicaid and NCHC shall cover a continued stay if 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, history, or the tenuous nature of the functional gains; AND **One** of the following applies:

- a. The beneficiary has achieved current PCP goals and additional goals are indicated as evidenced by documented symptoms;
- b. The beneficiary 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 PCP;
- c. The beneficiary is making some progress, but the specific interventions in the PCP need to be modified so that greater gains, which are consistent with the beneficiary's pre-morbid or potential level of functioning, are possible;
- d. The beneficiary fails to make progress or demonstrates regression in meeting goals through the interventions outlined in the PCP. (In this case, the beneficiary's diagnosis must be reassessed to identify any unrecognized co-occurring disorders, and treatment recommendations should be revised based on the findings); or
- e. If the beneficiary is functioning effectively with this service and discharge would otherwise be indicated, The ACT team services must be maintained when it can be reasonably anticipated that regression is likely to occur if the service is withdrawn. The decision must be based on either of the following:
 1. The beneficiary has a documented history of regression in the absence of ACT team services, or attempts to titrate ACT team services downward have resulted in regression; or

2. There is an epidemiologically sound expectation that symptoms will persist and that ongoing outreach treatment interventions are needed to sustain functional gains.

3.2.1.3 Transition or Discharge Criteria

Beneficiary shall meet at least one of the following:

- a. The beneficiary and team determine that ACT services are no longer needed based on the attainment of goals as identified in the person-centered plan and a less intensive level of care would adequately address current goals;
- b. The beneficiary moves out of the catchment area and the ACT has facilitated the referral to either a new ACT provider or other appropriate mental health service in the new place of primary private residence and has assisted the beneficiary in the transition process;
- c. The beneficiary and, if appropriate, the legally responsible person, choose to withdraw from services and documented attempts by the program to re-engage the beneficiary with the service have not been successful; or
- d. The beneficiary has not demonstrated significant improvement following reassessment and several adjustments to the treatment plan over at least three months and:
 1. Alternative treatment or providers have been identified that are deemed necessary and are expected to result in greater improvement; or
 2. The beneficiary's behavior has worsened, such that continued treatment is not anticipated to result in sustainable change; or
 3. More intensive levels of care are indicated.

ACT team services may be billed for up to 30 days in accordance with the Person-Centered Plan for beneficiaries who are transitioning to or from Community Support Team, Partial Hospitalization, Substance Abuse Intensive Outpatient Program (SAIOP), Substance Abuse Comprehensive Outpatient Treatment (SACOT), Inpatient Hospitalization – refer to concurrent services below.

To make timely and seamless transitions to and from ACT team services, beneficiaries receiving Community Support Team (CST) services and Psychosocial Rehabilitation services (PSR) may continue to receive the case management component of these services for the first and last 30 days of the transition to and from ACT team services in accordance with the PCP. All CST transition activities are performed by the QP or ACT QP.

3.2.1.4 Concurrent Services

The following services may be provided concurrently with ACT services only if deemed medically necessary:

- a. Opioid Treatment;
- b. Detoxification Services;
- c. Facility Based Crisis;
- d. IPS-Supportive Employment of Long-Term Vocational Supports (non-Medicaid reimbursable only);

- e. Clinical need for a specialized acute inpatient or outpatient therapy (i.e. therapy for eating disorders, personality disorders) which the Licensed Professionals may not be trained to provide;
- f. Substance Abuse Residential Treatment; or Adult mental health residential programs (for example, supervised living low or moderate; or group living low, moderate, or high).
- g. Psychosocial Rehabilitation for a 30-day transition period.

Service delivery to individuals other than the beneficiary may be covered only when the activity is directed exclusively toward the benefit of that beneficiary.

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 or NCHC shall not cover procedures, products, and services 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 under ACT activities and these activities may not be billed or considered the activity for which the ACT per diem is billed:

- a. Time spent doing, attending or participating in recreational activities unless tied to specific planned social skill training or other therapeutic interventions related to a PCP goal;
- b. Services provided to teach academic subjects or as a substitute for educational personnel, including a: teacher, teacher's aide or an academic tutor;
- c. Habilitative services for the adult to acquire, retain and improve the self-help, socialization and adaptive skills necessary to reside successfully in community settings;

- d. Childcare services or services provided as a substitute for the parent or other individuals responsible for providing care and supervision.
- e. Respite care;
- f. Transportation for the individual or family. Services provided in a moving car are considered transportation;
- g. Services provided to beneficiaries under age 18;
- h. Covered services that have not been rendered;
- i. Services provided before the MCO (including the Prepaid Inpatient Health Plan) has approved authorization;
- j. Services not identified on the adult's authorized treatment plan;
- k. Services provided without prior authorization by the MCO;
- l. 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 issues and not listed on the eligible beneficiary's treatment plan;
- m. Any art, movement, dance or drama therapies;
- n. Any service not covered in **Section 3.0** of this policy;
- o. Clinical and administrative supervision of staff; or
- p. Individuals with a primary diagnosis of a substance use disorder, or intellectual or developmental disabilities, autism spectrum disorder, personality disorders, or traumatic brain injury.

4.2.1.1 Non-Concurrent Services

The following services must not be provided concurrently with ACT:

- a. Individual, Group, or Family Outpatient;
- b. Outpatient Medication Management;
- c. Outpatient Psychiatric Services;
- d. Mobile Crisis Management;
- e. Psychosocial Rehabilitation after a 30-day transition period;
- f. Community Support Team;
- g. Partial Hospitalization;
- h. Tenancy Support Services;
- i. Nursing home facility, or
- j. Medicaid-funded IPS-Supported Employment or Long Term Vocational Supports.

4.2.2 Medicaid Additional Criteria Not Covered

None

4.2.3 NCHC Additional Criteria Not Covered

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 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."

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 and NCHC shall require prior approval for ACT. The provider shall obtain prior approval before rendering ACT. Prior authorization is required on the first day of this service.

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

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 PCP. Medical necessity is determined by North Carolina community practice standards, as verified by the LME-MCO which will evaluate the request to determine if medical necessity supports more or less intensive services.

Medically necessary services are authorized in the most cost-effective mode, as long as the treatment that is made available is similarly efficacious as services requested by the beneficiary's physician, therapist, or other licensed practitioner. Typically, the medically necessary service must be generally recognized as an accepted method of medical practice or treatment.

Medicaid and NCHC covers 180 calendar days for the initial authorization period based on medical necessity documented on the authorization request form, and supporting documentation. Refer to **Subsection 2.1.2**.

A signed service order must be completed by a physician, licensed psychologist, physician assistant, or nurse practitioner according to his or her scope of practice. Each service order must be signed and dated by the authorizing professional and must indicate the *date* on which the service was ordered. A service order must be in place *prior to* or on the day that the service is initially provided in order to bill Medicaid or NCHC for the service. The service order must be based on a comprehensive clinical assessment of the beneficiary's needs.

The provider shall obtain prior authorization required on the first day of this service. In order to request the initial authorization, the Comprehensive Clinical Assessment, order for medical necessity, and the required NC MEDICAID authorization request form must be submitted to the LME-MCO. A PCP must be completed within 15 days of the initial authorization date. In addition, a completed LME Consumer Admission and Discharge Form must be submitted to the LME-MCO.

Reauthorization

Medicaid and NCHC cover up to 180 calendar days for the reauthorization, based on the medical necessity documented in the PCP, the authorization request form, and supporting documentation. Reauthorization should be submitted prior to initial or concurrent authorization expiring. The expectation is that the majority of ACT beneficiaries receive more than 4 contacts in a given 30-calendar day period, with an expected minimum caseload average (median) of 1.5 contacts per week.

5.3 Limitations or Requirements

- a. A beneficiary can receive ACT services from only one ACT team at a time.
- b. A beneficiary's informed choice over needed services is made when the individual has agreed to be served by an ACT team.

5.4 Service Orders

Service orders are a mechanism to demonstrate medical necessity for a service and are based upon an assessment of each beneficiary's needs. Service order is required for ACT team services, and must be written by a Medical Doctor (MD), Doctor of Osteopathic Medicine (OD), Licensed Psychologist, Nurse Practitioner (NP), or Physician Assistant (PA). All of the following applies to a service order:

- a. Backdating of a 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 day that the service is initially provided in order to bill Medicaid or NCHC for the service. Even if the beneficiary is retroactively eligible for Medicaid the provider cannot bill Medicaid without a valid service order.

Service orders are valid for one year. Medical necessity must be revised, and services must be ordered at least annually, based on the date of the original service order.

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, rehabilitation and recovery, and applies to everyone supported and served in the system. Person-centered planning provides for the beneficiary with the disability to assume an informed and in-command role for life planning and for treatment, service and support options. The beneficiary with a disability, the legally responsible person, or both, direct

the process and share authority and responsibility with system professionals for decisions made.

For all beneficiaries receiving services, it is important to include people who are important in the person's life given the beneficiary's consent, such as family members, the legally responsible person, professionals, friends and other identified by the beneficiary (for example, employers, teachers and faith leaders). These individuals can be essential to the planning process and help drive its success. Person-centered planning uses a blend of paid, unpaid, natural and public specialty resources uniquely tailored to the individual or family needs and desires. It is important for the person-centered planning process to explore and use all these resources.

Before any service can be billed to Medicaid or NCHC, a written CCA and order for medical necessity must be in place. The PCP must be completed within 15 days of the initial authorized start date. When services are provided prior to the establishment and implementation of the plan, strategies to address the beneficiary's presenting problem shall be documented. Information gathered from discussions with the person or family receiving services and others identified by them, along with recommendations and other information obtained from the comprehensive clinical assessment, together provide the foundation for the development of the PCP. **Refer to Attachment B** for effective PCP goal writing guidelines.

If limited information is available at admission, staff shall document on the PCP whatever is known and update it when additional information becomes available.

5.4.1 PCP Reviews and Annual Rewriting

All PCPs must be updated as needed and must be rewritten at least annually. At a minimum, the PCP must be reviewed by the responsible professional based upon the following:

- a. Target date or expiration of each goal. Each goal on the PCP must be reviewed separately, based on the target date associated with it. Short-range goals in the PCP may never exceed 12 months from the Date of Plan;
- b. Change in the beneficiary's needs;
- c. Change in service provider; and
- d. Addition of new service.

5.5 Documentation Requirements

The service record documents the nature and course of a beneficiary's progress in treatment. In order to bill Medicaid or NCHC, providers shall ensure that their documentation is consistent with the requirements contained in this policy.

5.5.1 Responsibility for Documentation

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

- a. The staff person who provides the service shall sign the written entry. The signature must include credentials (professionals) or a job title (associate professional)-
- b. A Qualified Professional (QP) is not required to countersign service notes written by a staff person who does not have QP status.

5.5.2 Contents of a Service Note

More than one intervention, activity, or goal may be reported in one service note, if applicable. For this service, one of the documentation requirements is a full service note for each contact or intervention (for example, counseling, case management, crisis response) for each date of service, written and signed by the person(s) who provided the service, that includes all of the following:

- a. Beneficiary's name;
- b. Medicaid identification number;
- c. Date of service provision;
- d. Name of service provided;
- e. Type of contact;
- f. Place of service;
- g. Purpose of the contact as it relates to the goal(s) on the PCP;
- 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 performing the intervention;
- j. Assessment of the effectiveness of the intervention and the beneficiary's progress towards the beneficiary's goal;
- k. Signature and credentials or job title of the staff member who provided the service; and
- l. Each service note page must be identified with the beneficiary's name Medicaid or NCHC identification number and record number.

Documentation of discharge or transition to lower levels of care must include all of the following:

- a. The reasons for discharge or transition as stated by both the beneficiary and the ACT Team;
- b. The beneficiary's biopsychosocial status at discharge or transition;
- c. A written final evaluation summary of the beneficiary's progress toward the goals set forth in the PCP;
- d. A plan for follow-up treatment, developed in conjunction with the beneficiary; and
- e. The signatures of the beneficiary, the team leader, and the psychiatrist.
- f. A completed LME-MCO Consumer Admission and Discharge Form must be submitted to the LME-MCO.

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

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

To be eligible to bill for procedures, products, and services 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;
- 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

In addition to the qualifications in **Section 6.0** above, the provider(s) shall:

- a. meet the provider qualification policies, procedures, and standards established by the North Carolina Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS);
- b. fulfill the requirements of 10A NCAC 27G;
- c. demonstrate that they meet these standards by being certified by the Local Management Entities-Managed Care Organizations (LME-MCO); and
- d. become established as a legally constituted entity capable of meeting all of the requirements of the Provider Certification, Medicaid Enrollment Agreement, Medicaid Bulletins, and service implementation standards.
- e. comply with all applicable federal and state requirements. This includes the North Carolina Department of Health and Human Services statutes, rules, policies, and implementation updates, Medicaid bulletins, and other published instructions.

ACT team staffing should be clearly indicated, with specific dedicated time and schedules for all ACT team members. ACT team services shall be provided by a team of individuals who have strong clinical skills, professional qualifications, experience, and competency to provide a full breadth of biopsychosocial rehabilitation services. While all staff shall have some level of competency across disciplines, areas of staff expertise and specialization must be emphasized to fully benefit ACT service beneficiaries. Team members strive to offer evidence-based practices, which are clinical and rehabilitation services that have been demonstrated to be effective for beneficiaries with severe and persistent mental illness. Teams must have staff that provides tenancy supports to beneficiaries living independently in the community.

Team staffing is dependent on the program size and the maximum beneficiary to team member ratio (psychiatric care providers and program assistants excluded from ratio calculation). Three program sizes may be implemented: small, mid-size, and large ACT teams.

Program Size:

- a. Small teams serve a maximum of 50 beneficiaries ,with 1 team member per 8 or fewer beneficiaries;
- b. Mid-size teams serve 51-74 beneficiaries, with 1 team member per 9 or fewer beneficiaries; and
- c. Large teams serve 75-120 beneficiaries, with 1 team member per 9 or fewer beneficiaries.

Movement onto (admissions) and off of (discharges) the team may temporarily result in breaches of the maximum caseload. Therefore, teams shall be expected to maintain an annual average not to exceed 50, 74, and 120 beneficiaries, respectively.

Teams in urban locations should implement mid-size to large teams. Teams in more rural locations will likely implement small or mid-size teams as large teams may be impractical in a sparsely populated area.

To ensure appropriate ACT team development, each new ACT team is recommended to titrate ACT intakes (example, 4–6 individuals per month) to gradually build up capacity to serve no more than 100–120 individuals (with a 1:9 ratio) and no more than 42–50 individuals (a 1:8 ratio) for smaller teams.

6.2 Provider Certifications

A tiered certification process for ACT teams is used to both ensure that a minimum level of program fidelity is met by teams and to guide technical assistance and consultation. These tiers define ranges for exceptional practice and provide opportunities for growth for marginal teams through strategic plans for improvement of practice.

TMACT fidelity evaluation certification statuses are outlined in **Table 1** below. Along with the fidelity evaluation rating, teams must meet all the minimum requirements for an ACT team as outlined in this policy. If a new team is implemented, they will receive a TMACT review 6 months post implementation date.

Table 1. Tiered Certification Process for ACT Based on the Tool for Measurement of ACT (TMACT) Total Rating.	
No Certification	TMACT Rating below 3.0
<u>Provisional Certification</u>	TMACT Rating 3.0-3.6
<u>Full Certification</u>	TMACT Rating 3.7-4.2
<u>Exceptional Practice Certification</u>	TMACT Rating 4.3+

- a. **Provisional Certification Level:** ACT teams scoring an overall TMACT fidelity of at least a 3.0 on average.
- b. **Full Certification Level:** ACT teams scoring an overall TMACT fidelity score of at least 3.7.
- c. **Exceptional Practice Certification Level:** ACT teams scoring a TMACT fidelity score of at least 4.3.

Some teams not meeting at least provisional status criteria may be eligible for a follow up TMACT evaluation. The follow up TMACT evaluation must be scheduled within 90 days from the date of the initial final TMACT score. Each team is allowed a maximum of one re-evaluation per TMACT evaluation.

If an ACT team is given the opportunity for a re-evaluation, no more than two MCO staff will be involved in the subsequent TMACT evaluation in addition to the original evaluation team.

In order to qualify for a TMACT re-evaluation the ACT team must meet all of the following criteria:

The ACT team must score between a 2.8 and a 2.94,

Score a minimum of a 3.0 on all of the following areas:

Core Team 1- Team Lead
Core Team 3- Psychiatric Care Provider
Core Team 6- Nursing

AND

Hold daily team meetings five days a week;

AND

Operate the ACT team crisis line.

If an ACT team is granted a re-evaluation and they do not pass the subsequent TMACT, they will not be eligible for an additional re-evaluation. If an ACT team's second score falls below the 3.0 threshold identified in policy, they will not be TMACT certified to provide ACT services.

ACT Services

The ACT team directly provides a full range of biopsychosocial and rehabilitation services to beneficiaries. The interventions and activities, grouped by service domain, include, but are not limited to, those listed in Table 2 below.

Table 2. Interventions and Activities to be Directly Delivered by ACT Teams.

<p><u>Assertive Engagement of beneficiaries</u></p>	<ul style="list-style-type: none"> ● Use collaborative and motivational interventions that promote beneficiaries' development of intrinsic motivation to receive services from the ACT team. ● Use for a short time when collaborative approaches fail and risks are high, therapeutic limit-setting interventions that promote beneficiaries' development of motivation to receive services from the ACT team.
<p><u>Assessment and Service Planning:</u></p>	<ul style="list-style-type: none"> ● Identify or update primary psychiatric and co-occurring disorders, symptoms, and related functional problems, particularly as they relate to impediments to beneficiaries' desired life roles, as a part of the comprehensive clinical assessment as described in the Medicaid State Plan. ● Assess transition readiness on an ongoing basis using standardized tools. ● Update and revise, in partnership with the beneficiary, an individualized, comprehensive, culturally sensitive, goal-oriented Person-Centered Plan. ● Identify individualized strengths, resources, preferences, needs, and goals, and include identified strengths in the treatment plan goals and action steps. ● Create specific and clinically thoughtful interventions to be delivered by the team, which are then cross-walked to a beneficiary weekly/monthly schedule used to guide day-to-day team planning. ● Identify risk factors for harm to self or others. ● Monitor response to treatment, rehabilitation, and support services. ● Develop person-centered, functional crisis plans.

<p><u>Empirically Supported Interventions and Psychotherapy</u></p>	<ul style="list-style-type: none"> • Provide cognitive-behavioral interventions targeting specific psychological and behavioral problems (example, anxiety, psychotic symptoms, emotional dysregulation, and trauma symptoms). • All psychotherapy services shall be provided by a trained, Licensed or Associate Licensed therapist; however basic cognitive-behavioral interventions may be carried out by non-licensed staff with appropriate training and supervision.
<p><u>Family Life & Social Relationships</u></p>	<ul style="list-style-type: none"> • Restore and strengthen the beneficiary’s unique social and family relationships. • Provide psycho-educational services (example, provide accurate information on mental illness & treatment to families and facilitate communication skills and problem solving). • Coordinate with child welfare and family agencies. • Support in carrying out parent role. • Teach coping skills to families in order to support beneficiary’s recovery. • Enlist family support in recovery of the beneficiary. • Facilitate the beneficiary’s natural supports through access to local support networks and trainings, such as NAMI’s Family-to-Family. • Help beneficiaries expand network of natural supports.
<p><u>Health</u></p>	<ul style="list-style-type: none"> • Educate to prevent health problems. • Provide and coordinate medical screening and follow up. • Schedule routine and acute medical and dental care visits, and assist beneficiary in attending these visits. • Sex education and counseling. • Health and nutrition counseling.
<p><u>Housing</u></p>	<ul style="list-style-type: none"> • Assist beneficiaries in obtaining safe, decent, and affordable housing that follows the beneficiary’s preferences in level of independence and location, consistent with an evidenced based Supportive Housing model. • Locate housing options with a focus on integrated independent settings. • Apply for housing subsidies and housing programs. • Assist the beneficiary in developing amicable relationships with local landlords. • Assist the beneficiary in negotiating and understanding the terms of the lease and paying rent and utilities. • Provide tenancy support and advocacy for the beneficiary’s tenancy rights at the individual’s home at least monthly. Examples of these interventions include: utility management, cleaning, and relationships with other tenants and the landlord. • Assist with relocation • Teach skills in purchasing and repairing household items. • Provide tenancy support services to beneficiaries transitioning to the community from institution or congregate settings.
<p><u>Integrated Dual Disorders Treatment for</u></p>	<ul style="list-style-type: none"> • Provide support that is non-confrontational and promotes harm reduction or abstinence, depending on the beneficiary’s stage of change readiness. • Assess stages of change readiness and related stage of treatment.

<p><u>Substance Abuse</u></p>	<ul style="list-style-type: none"> ● Provide outreach and engagement to those in a pre-contemplation or contemplation stage of change readiness. ● Use motivational interviewing for those in a contemplation and preparation phase of change readiness. ● Provide active substance abuse counseling and relapse prevention, using cognitive-behavioral interventions, for those in later stages of change readiness. ● Educate on substance abuse & interaction with mental illness. ● Provide individual & group modalities for dual disorders treatment. ● All staff providing substance abuse treatment must be appropriately registered, certified, or licensed.
<p><u>Medication Support</u></p>	<ul style="list-style-type: none"> ● Use a shared decision-making model in identifying medication needs and preferences. ● Prescription, administration, and ordering of medication by appropriate medical staff. ● Assist the beneficiary in accessing medications. ● Carefully monitor medication response and side effects. ● Educate beneficiaries about medications. ● Help beneficiaries develop ability to take medications with greater independence. ● Assist in medication dispensing for those who require closer medication support.
<p><u>Money Management & Entitlements</u></p>	<ul style="list-style-type: none"> ● Assist beneficiary in gathering documents and completing entitlement and other benefit applications. ● Accompany beneficiaries to entitlement offices. ● Assist with re-determination of benefits. ● Provide financial crisis management. ● Teach budgeting skills and asset development. ● Teach skills in managing food stamps. ● Assist with representative payeeship.
<p><u>Psychiatric Rehabilitation and Assistance with Activities of Daily Living</u></p>	<ul style="list-style-type: none"> ● Provide skill-building, coaching, and access to necessary resources to help beneficiaries with: <ul style="list-style-type: none"> - Personal care - Safety skills - Money management skills - Grocery shopping, cooking, and food safety/storage. - Purchasing and caring for clothing. - Household maintenance and cleaning skills. - Social skills - Using transportation and other community resources.

<p><u>Vocational Services</u></p>	<ul style="list-style-type: none"> • Encouraging and motivating beneficiaries competitive employment, and school as achievable goals. • Identifying and developing interests and skills. • Directly assisting the beneficiary with job development, locating preferred jobs and going through the application process, and talking to employers in alignment with the evidence-based Supported Employment model. • Providing ongoing supports, such as job coaching. • Developing and strengthening relationships with local employers and other vocational support agencies. • Educating employers about available vocational supports and working with individuals with disabilities, such as serious mental illness. • Surveying local employers to identify various work settings and job roles. • Exploring and proposing job carving options with employers. Example, breaking down a job role into multiple job roles with a more limited list of tasks and responsibilities, and Full-Time Equivalent (FTE) requirements. • Finding, enrolling, and supporting participation in school/training programs. • Providing benefits counseling and linkage to SSA work incentives.
<p><u>Wellness Self-Management & Relapse Prevention</u></p>	<ul style="list-style-type: none"> • Educating about mental illness, treatment, and recovery. • Teaching skills for coping with specific symptoms and stress management. • Facilitating the development of a personal crisis management plan, including suicide prevention or psychiatric advance directive. • Developing a relapse prevention plan, including identification/recognition of early warning signs and rapid intervention strategies. • Delivery of manualized wellness management interventions via group and individual work such as Wellness Recovery Action Plans (WRAP) or Illness/Wellness Management and Recovery (IMR/WMR).

6.3 Staffing Requirements

An ACT team shall have sufficient staffing to meet the varying needs of beneficiaries. As an all-inclusive treatment program, a variety of expertise should be represented on the team. ACT team staffing is to be clearly defined and dedicated to the operation of the team. To provide the appropriate level of coverage and services across all beneficiaries, a low beneficiary to staff ratio must be maintained. Staffing requirements are outlined in **Table 1** below, followed by a description of the each team member’s qualifications and roles within the team. For all staff listed, it is expected that the assignment to the team reflects practice in service to the team, including direct care to the beneficiaries.

Table 1. Assertive Community Treatment Team Staffing Level Requirements

	<u>Small Team</u> <u>(Up to 50</u> <u>beneficiaries¹)</u>	<u>Mid-Size Team</u> <u>(Between 51 and 74</u> <u>beneficiaries¹)</u>	<u>Large Team</u> <u>(75 to 120 beneficiaries¹)</u>
<u>Staff to Beneficiary Ratios</u> Includes all team members, except psychiatrists and program assistants.	1 team member per 8 or fewer beneficiaries	1 team member per 9 or fewer beneficiaries	1 team member per 9 or fewer beneficiaries
<u>Team Leader</u> This position is to be occupied by only one person.	One full-time team leader.	One full-time team leader.	One full-time team leader.
<u>Psychiatric Care Provider</u> Prorating of FTE allowed given number of beneficiaries actually served. No more than two psychiatric care providers may assume this role.	<ul style="list-style-type: none"> At least 16 hours each week for 50 beneficiaries, or equivalent if fewer beneficiaries. The psychiatrist works a minimum of eight hours each week, with the Psychiatric Nurse Practitioner (PNP) or Physician Assistant (PA) fulfilling the balance of the requirement given the beneficiary caseload size. 	<ul style="list-style-type: none"> Minimum of 16 hours of psychiatry time for 51 beneficiaries, with an additional 2 hours for every 6 beneficiaries added to the team (example, 20 hours for 63 beneficiaries). Half of the psychiatric care provider time must be fulfilled by a psychiatrist; a PNP, or PA may be employed to fulfill the balance of the requirement given the beneficiary caseload size. 	<ul style="list-style-type: none"> At least 32 hours each week per 100 beneficiaries, or equivalent (example, a team serving 75 beneficiaries are expected to have a minimum of 24 hours of psychiatric care provider time or a team serving 120 consumers are expected to have a minimum of 40 hours of psychiatric care provider). Half of the psychiatric care provider time must be fulfilled by a psychiatrist; a PNP, or PA may be employed to fulfill the balance of the requirement given the beneficiary caseload size.
<u>Nurses</u> Prorating of FTE allowed given number of beneficiaries actually served. No more than two individuals can share a 1.0 FTE.	1.0 FTE Nurse who is an RN or APRN with a minimum of 1 year experience working with adults with serious mental illness and working knowledge of psychiatric medications.	<ul style="list-style-type: none"> 2.0 FTE RNs or APRNs. At least one RN with a minimum of 1 year experience working with adults with serious mental illness and working knowledge of psychiatric medications. The remaining 1.0 nurse can be an RN or LPN 	<ul style="list-style-type: none"> 3.0 FTE Nursing. At least two Nurses are an RN or APRN, with at least one having a minimum of 1 year experience working with adults with serious mental illness and working knowledge of psychiatric medications. The remaining 1.0 nurse can be an RN or LPN.

Table 1. Assertive Community Treatment Team Staffing Level Requirements

	<u>Small Team</u> <u>(Up to 50 beneficiaries¹)</u>	<u>Mid-Size Team</u> <u>(Between 51 and 74 beneficiaries¹)</u>	<u>Large Team</u> <u>(75 to 120 beneficiaries¹)</u>
<u>Substance Abuse Specialist</u> No more than two individuals can share this position.	1.0 FTE with QP status and licensed or certified CCS, LCAS, LCAS-A, CSAC or CADC	1.0 FTE with QP status and licensed or certified CCS, LCAS, LCAS-A, CSAC or CADC	1.0 FTE with QP status and licensed or certified CCS, LCAS, LCAS-A, CSAC or CADC
<u>Peer Specialist</u> No more than two individuals can share this position.	1.0 FTE NC Certified Peer Support Specialist	1.0 FTE NC Certified Peer Support Specialist	1.0 FTE NC Certified Peer Support Specialist
<u>Vocational Specialist</u> This position is to be occupied by only one person.	One full-time AP or QP. Preference for someone who has at least one year experience providing employment services or has advanced education that involved field training in vocational services.	One full-time AP or QP. Preference for someone who has at least one year experience providing employment services or has advanced education that involved field training in vocational services.	One full-time AP or QP. Preference for someone who has at least one year experience providing employment services or has advanced education that involved field training in vocational services.
<u>Dedicated Office-Based Program Assistant</u>	1.0 FTE office-based program assistant solely dedicated to supporting the ACT team.	1.0 FTE office-based program assistant solely dedicated to supporting the ACT team.	1.0 FTE office-based program assistant solely dedicated to supporting the ACT team.
<u>Additional Staff</u> Any additional staffing should reflect the intended program size, number of beneficiaries served, and needs of the team. ²	At least 1 FTE ACT member with QP or AP status.	At least 2.0 FTE ACT team members, with at least one dedicated full-time staff with a Master's Level QP status. Remaining team members may be QP or AP status.	At least 3.0 FTE ACT team members, with at least one dedicated full-time staff with a Master's Level QP status. Remaining team members may be QP or AP status.
<p>¹Movement on to (admissions) and off of (discharges) the team may temporarily result in breaches of the maximum caseload. Therefore, teams will be expected to maintain an annual average not to exceed 50, 74, and 120 beneficiaries, respectively.</p> <p>²Areas of expertise and training may include, for example: supportive housing, psychiatric rehabilitation example., assistance with ADLs, money management, benefits), empirically-supported therapy example., trauma-focused care, CBT for psychosis), family liaison, and forensic and legal issues. If teams are targeting a specific clinical population, it is recommended they hire additional staff reflecting the expertise and training needed for the targeted clinical population (example., a second substance abuse counselor for teams serving primarily beneficiaries with co-occurring substance use disorders).</p>			

6.3.1 Team Leader

The ACT team shall be staffed with one full-time team leader whose primary responsibilities is to provide clinical leadership and oversight, in collaboration with the psychiatric care provider(s), to the ACT program, and supervise and manage the team operations and staffing. The team leader shall be a licensed mental health professional holding any of the following licenses: licensed psychologist, licensed psychological associate, licensed clinical social worker, licensed professional counselor or licensed clinical mental health counselor, licensed marriage and family therapist, licensed psychiatric nurse practitioner, clinical nurse specialist certified as an advanced practice psychiatric clinical nurse specialist.

An associate level licensed professional may serve as the team leader conditional upon being fully licensed within 30 months from the effective date of this policy. For associate level licensed team leaders hired after the effective date of this policy, the 30-month timeline begins at date of hire.

The team leader shall have three years of clinical experience with severe and persistent mental illness, with a minimum of two years post-graduate school.

The full-time Team Leader is responsible for:

- a. overseeing the administrative operations of the team;
- b. providing clinical oversight of services in conjunction with the Psychiatric Care Provider; as well as clinical supervision;
- c. supervising team members to assure the delivery of best and ethical practices;
- d. providing direct services to ACT service beneficiaries, where a therapeutic relationship is developed between ACT service beneficiaries and the Team Leader. Example roles include:
 1. assuming an active role in screening referrals and assessing beneficiaries at intake;
 2. acting as a lead clinician, therefore working closely with a select group of service beneficiaries who can benefit from the Team Leader's clinical expertise;
 3. modeling behaviors through service provision for the purpose of clinical supervision;
 4. participating in person-centered planning meetings; and
 5. working with beneficiary's natural supports.

The Team Leader is exclusively dedicated to the ACT team, with no responsibilities to other roles outside of the ACT team. Only one Qualified Professional shall assume the role as Team Leader. Qualifications are set forth in the above paragraph and in the Division of Medical Assistance Clinical Coverage Policy 8C; the Team Leader shall meet a Qualified Professional status according to 10A NCAC 27G .0104.

6.3.2 Psychiatric Care Provider

The psychiatric care provider's minimal full time equivalent (FTE) is determined by the number of service beneficiaries. Part-time psychiatric care providers shall have designated hours to work on the team, with sufficient blocks of time on consistent days in order to carry out his or her clinical, supervisory, and administrative responsibilities. The role of psychiatric care provider is to be filled by a psychiatrist(s), or shared by a psychiatrist and a nurse practitioner (NP) or a physician assistant (PA) under the supervision of the psychiatrist. No more than two psychiatric care providers may share this role. If a physician extender assumes the provider role part-time, the team psychiatrist must assume at least half of the minimum FTE required given the team size. All psychiatric care providers are to be integrated on the team by providing direct services to the beneficiaries. The specific roles and responsibilities required by the psychiatric care providers cannot be adequately met when relying on telemedicine or telepsychiatry, and therefore are not covered when delivering this community based service.

For teams with two psychiatric care providers, it is expected that each provider meets all of the listed roles and responsibilities.

The ACT team psychiatrist shall be board-eligible or certified by the American Board of Psychiatry and Neurology and Licensed to practice in NC and meet the credentialing and qualifications as specified in NCAC 27G .0104(16).

The ACT team psychiatric nurse practitioner (PNP) shall be currently licensed as a NP in NC and meet the requirements as specified in 21 NCAC 36.0800, approval and practice parameters for nurse practitioners, with at least three years full-time experience treating individuals with SPMI.

The ACT team physician assistant (PA) shall be currently licensed as a PA in NC and must meet the requirements as specified in 21 NCAC 32S.0200 with at least three years full-time experience treating individuals with SPMI.

Psychiatric Care Providers are full members of the team and shall perform the following activities in the community in support of both the beneficiaries and the ACT team staff:

- a. Typically sees the beneficiaries for the assessment and treatment of the beneficiary's symptoms and response to medication including side effects. Frequency will vary for each beneficiary, with the majority seen within 4 to 6 weeks of last appointment, with many of the contacts being in the community. Less frequent visits should only occur when there are unusual circumstances present (for example, when the beneficiary has been difficult to find);
- b. ACT Team psychiatrist provides clinical supervision and oversight of the psychiatric services delivered by the NP or PA. In addition to the other roles listed for the psychiatric care provider, the ACT team psychiatrist provides clinical supervision and oversight of the psychiatric services delivered by the NP or PA;

- c. collaborates with the team leader in sharing overall clinical responsibility for monitoring beneficiary treatment and clinical supervision to the team;
- d. actively collaborates with nurses to develop and implement medication administration policies and procedures as well as oversee the medical care of beneficiaries that include regular screenings for medical conditions and assessment of wellness and health management;
- e. educates non-medical team members on psychiatric & non-psychiatric medications, their side effects, & health-related conditions; provides diagnostic and medication education to beneficiary, with medication decisions based on shared-decision making;
- f. regularly participates in daily team meetings and treatment planning meetings; attends daily team meetings in proportion to time allocated on team;
- g. provides brief therapy (formal or informal); and
- h. provides psychiatric back-up to the program after-hours and weekends. (Note: may be on a rotating basis as long as other psychiatric care providers who share on-call have access to beneficiary's current status and medical records/current medications).

6.3.3 Nurse

An ACT team shall be staffed with one to three registered nurse(s) (RN) or advanced practice registered nurse (APRN), of whom at least one has a minimum of one year experience working with adults with serious mental illness and a working knowledge of psychiatric medications, regardless of team size. Prorating of the Nursing FTE allowed given the number of beneficiaries actually served. No more than two individuals can share a 1.0 FTE. See guidance in Table 1. Assertive Community Treatment Team Staffing Level Requirements for a break down by team size of specific nursing requirements.

Nursing staff are responsible for performing the following key roles, with LPNs responsible for tasks within their scope of practice and under the supervision of an ACT team RN:

- a. manages the medication system in conjunction with the psychiatrist, administers and documents medication treatment;
- b. manages a secure medication room to support the dispensing of medications, which includes both oral and intramuscular psychotropic medications for beneficiaries in need of such support;
- c. screens and monitors the beneficiary for medical problems and side effects;
- d. engages in health promotion, prevention and education activities;
- e. if the beneficiary is in agreement, develop strategies to maximize taking medications as prescribed (example reviewing home environment to find cues to remind beneficiary to take medications; work with beneficiary and psychiatric care provider to scale back the number of times medications are taking each day);
- f. communicating and coordinating services with other medical providers; and
- g. educating the team in monitoring psychiatric symptoms and medication side-effects.

6.3.4 Substance Abuse Specialist

The ACT team shall be staffed with a 1.0 FTE substance abuse specialist who shall meet qualified professional credentials and qualifications according to 10A NCAC 27G .0104(19), and have a designation of certified clinical supervisor, licensed clinical addiction specialist, licensed clinical addiction specialist associate, certified substance abuse counselor or certified alcohol and drug counselor. No more than two substance abuse specialists may occupy this role.

The responsibilities of the substance abuse specialist are as follows:

- a. conducts comprehensive substance abuse assessments considering the relationship between substance use and mental health;
- b. assesses and tracks beneficiary's stages of change readiness and stages of treatment;
- c. uses outreach and motivational interviewing techniques to work with beneficiaries in earlier stages of change readiness;
- d. facilitates access to 12-step groups and other community supports;
- e. uses cognitive behavioral approaches and relapse prevention to work with beneficiaries in later stages of change readiness;
- f. ensures that the team's treatment approaches are consistent with beneficiary's stages of change readiness;
- g. facilitates the Person-Centered Planning process for beneficiaries assigned to him or her; and
- h. serves as a consultant and educator to fellow ACT team members on the topic of integrated dual disorder treatment (IDDT).

6.3.5 Vocational Specialist

A team shall be staffed with a full-time vocational specialist who shall meet either associate professional (AP) according to 10A NCAC 27G (1) or QP status according to 10A NCAC 27G .0104(19). Preference is for someone who has at least 1 year experience **providing** employment services or has advanced education that involved field training in vocational services. The vocational specialist shall provide evidence-based supported employment, also known as the Dartmouth Individual Placement and Support (IPS) model. Vocational specialists should provide direct employment services in a way that is consistent with the eight practice principles of IPS. Vocational specialists should not refer individuals to receive any type of vocational services or linkage by providers outside of the ACT team. For example, referrals to employment placement programs, sheltered workshops, or Psychosocial Rehabilitation. The primary outcome of vocation services is competitive employment, which is defined as jobs that pay at least minimum wage, which anyone can apply for and are not set aside for persons with disabilities. This may include temporary and seasonal jobs.

The responsibilities of the vocational specialist are as follows:

- a. engages the beneficiary on the topic of school or work, particularly competitive employment, educating them about their opportunities and the benefits of working and school;
- b. completes a pre-vocational assessment that is focused on beneficiary's strengths and preferences, and on-the-job assessments, where appropriate;
- c. conducts job development, where the vocational specialist builds relationships with local businesses and educates them about the services that

- the vocational specialist provides, collects information about positions, and ideally determines potential for job carving options;
- d. facilitates individualized job placement according to beneficiary's preferences, per the evidence-based supportive employment model;
 - e. provides job coaching and ongoing supports, assisting the beneficiary in learning the job skills, navigating the work place, managing work relationships with other employees and supervisor;
 - f. provides benefits counseling directly, as well as connects beneficiaries to experts for more extensive benefits counseling as needed; this includes development of SSI/SSDI Work Incentives and NC Medicaid Buy-in: *Health Coverage For Workers With Disabilities*;
 - g. facilitates the Person-Centered Planning process for beneficiaries assigned to him or her; and
 - h. serves as a consultant and educator to fellow ACT team members on the topic of evidence-based supported employment, which is the Individual Placement and Support (IPS-SE) model.

Beneficiaries receiving ACT services shall have immediate access to vocational services from the ACT team. Vocational Specialists on ACT teams shall be the main provider of employment services for ACT beneficiaries and with the support and assistance from all ACT team members (example, all team members may provide ongoing support to beneficiaries who are employed). ACT vocational specialists shall collaborate and consult with IPS-SE Program staff to enhance job development opportunities and business networking opportunities as appropriate. Referrals to the Division of Vocational Rehabilitation Services (DVRS) should only be made to access additional resources or supports that fall outside the scope of the ACT team's responsibility or resources.

6.3.6 Peer Specialist

Each ACT team has at least 1.0 FTE NC Certified Peer Support Specialist. No more than two individuals can share this position. This professional's life experience with mental illness or substance abuse and behavioral health services provides expertise that professional training cannot replicate. To ensure that the experience of the peer specialist is commensurate with those served by ACT, for this position, the individual must have "lived experience" and a personal recovery story specific to primary mental illness. The certified peer support specialist is a fully integrated team member who provides highly individualized services in the community and promotes the self-determination and shared decision-making abilities of beneficiaries. The responsibilities of the Peer Support Specialist are as follows:

- a. Provides coaching, mentoring, and consultation to the beneficiary to promote recovery, self-advocacy, and self-direction;
- b. promotes wellness management strategies, which includes delivering manualized interventions (example, Wellness Recovery Action Planning or Illness Management and Recovery);
- c. assists beneficiaries in developing psychiatric advance directives;
- d. models recovery values, attitudes, beliefs, and personal action to encourage wellness and resilience;

- e. provides consultation to team members to assist in understanding of recovery and the role of the Peer Support Specialists, promoting a culture in which beneficiaries' points of view and preferences are recognized, understood, respected, and integrated into treatment;
- f. serves as an active member of the ACT team, equivalent to other team members, which includes facilitating the Person-Centered Planning process for beneficiaries assigned to him or her if a QP; and
- g. supports and empowers the individual to exercise his or her legal rights within the community.

6.3.7 Additional Staff

The additional clinical staff may include licensed mental health professionals, QP, or an AP. These individuals shall have the knowledge, skills, and abilities required by the population and age to be served to carry out rehabilitation and support functions. Staff who are QPs are responsible for facilitating the person-centered planning process for assigned beneficiaries. Activities of these additional staff may include a range of psychosocial rehabilitative interventions and case coordination tasks. Specialization is encouraged in such areas as: psychiatric rehabilitation; therapy; and additional supports in the areas of substance abuse counseling, housing, and vocational services, etc.

6.3.8 Program Assistant

The full-time office-based program administrative assistant position is assigned to solely work with the ACT team, providing a range of supports to the team including:

- a. organizing, coordinating, and monitoring all non-clinical operations of the ACT Team, including:
 - 1. managing medical records;
 - 2. operating and coordinating the management information system; and
 - 3. maintaining accounting and budget records for beneficiary and program expenditures.
- b. entering and tracking team performance and beneficiary outcome data, as well as running reports on such data;
- c. providing support to the team by receiving calls and responding to office walk-ins, triaging and coordinating communication between the team and individuals; and
- d. actively participating in the daily team meeting, assisting with organizational record-keeping and scheduling activities.

Note: To comply with NC General Assembly Session Law 2019-240 Senate Bill 537, licensure name for Licensed Professional Counselor (LPC) is amended to Licensed Clinical Mental Health Counselor (LCMHC) and certification name for Certified Substance Abuse Counselor (CSAC) is amended to Certified Alcohol and Drug Counselor (CADC). Policy amendment(s) will be effective the date the related rule Change for 10A NCAC 27G is finalized.

6.4 Staff Training and Supervision Requirements

ACT services shall be provided by a team of individuals who have strong clinical skills, professional qualifications, experience, and competency to provide the range of practices.

All ACT team members are expected to receive initial and ongoing training in core and evidence-based practices that support the implementation of ethical, person-centered, high-fidelity ACT practice, as defined in the required fidelity model.

Each ACT team staff member shall successfully complete the DHHS approved training in high-fidelity ACT, Crisis Response, brief Motivational Interviewing, and Person-Centered Thinking. QP staff responsible for PCP development shall complete “PCP Instructional Elements” training. The substance abuse specialist(s) shall participate in training in integrated dual disorder treatment. The vocational specialist shall participate in training in the Individual Placement and Support (IPS) model of supported employment. The primary team member responsible for delivering tenancy support services shall complete the DHHS approved Tenancy Support training. All these trainings must be completed within the first 120 calendar days of the team member’s date of hire.

These initial training requirements may be waived if the employee can produce written documentation certifying their successful completion of the required trainings within the past 12 months.

For each year of employment, each ACT team member (excluding the program assistant) shall receive additional three hours of training in an area that is fitting with their area of expertise, which they then, in turn, cross-train their fellow team members. This additional training may be in the form of locally provided training, online workshops, or regional or national conferences. Cross-training would involve relatively brief (example, 20 minutes), topic-focused lessons shared with fellow team members.

Broader topics of additional training may include:

- a. Benefits counseling;
- b. Cognitive behavioral therapy for psychosis;
- c. Critical Time Intervention;
- d. Culturally and Linguistically Appropriate Services (CLAS) ;
- e. DHHS Approved Individual Placement and Support- Supported Employment;
- f. Family Psychoeducation;
- g. Functional assessments and psychiatric rehabilitation;
- h. Integrated Dual Disorders Treatment;
- i. Limited English Proficiency (LEP), blind or visually impaired, and deaf and hard of hearing accommodations;
- j. Medication algorithms;
- k. NAMI Psychoeducational trainings;
- l. Psychiatric advanced directives;
- m. Recovery Oriented Systems of Care: policy and practice;
- n. SOAR (SSI/SSDI Outreach, Access and Recovery) Stepping Stones to Recovery;
- o. Permanent Supportive Housing, such as the SAMHSA evidenced based practices toolkit, Housing First: The Pathway’s Model to End Homelessness for People with Mental Illness and Addiction, and other evidenced based models;
- p. Trauma-informed care;
- q. Wellness and integrated healthcare;
- r. Wellness management and recovery interventions (includes WRAP, IMR/WMR);
and
- s. Supervising NC Certified Peer Support Specialists.

t. DHHS Approved Tenancy Supports

The team leader shall maintain documentation of both supervision and training activities, including cross-training activities.

All team members shall receive ongoing clinical supervision from ACT team clinical leadership, with the ACT team leader as the primary clinical supervisor. The majority of team members shall receive scheduled clinical supervision bi-weekly, either in individual or group format; no staff shall go without a supervision session in a given month in accordance with Administrative Publication System Manual 30-01 (APSM).

Clinical Supervision is the provision of guidance, feedback, and training to team members to assure that quality services are provided to beneficiaries (example following evidence-based practices, negotiating ethical quandaries, managing transference and counter transference) and maintaining and facilitating the supervisee's competence and capability to best serve beneficiaries in an effective manner. Clinical supervision is a critical factor in determining the appropriate acquisition of evidence-based practices by supervised staff.

The following clinical supervision may be delivered within ACT:

- a. Meeting as a group (separately from the daily team meeting) or individually to discuss specific clinical cases;
- b. Field mentoring (example, helping staff by going out in the field with them to teach, role model skills, and providing feedback on skills);
- c. Reviewing and giving feedback on the specific tools example, the quality of assessments, treatment plans, progress notes) to better capture and document clinical content);
- d. Didactic teaching and individual and group cross-training; and
- e. Formal in-office individual supervision (includes both impromptu and scheduled supervision).

6.5 Daily Team Meeting

The daily team meeting is the central hub of communication for ACT team staff, sharing recent assessment information and planning for the day's activities. Daily team meetings (Monday-Friday) allow ACT staff to systematically update information, briefly discuss beneficiary status over the past 24 hours, problem-solve emerging issues, and plan approaches to address and prevent crises. This critical organizational meeting is also used to plan the service contacts for the following 24 hour period or weekend according to the PCPs, ensuring that all beneficiaries receive the best possible services with continuity. All team members shall prioritize this meeting, with full attendance on all or most days. There must be a reliable communication mechanism in place to relay important information to team members not present during that day or shift.

The ACT team shall use its daily team meeting to accomplish the following:

- a. Conduct a brief, but clinically relevant, review of significant events or change in status of all beneficiaries in the past 24 hours and record status of all beneficiaries.
 1. A Beneficiary Log is maintained that succinctly documents important clinical information (example, whether a beneficiary was seen or attempted to be seen, by whom, notable comments about symptoms, functioning, medication,

- intervention, and response to intervention) and housing status and housing issues to serve as a snapshot of care, it is recommended the Beneficiary Log should be organized by beneficiary for each month.
2. Develop a Daily Team Schedule for the day's contacts based on a central file of beneficiaries' weekly or monthly schedules, which are derived from interventions specified within the person-centered plans. The Daily Team schedule is flexible.
 - b. Assistance with a beneficiary's emerging needs and planned proactive contacts to prevent future crises are also worked into the schedule. A process must be in place to assure that planned activities are carried out or, if not, are rescheduled.
 - c. The Team Leader shall assume a leadership role within the daily team meeting, guiding the direction and pace of the discussion. If more extensive conversation and planning are needed in regard to a specific beneficiary, the Team Leader directs relevant team members to convene to assess and plan following the team meeting. All team members share responsibility in conducting the roll call, maintaining the Log, and creating the Daily Team Schedule.

6.6 Nature and Intensity of ACT Services

Team Approach

To effectively meet the varying needs of beneficiaries and mitigate the effects of staff turnover, ACT uses a team approach to delivering services. All ACT team members shall know all beneficiaries, but not all team members necessarily work closely with all beneficiaries. To achieve desired beneficiary outcomes, interventions must be carried out with consistency and following empirically-supported practices, and within the context of strong therapeutic relationships. Each beneficiary is assigned to work more closely with a select group of team members, determined by a variety of factors, including team members' expertise and skills, rapport, and other factors specific to beneficiary preferences. In using an individualized treatment team approach, it is expected that the majority of beneficiaries shall see at least 3 team members in a given month.

Meeting with multiple team members also helps increase the chances that beneficiaries will receive the range of services needed for recovery; including Supported Employment, Illness Management/Recovery, and other vital services. It also means that when some staff are on vacation or otherwise away from work, there are team members who know the beneficiary well and can respond promptly and effectively to service needs. It is highly recommended that ACT beneficiaries meet with a select group of team members each month as a result of careful team member assignment given the interventions identified in the person-centered plan.

Beneficiaries meeting with a high number of team members (example, 6 or more) in a month are less likely to develop necessary therapeutic relationships and receive consistent care (the exception here is when a beneficiary requires a high level of team monitoring, the entire team often shares responsibility due to the resources required).

Assertive Engagement and Organizational Boundaries

Providers shall make an effort to engage beneficiaries in services. Efforts to engage beneficiaries are not limited to the initial treatment phase. Engagement is a fluid, on-going process that extends throughout a beneficiary's relationship with the ACT team. Engagement strategies are individualized, well planned, and based on input from a variety of sources.

The input of family members, natural supports, and previous and subsequent treatment providers is essential in developing engagement strategies that can effectively reach the beneficiary. Specifically, ACT Teams shall:

- a. Include the beneficiary in the admission, initial assessment, and initial planning process as the primary stakeholder;
- b. Include beneficiary's identified family, natural supports, and others as identified by the beneficiary;
- c. Meet with the beneficiary in his or her environment at times of the day/week that honors the beneficiary's preferences; and
- d. Meet beneficiaries at home and in jails or prisons, streets, homeless shelters, or hospitals.

Retention of beneficiaries is a high priority for ACT. ACT teams shall ensure that a process is in place for identifying beneficiaries in need of more or less assertive engagement. Interventions are monitored to determine the success of these techniques, and the need to adapt the techniques or approach accordingly.

Service Frequency and Duration

ACT beneficiaries have varying needs and the ACT team is the sole provider of the services to address those needs. Therefore, a high level of service is required reflecting crisis response, maintenance, and rehabilitation and growth-oriented interventions.

ACT is a flexible service provided in an individualized manner. As such, service frequency and intensity will vary across beneficiaries. However, when considering caseload averages, the team must see beneficiaries, on average, 1.5 times per week and for at least 60 minutes per week. For the purpose of ACT program fidelity monitoring, of interest is the *median rate* of service frequency and the *median rate* of service intensity.

To calculate the median rate of service frequency the mean number of face-to-face contacts the team has with a given beneficiary in a week is calculated by totaling the number of such contacts in a 4-week period and dividing by 4. The weekly averages (means) across all beneficiaries are then rank-ordered low to high, and the middle beneficiary is selected to represent all beneficiaries.

It is expected that additional face-to-face and phone contacts are made with beneficiaries, their natural supports, and other providers on their behalf (example, inpatient hospital staff, landlord, residential staff).

6.7 Monitoring

6.7.1 ACT Program Fidelity Monitoring

Programs operating ACT teams must be evaluated according to a standardized fidelity measure to evaluate the extent to which defining elements of the program model are being implemented. The Tool for Measurement of ACT (TMACT; Monroe-DeVita, Moser, & Teague, 2011), or its successor as approved by DHHS, must be used to evaluate teams. The aim of these evaluations is not only to ensure that the model is being implemented as intended, but also to provide a mechanism for quality improvement feedback and guided consultation.

DHHS shall track adherence to the ACT model and determine annual ACT performance outcomes from teams through their participation in the administration of the most current ACT fidelity assessment.

6.7.2 Expected Clinical Outcomes

Given the provision of High-Fidelity ACT team services, it is expected that beneficiaries will reduce the amount of time spent in institutional settings and become more integrated within their own community. To provide a standardized mechanism for ACT teams to track beneficiary outcomes, which can then guide their own performance initiatives; teams will be required to regularly submit data through the ACT Monitoring Application. The data submitted will include:

- a. Beneficiary satisfaction;
- b. Increased adherence to treatment/service plan;
- c. Vocational/educational gains;
- d. Increased length of stay in community residence;
- e. Increased use of natural supports;
- f. Reduced utilization of inpatient level of support;
- g. Improved physical health;
- h. Increased use of wellness self-management and recovery tools; and
- i. Increased use of community living settings and supports.

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 NC Medicaid's clinical (medical) coverage policies, guidelines, policies, provider manuals, implementation updates, and bulletins published by the Centers for Medicare and Medicaid Services (CMS), DHHS, its divisions or its fiscal agent.

7.2 Audits and Compliance Reviews

DMHDDSAS and NC Medicaid (DHHS team) jointly conduct annual audits of a sample of Medicaid and NCHC funded mental health, developmental disabilities, and substance abuse services. The purpose of the audit is to ensure that these services are provided to Medicaid and NCHC beneficiaries in accordance with federal and state regulations and that the documentation and billing practices of directly enrolled providers demonstrate accuracy and integrity. It is a quality control process used to ensure that medical necessity has been determined and to monitor the quality of the documentation of services provided (in accordance with the authorities listed in **Subsection 7.3** of this policy). The LME-MCO may also conduct compliance reviews and monitor provider organizations under the authority of NC Medicaid.

Any deficiencies identified in an audit are forwarded to NC MEDICAID's Program Integrity Section, with all of the following information:

- a. A report of finding that summarizes the issues identified;
- b. Time period covered by the review;
- c. Type of sampling, and
- d. Copies of supporting documentation, showing the specific billing errors identified in the audit and including the beneficiary's name, Medicaid or NCHC identification number, date(s) of service, procedure code, number of units billed in error, and reason for error.

Refunds or request for withholding from future payments must be sent to:

Office of Controller
NC Medicaid Accounts Receivable
2022 Mail Service Center
Raleigh, NC 27699-2022

8.0 Policy Implementation and History

Original Effective Date: Month Day, Year

History:

Date	Section or subsection Revised	Change
08/01/2015	All sections and attachment(s)	Service definition for Assertive Community Treatment removed from policy 8A, to become a stand-alone clinical coverage policy, 8A-1, <i>Assertive Community Treatment (ACT) Program</i> . Policy documents current coverage of ACT services from the Department of Justice settlement, and for adherence to TMACT fidelity.
10/01/2015	All Sections and Attachments	Updated policy template language and added ICD-10 codes to comply with federally mandated 10/1/2015 implementation where applicable.
10/01/2015	Subsection 2.1.2	Corrected age range error to read, “Medicaid shall cover ACT services for an eligible beneficiary 18 years of age and older ...” The eligibility cap of 18-64 was made in error.
10/01/2015	Subsection 5.4	“Department of Mental Health, Developmental Disabilities and Substance Abuse Services,” changed to “Division of Mental Health, Developmental Disabilities and Substance Abuse Services.
10/01/2015	Section 6.2	Changed “service definition” to “policy.”
12/01/2015	Subsection 3.2.1	Changed e.g. to example and deleted a strikethrough that was inadvertently left in the policy.
12/01/2015	Subsection 5.2.2	Deleted a strikethrough that was inadvertently left in the policy.
12/01/2015	Subsection 5.4	The following sentence was deleted because it referenced another Division’s manual, “Refer to the Person-Centered Planning Instruction Manual (http://www.ncdhhs.gov/mhddsas/statspublications/Manuals/pcp-instructionmanual2-3-10.pdf) and the Records Management and Documentation Manual at (http://www.ncdhhs.gov/mhddsas/providers/recordsmanagement/resources.htm) for more detailed information.”
12/01/2015	Subsection 5.4.1	The following sentence was deleted because it referenced another Division’s manual, “Refer to the Person-Centered Planning Instruction Manual (http://www.ncdhhs.gov/mhddsas/statspublications/Manuals/pcp-instructionmanual2-3-10.pdf) and the Records Management and Documentation Manual at (http://www.ncdhhs.gov/mhddsas/providers/recordsmanagement/resources.htm) for more detailed information.”

Date	Section or subsection Revised	Change
12/01/2015	Subsection 5.5	The following sentence was deleted because it referenced another Division’s manual, “Refer to the DMHDDSAS Person-Centered Planning Instruction Manual, (http://www.ncdhhs.gov/mhddsas/statpublications/Manuals/pcp-instructionmanual2-3-10.pdf) and the DMHDDSAS Records Management and Documentation Manual (http://www.ncdhhs.gov/mhddsas/providers/recordsmanagement/resources.htm) for specific information.”
12/01/2015	Section 5.5.2	The following sentence was deleted because it referenced another Division’s manual, “Refer to DMA Clinical Coverage Policies and the DMH/DD/SAS <i>Records Management and Documentation Manual</i> for a complete listing of documentation requirements.”
12/01/2015	Subsection 6.1	Changed e.g. to example
12/01/2015	Subsection 6.2	Table 2 under Empirically Supported Interventions and Psychotherapy, changed e.g. to example; under under Family Life and Social Relationships changed e.g. to example; and under Vocational Services changed e.g. to example.
12/01/2015	Subsection 6.3	Table 1, Mid-Size Team, changed e.g. to example and under Large Team changed e.g. to example. Under footnote section of the table changed e.g. to example
12/01/2015	Subsection 6.3.1	Removed a strikethrough that was inadvertently left in the policy.
12/01/2015	Subsection 6.3.3	Changed e.g. to example.
12/01/2015	Subsection 6.3.5	Deleted “and” and left “or” from the sentence, “Preference is for someone who has at least 1 year experience providing employment services and/or has advanced education that involved field training in vocational services.” Changed e.g. to example.
12/01/2015	Subsection 6.3.4	Moved sentence, “The substance abuse specialist(s) shall participate in training in integrated dual disorder treatment” to Section 6.4 Staff Training and Supervision Requirements.
12/01/2015	Subsection 6.3.6	Changed e.g. to example.
12/01/2015	Section 6.4	The sentence, “The vocational specialist shall participate in training in the Individual Placement and Support (IPS) model of supported employment” was inadvertently left out and has been placed back into the policy as approved by PAG on July 25, 2013. Changed e.g. to example Deleted “or” and left “and” in the sentence, “Didactic teaching and/or individual and group cross-training;”

Date	Section or subsection Revised	Change
12/01/2015	Subsection 7.3	The following subsection was deleted because it referenced another Division’s manual, “The following resources, and the rules, manuals, and statutes referenced in them, give the Division of Mental Health, Developmental Disabilities and Substance Abuse Services the authority to set the requirements included in the DMHDDSAS Records Management and Documentation Manual at (http://www.ncdhhs.gov/mhddsas/providers/recordsmanagement/resources.htm), APSM 45-2 and DMHDDSAS Person-Centered Planning Instruction Manual (http://www.ncdhhs.gov/mhddsas/statspublications/Manuals/pcp-instructionmanual2-3-10.pdf).”
04/12/2016	Subsection 3.2.1	Removed highlight and underline that was inadvertently left in during policy revision.
11/15/2018	Subsection 6.3.2	Removed the term “board eligible” and replaced with “board-certified.” Effective 2012, the Board of Psychiatry and Neurology stopped using the term "board eligible".
04/12/2016	Subsection 6.3.2	Reverted wording to 04/12/2016 version. “Board certified” changed back to “board-eligible or certified.” Policy posted on 12/05/2018 with an Amended/Effective Date of April 12, 2016.
03/15/2019	Table of Contents	Added, “To all beneficiaries enrolled in a Prepaid Health Plan (PHP): for questions about benefits and services available on or after November 1, 2019, please contact your PHP.”
03/15/2019	All Sections and Attachments	Updated policy template language.
12/15/2019	Attachment A	Added: Note: North Carolina Medicaid and North Carolina Health Choice will not reimburse for conversion therapy.
12/15/2019	Attachment A	Added, “Unless directed otherwise, Institutional Claims must be billed according to the National Uniform Billing Guidelines. All claims must comply with National Coding Guidelines.
12/15/2019	Table of Contents	Updated policy template language, “To all beneficiaries enrolled in a Prepaid Health Plan (PHP): for questions about benefits and services available on or after implementation, please contact your PHP.”
<u>10/01/2020</u>	<u>Section 5.4</u>	<u>Removed misplaced PCP reference from Service Orders section.</u>
10/01/2020	Section 6.3	Added “CADC” [Certified Alcohol and Drug Counselor] to Table 1 to comply with NC General Assembly Session Law 2019-240 Senate Bill 537. Policy amendment(s) will be effective the date the related rule change for 10A NCAC 27G is finalized.
10/01/2020	Subsection 6.3.1	Added “licensed clinical mental health counselor” to comply with NC General Assembly Session Law 2019-240 Senate Bill 537. Policy amendment(s) will be effective the date the related rule change for 10A NCAC 27G is finalized.
10/01/2020	Subsection 6.3.4	Added “certified alcohol and drug counselor” to comply with NC General Assembly Session Law 2019-240 Senate Bill 537. Policy amendment(s) will be effective the date the related rule change for 10A NCAC 27G is finalized.

Date	Section or subsection Revised	Change
10/01/2020	Subsection 6.3.8	Added "Note: To comply with NC General Assembly Session Law 2019-240 Senate Bill 537, licensure name for Licensed Professional Counselor (LPC) is amended to Licensed Clinical Mental Health Counselor (LCMHC) and certification name for Certified Substance Abuse Counselor (CSAC) is amended to Certified Alcohol and Drug Counselor (CADC). Policy amendment(s) will be effective the date the related rule Change for 10A NCAC 27G is finalized."

Attachment A: Claims-Related Information

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

A. Claim Type

Professional (CMS-1500/837P transaction)

Unless directed otherwise, Institutional Claims must be billed according to the National Uniform Billing Guidelines. All claims must comply with National Coding Guidelines.

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

Provider(s) shall report the ICD-10-CM and Procedural Coding System (PCS) to the highest level of specificity that supports medical necessity. Provider(s) shall use the current ICD-10-CM 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.

HCPCS Code	Billing Unit
H0040	1 unit =1 event

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

The provider(s) shall report the appropriate code(s) used which determines the billing unit(s).
1 Unit = 1 event.

Billing Guidance: ACT per diems may only be billed on days when the ACT team has performed a face-to-face service with the beneficiary or a family member. Collateral contacts shall only account for up to 25 % of the team’s time. Only one per diem may be billed per beneficiary per

day. All other contacts, meetings, travel time, etc. is considered indirect costs and is accounted for in the buildup of the per diem rate.

For per diem rate to be generated, a 15-minute face-to-face contact that meets all requirements outlined below must occur. A 15-minute contact is defined as lasting at least 8 minutes.

Practitioners may not bill for services included in the ACT per diem (H0040) and also bill for the that service outside of the per diem rate for beneficiaries enrolled in ACT. Licensed direct care staff shall provide services within the scope of practice for their license.

F. Place of Service

A fundamental feature of ACT is that services are taken to the beneficiary in his or her natural environment, rather than having the beneficiary come into an office or clinic setting to receive services. Three reasons for this fundamental feature of the ACT model include:

1. Individuals who are appropriate for ACT may not elect to or may be unable to consistently seek out care on his or her own accord;
2. Interventions will be more effective when delivered within the beneficiary's natural environment, where learned skills are applicable within the immediate setting; and
3. Team members gather critical assessment data while in the field.

Natural settings include: a beneficiary's primary private residence (home), place of recreation or socialization, place of work or school, or the street. Delivering services to a beneficiary's natural environment must be done in a respectful manner (example, team members shall not appear at the beneficiary's place of work without receiving permission to do so beforehand).

Note: For Medicaid beneficiaries, ACT team services cannot be provided in an Institute for Mental Diseases (IMD) (for adults) or in a public institution (example, jail, detention center, or prison). For ACT, the case management component may be billed when provided 30 days prior to discharge when a beneficiary resides in a general hospital or psychiatric inpatient setting and retains Medicaid eligibility.

ACT teams shall provide the majority of services to beneficiaries in the community. **On average, 75% of face-to-face service contacts shall be provided in the community** (non-office-based or non-facility-based settings). For the purpose of ACT program fidelity monitoring, of interest is the *median rate* of community-based services. To calculate the median, the number of face-to-face contacts in the community is divided by the total number of face-to-face contacts, for each beneficiary in a given month. Beneficiaries' community-based service percentages are rank-ordered low to high, and the middle beneficiary is selected to represent all beneficiaries.

Hours of Operation

ACT teams are available to beneficiaries 24 hours a day, 7 days a week, and 365 days a year. ACT Teams shall have an office open 8 hours per day, Monday through Friday, for walk-ins and calls with extended hours based on the needs of the beneficiaries receiving services. Planned services must be available seven days per week.

Delivery of Planned Services

Typically, only one to three ACT team members may be needed to cover the extended afternoon and early evening hours. Team members shall flex their opening and closing hours appropriate to each beneficiary's needs at that time (example, if a beneficiary is in need of evening medication monitoring for a limited time, the team makes arrangements to provide such monitoring; if a beneficiary needs vocational supports in the evening, the team shall make arrangements to provide such supports).

Services are expected to be provided over the weekend, including medication monitoring, rehabilitation services, and all other applicable ACT team services. Services shall be provided over holidays, with these services typically consisting of basic coverage for those beneficiaries who may need more intensive crisis response stabilization or medication management.

Crisis Response

ACT team members shall provide "first responder" crisis response 24 hours a day, 7 days a week, and 365 days a year to beneficiaries experiencing a crisis.

1. Team members shall directly receive all crisis calls from beneficiaries without routine triaging by a third party.
2. Team members who are on-call shall have access to necessary information, such as all beneficiaries' crisis plans.
3. Many crisis calls will likely be handled on the phone directly with the beneficiary or coordinating with other providers or natural supports (example hospital staff, residential workers, housing provider, and family members).
4. As needed, licensed team members shall be available to provide on-site assessment, de-escalation, and follow-up.
5. Psychiatric coverage shall be available 24 hours per day. It is also necessary to arrange for and provide psychiatric back-up for all hours that the psychiatric care provider is not regularly scheduled to work.

G. Co-payments

For Medicaid refer to Medicaid State Plan:

<https://medicaid.ncdhhs.gov/get-involved/nc-health-choice-state-plan>

For NCHC refer to NCHC State Plan:

<https://medicaid.ncdhhs.gov/get-involved/nc-health-choice-state-plan>

H. Reimbursement

Provider(s) shall bill their usual and customary charges.

For a schedule of rates, refer to: <https://medicaid.ncdhhs.gov/>

A qualified provider who renders services to a Medicaid beneficiary shall bill all other third-party payers, including Medicare, before submitting a claim for Medicaid reimbursement.

Note: North Carolina Medicaid and North Carolina Health Choice will not reimburse for conversion therapy.

Attachment B: 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 or 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, 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
- c. 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 C: Documentation—Best Practice Guidelines

Services that are billed to Medicaid or NCHC must comply with Medicaid and NCHC reimbursement guidelines, and all documentation must relate to goals in the beneficiary's PCP. 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 or rehabilitation. Document pertinent findings, services rendered, changes in the beneficiary's condition, and response to treatment or rehabilitation, as appropriate. Include justification for initial services as well as continued treatment or rehabilitation needs. Document reasons for any atypical treatment or rehabilitation utilized.
- g. **Clear**—recording meaningful information, particularly for other staff involved in the care or treatment of the individual. **Write in non-technical terms** to the extent possible.