

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.

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Related Clinical Coverage Policies

Refer to <https://medicaid.ncdhhs.gov/> for the related coverage policies listed below:

1.0 Description of the Procedure, Product, or Service

Community Support Team (CST) provides direct support to adults with a Diagnostic and Statistical Manual of Mental Disorders Fifth Edition (DSM-5) diagnosis of mental illness, substance use, or co-morbid disorder and who have complex and extensive treatment needs. This service consists of community-based mental health and substance use services, and structured rehabilitative interventions intended to increase and restore a beneficiary's ability to live successfully in the community. The team approach involves structured, face-to-face therapeutic interventions that assist in reestablishing the beneficiary's community roles related to the following life domains: emotional, behavioral, social, safety, housing, medical and health, educational, vocational, and legal.

This is an intensive community-based rehabilitation team service that provides direct treatment and restorative interventions as well as case management. CST is designed to provide:

- a. symptom stability by reducing presenting psychiatric or substance use disorder symptoms;
- b. restorative interventions for development of interpersonal, community, coping and independent living skills;
- c. psychoeducation;
- d. first responder intervention to deescalate a crisis; and
- e. service coordination and ensure linkage to community services and resources.

This team service consists of a variety of interventions available 24-hours-a-day, 7-days-a-week, 365-days-a-year, and delivered by the CST staff, who maintain contact and intervene as one organizational unit. CST services are provided through a team approach, however discrete interventions may be delivered by any one or more team members if clinically indicated. Not all team members are required to provide direct intervention to each beneficiary on the caseload. The Team Lead shall provide direct clinical interventions with each beneficiary.

1.1 Definitions

None

2.0 Eligibility Requirements

2.1 Provisions

2.1.1 General

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

- a. An eligible beneficiary shall be enrolled in either:
 1. the NC Medicaid Program (*Medicaid is NC Medicaid program, unless context clearly indicates otherwise*); or
 2. the NC Health Choice (*NCHC is NC Health Choice program, unless context clearly indicates otherwise*) Program on the date of service and shall meet the criteria in **Section 3.0 of this policy**.

- b. Provider(s) shall verify each Medicaid or NCHC beneficiary's eligibility each time a service is rendered.
- c. The Medicaid beneficiary may have service restrictions due to their eligibility category that would make them ineligible for this service.
- d. Following is only one of the eligibility and other requirements for participation in the NCHC Program under GS 108A-70.21(a): Children must be between the ages of 6 through 18.

2.1.2 Specific

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

a. Medicaid

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

Retroactively eligible beneficiaries are entitled to receive Medicaid covered services and to be reimbursed by the provider for all money paid during the retroactive period except for any third-party payments or cost-sharing amounts. The qualified provider may file for reimbursement with Medicaid for these services.

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

b. NCHC

NCHC shall cover Community Support Team services for an eligible beneficiary who is 18 years of age till he or she reaches their 19th birthday and meets the criteria in **Section 3.0** of this policy.

Retroactive eligibility does not apply to the NCHC program.

2.2 Special Provisions

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

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

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

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

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

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

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

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

b. EPSDT and Prior Approval Requirements

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

NCTracks Provider Claims and Billing Assistance Guide:

<https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html>

EPSDT provider page: <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 an NCHC beneficiary who does not meet the criteria within **Section 3.0** of this policy. Only services included under the NCHC State Plan and the NC Medicaid clinical coverage policies, service definitions, or billing codes are covered for an NCHC beneficiary.

3.0 When the Procedure, Product, or Service Is Covered

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

3.1 General Criteria Covered

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

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

3.2 Specific Criteria Covered

3.2.1 Specific criteria covered by both Medicaid and NCHC

Medicaid and NCHC shall cover Community Support Team (CST) when ALL following criteria are met:

- a. The beneficiary has a mental health or substance use disorder (SUD) diagnosis as defined by the DSM-5, or any subsequent editions of this reference material, other than a sole diagnosis of intellectual and developmental disability;
- b. There is documented, significant impairment in at least two of the life domains (emotional, social, safety, housing, medical or health, educational, vocational, and legal). This impairment is related to the beneficiary's diagnosis and impedes the beneficiary's use of the skills necessary for independent functioning in the community;
- c. For a beneficiary with a primary substance use disorder diagnosis, the American Society for Addiction Medicine Criteria Level I or higher level is met;
- d. The beneficiary is capable of developing skills to manage symptoms, make behavioral changes, and respond favorably to therapeutic interventions; and there is no evidence to support that alternative interventions would be more effective, based on North Carolina community practice standards; and
- e. Two or more of the following conditions related to the diagnosis are present:
 1. The beneficiary requires active rehabilitation and support services to achieve the restoration of functioning and community integration and valued life roles in social, employment, daily living, personal wellness, educational or housing domains;
 2. Deterioration in functioning in the absence of community-based services and supports would lead to hospitalization, other long-term treatment setting or congregate care, such as adult care or assisted living;
 3. The beneficiary's own resources and support systems are not adequate to provide the level of support needed to live safely in the community;

4. One or more admissions in an acute psychiatric hospital or use of crisis or emergency services per calendar year, or a hospital stay more than 30-calendar days within the past calendar year;
5. Pending discharge (less than 30-calendar days) from an adult care home, acute psychiatric hospital, emergency department or other crisis setting;
6. Traditional behavioral health services alone, are not clinically appropriate to prevent the beneficiary's condition from deteriorating (such as missing office appointments, difficulty maintaining medication schedules);
7. Legal issues related to the beneficiary's mental or substance use disorder diagnosis;
8. Homeless or at high risk of homelessness due to residential instability resulting from the beneficiary's mental health or substance use disorder diagnosis or has difficulty sustaining a safe stable living environment; or
9. Clinical evidence of suicidal gestures, persistent ideation, or both in past three months.

Admission Criteria

A comprehensive clinical assessment (CCA) is completed by a licensed clinician that meet the criteria included in 10A NCAC 27G. 0104 (12). The CCA demonstrates medical necessity must be completed prior to the provision of this service. If a substantially equivalent assessment is available, reflects the current level of functioning, and contains all the required elements as outlined in community practice standards as well as in all applicable federal and state requirements, it may qualify as a current CCA. Relevant diagnostic information must be obtained and documented in the beneficiary's Person-Centered Plan (PCP).

Continued Stay Criteria

- a. The desired outcome or level of functioning has not been restored, improved, or sustained over the time frame outlined in the beneficiary's PCP; or the beneficiary continues to be at risk for relapse based on current clinical assessment, and history, or the tenuous nature of the functional gains; and
- b. ONE of the following applies:
 1. The beneficiary has achieved current PCP goals and additional goals are indicated, as evidenced by documented symptoms;
 2. The beneficiary is making satisfactory progress toward meeting goals and there is documentation supporting continuation of this service is effective in addressing the goals outlined in the PCP;
 3. 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; OR
 4. The beneficiary fails to make progress or demonstrates regression in meeting goals through the interventions outlined in the PCP. The beneficiary must be reassessed to identify any unrecognized co-occurring

disorders, and treatment recommendations need to be revised based on the findings.

Transition and Discharge Criteria

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

- a. The beneficiary's level of functioning has improved with respect to the goals outlined in the PCP, inclusive of a transition plan to step down to a lower level of care;
- b. The beneficiary has achieved positive life outcomes that support stable and ongoing recovery, and is no longer in need of CST services;
- c. The beneficiary has made limited or no progress, and all reasonable strategies and interventions have been exhausted, indicating a need for more intensive services; or
- d. The beneficiary or person legally responsible for the beneficiary requests a discharge from the service.

3.2.2 Medicaid Additional Criteria Covered

None apply.

3.2.3 NCHC Additional Criteria Covered

None apply.

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

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

4.1 General Criteria Not Covered

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

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

4.2 Specific Criteria Not Covered

4.2.1 Specific Criteria Not Covered by both Medicaid and NCHC

Medicaid and NCHC shall not cover these activities:

- a. Transportation for the beneficiary or family members;
- b. Any habilitation activities;
- c. Time spent doing, attending or participating in recreational activities unless tied to specific planned social skill assistance;
- d. Clinical and administrative supervision of CST staff, which is covered as an indirect cost and part of the rate;

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

4.2.2 Medicaid Additional Criteria Not Covered

None Apply

4.2.3 NCHC Additional Criteria Not Covered

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

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

Upon admission to Community Support Team, a beneficiary is allowed up to 36 units of service for an initial 30-day pass-through (calendar days). An authorization from the approved Department of Health and Human Services (DHHS) utilization review contractor is required after this initial 30-day pass-through. This pass-through is available only once per treatment episode per state fiscal year.

5.2 Prior Approval Requirements

5.2.1 General

The provider(s) shall submit to the DHHS Utilization Review Contractor the following:

- a. the prior approval request; and

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

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 an eligible beneficiary.

Initial Authorization

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

To request an initial authorization, the CCA, service order for medical necessity, PCP, and the required NC Medicaid authorization request form must be submitted to the DHHS approved Utilization Management Review Contractor within the first 30-calendar days of service. Medicaid may cover up to 128 units for 60-calendar days for the initial authorization period.

For a beneficiary searching for stable housing in the community and require permanent supportive housing interventions, up to 420 units may be approved for the initial authorization period.

Reauthorization

NC Medicaid may cover up to 192 units for a 90-day reauthorization. For a beneficiary searching for stable housing in the community and require permanent supportive housing interventions, NC Medicaid may cover up to 630 units for a 90-day reauthorization. It is expected that service intensity titrates down as the beneficiary demonstrates improvement in targeted life domains.

Reauthorization shall be submitted prior to initial or concurrent authorization expiring. Authorizations are based on medical necessity documented in the PCP, the authorization request form, and supporting documentation.

When it is medically necessary for services to be authorized for more than six months, a new comprehensive clinical assessment (CCA) or an addendum to the original CCA must be completed and submitted with a new service authorization request.

5.3 Additional Limitations or Requirements

- a. A beneficiary will be offered a choice of CST providers that include Certified Peer Support Specialist (CPSS) on the team if it is medically necessary that beneficiary have a CPSS.
- b. A beneficiary can receive CST services from only one provider organization during any active authorization period. The beneficiary may choose a new provider at any time, which will initiate a new service authorization request and a new authorization period.
- c. Family members or legally responsible individuals of the beneficiary are not eligible to provide this service.
- d. CST must not be provided in conjunction with Assertive Community Treatment Team Services.
- e. CST may not be provided during the same authorization period as any other State Plan service that contains duplicative service components.
- f. CST may not be provided to beneficiaries residing in Institutions for Mental Disease (IMD) regardless of the facility type.
- g. For the purpose of helping a beneficiary transition to and from a service (facilitating an admission to a service, discharge planning, or both) and ensuring that the service provider works directly with the CST staff. CST services may be provided and billed for a maximum of eight units for the first and last 30-day period for beneficiaries who are authorized to receive one of the following services:
 1. Assertive Community Treatment Team
 2. Substance Abuse Intensive Outpatient Program
 3. Substance Abuse Comprehensive Outpatient Treatment

5.4 Service Orders

Service orders are a mechanism to demonstrate medical necessity for a service and are based upon an assessment of the beneficiary's needs. A signed service order must be completed by a physician, licensed psychologist, physician assistant, or nurse practitioner, per his or her scope of practice. Service orders are valid for twelve (12) months. Medical necessity must be revisited, and service must be ordered at least annually, based on the date of the original service order.

ALL the following apply to a service order:

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

5.5 Documentation Requirements

The service record documents the nature and course of a beneficiary's progress in treatment. To bill Medicaid, providers must ensure that their documentation is consistent with the requirements contained in this policy. The staff member who provides the service is responsible for documenting the services billed to and reimbursed by Medicaid. The staff person who provides the service must sign and date the written entry. The signature must contain the credentials for professional or job title for associate

professional. A qualified professional (QP) is not required to countersign service notes written by staff who do not have QP status. The PCP and a documented discharge plan must be discussed with the beneficiary and documented in the service record.

5.5.1 Contents of a Service Note

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

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

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

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

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

6.1 Provider Qualifications and Occupational Licensing Entity Regulations

CST services must be delivered by providers employed by mental health or substance abuse provider organizations that:

- a. are currently certified as a Critical Access Behavioral Healthcare Agency (CABHA);
- b. meet the provider qualification policies, procedures, and standards established by the NC Medicaid;
- c. meet the requirements of 10A NCAC 27G;
- d. demonstrate that they meet these standards by being credentialed and contracted by the DHHS designated contractor;
- e. within one year of enrollment as a provider with NC Medicaid, achieve national accreditation with at least one of the designated accrediting agencies; and

- f. become established as a legally constituted entity capable of meeting all the requirements of the Provider Certification Medicaid Enrollment Agreement, Medicaid Bulletins and service implementation standards.

6.2 Provider Certifications

The CST shall be able to provide multiple contacts a week, daily, if needed, based on the severity of the beneficiary's mental health and substance use disorder clinical and diagnostic needs, as indicated in the PCP.

It is understood that CST is appropriate to serve people who are homeless, transient, and challenging to engage. Therefore, the expectation is that collateral contacts made to locate and engage the beneficiary to continue the beneficiary's treatment are documented in the service record.

CST varies in intensity to meet the changing needs of beneficiaries with mental illness and substance use disorders who have complex and extensive treatment needs, to support them in community settings, and to provide a sufficient level of service as an alternative to hospitalization. CST service delivery is monitored continuously and "titrated," meaning that when a beneficiary needs more or fewer services, the team provides services based on that level of need.

Team Composition

CST staff work together as an organized, coordinated unit under the direct supervision of the Team Lead. All CST staff shall know all beneficiaries served by the team, but not all team members necessarily work closely with all beneficiaries. The case load is comprised of beneficiaries who require services ranging from minimal to an intensive nature. CST maintains a beneficiary-to-staff ratio of 12:1 with a team maximum of 48 individuals. The team caseload must be determined by the level of acuity and the needs of the beneficiaries served.

CST must be comprised of four full-time staff positions as follows:

- a. One full-time equivalent (FTE) dedicated Team Lead who is a licensed clinician (Licensed Psychologist, Licensed Psychological Associate, Licensed Clinical Social Worker, Licensed Clinical Social Worker Associate, Licensed Professional Counselor, Licensed Professional Counselor Associate, or Licensed Marriage and Family Therapist) who has at least one-year experience with the knowledge, skills, and abilities required by the population and age to be served. The Team Lead shall meet the requirements specified for licensed clinician, according to 10A NCAC 27G. 0104 (12). An associate level licensed clinician actively seeking licensure may serve as the Team Lead conditional upon being fully licensed within 30-calendar months from the effective date of hire.
- b. One FTE dedicated team member who is a licensed substance abuse professional. Team member can be a Certified Clinical Supervisor (CCS), Licensed Clinical Addiction Specialist (LCAS or LCAS-A), or a Certified Substance Abuse Counselor (CSAC).
- c. Two FTE team members that are Qualified Professionals, Associate Professionals, Paraprofessionals or NC Certified Peer Support Specialist (NCCPSS). These team members shall have at least one-year of experience working with beneficiaries with mental health or substance use disorders and have the knowledge, skills, and abilities

required by the population and age to be served. These positions shall be filled by no more than four individuals.

The following charts reflect the activities and appropriate scopes of practice for the CST members:

| Community Support Team |
|---|
| Team Lead |
| <ul style="list-style-type: none"> • Drives the delivery of this service • Provides individual therapy for beneficiaries served by the team • Behavioral interventions such as modeling, behavior modification, behavior rehearsal • Designates the appropriate team staff so that specialized clinical expertise is applied as clinically indicated for each beneficiary • Provides and coordinates the assessment and reassessment of the beneficiary’s clinical needs • Provides clinical expertise and guidance to the CST members in the team’s interventions with the beneficiary • Provides the clinical supervision of all members of the team for the provision of this service. An individual supervision plan is required for all CST members except the Team Lead • Determines team caseload by the level of acuity and the needs of the beneficiary served • Facilitates weekly team meetings of the CST • Monitors and evaluates the services, interventions, and activities provided by the team • Completes functional needs assessment(s) to determine the scope and anticipated outcomes to the services |

| QP, Team Lead or Licensed Substance Abuse Professional |
|--|
| <ul style="list-style-type: none"> • Provides psychoeducation as indicated in the PCP • Assists with crisis interventions • Assists the Team Lead with behavioral and substance use disorder treatment interventions • Assists with the development of relapse prevention and disease management strategies • Coordinates the initial and ongoing assessment activities • Develops the initial PCP and its ongoing revisions and ensures its implementation • Consults with identified medical (i.e., primary care and psychiatric) and non-medical providers, engages community and natural supports, and includes their input in the person-centered planning process • Ensures linkage to the most clinically appropriate and effective services including arranging for psychological and psychiatric evaluations • Monitors and documents the status of the beneficiary’s progress and the effectiveness of the strategies and interventions outlined in the PCP • Completes functional needs assessment(s) to determine the scope and anticipated outcomes to the services |

**AP, QP, Team Lead or
Licensed Substance Abuse Professional**

- Provides psychoeducation as indicated in the PCP
- Assists with crisis interventions
- Assists the Team Lead with behavioral and substance use disorder treatment interventions
- Assists with the development of relapse prevention and disease management strategies
- Participates in the initial development, implementation, and ongoing revision of the PCP
- Communicates the beneficiary's progress and the effectiveness of the strategies and interventions to the Team Lead as outlined in the PCP
- Provides intensive case management
- Linkage and referral to formal and informal supports
- Monitoring and follow up
- Completes functional needs assessment(s) to determine the scope and anticipated outcomes to the services
- Assist with beneficiary housing search including engaging landlords to rent to beneficiaries and writing reasonable accommodation letters
- Assist with connecting beneficiaries to financial and in-kind resources to set up and maintain their household
- Prevent and mitigate housing crises including being a point of contact for landlord concerns
- Assist with rehousing beneficiaries if they are no longer able to stay in their unit due to eviction or risk of eviction
- Assist in developing daily living skills to stabilize and maintain housing

Paraprofessional

- Provides psychoeducation as indicated in the PCP
- Assists with crisis interventions
- Assists the Team Lead with behavioral and substance use disorder interventions
- Assists with the development of relapse prevention and disease management strategies
- Participates in the initial development, implementation, and ongoing revision of the PCP
- Communicates the beneficiary's progress and the effectiveness of the strategies and interventions to the Team Lead as outlined in the PCP

Certified Peer Support Specialist

- Serves as an active member of the CST, participates in team meetings, and provides input into the person-centered planning process
- Guides and encourages beneficiaries to take responsibility for and actively participate

in their own recovery

- Assists the beneficiary with self-determination and decision-making
- Models recovery values, attitudes, beliefs, and personal action to encourage wellness and resilience
- Teaches and promotes self-advocacy to the beneficiary
- Supports and empowers the beneficiary to exercise his/her legal rights within the community
- Provides psychoeducation as indicated in the PCP
- Assists with crisis interventions
- Assists the Team Lead with behavioral and substance use disorder interventions
- Assists with the development of relapse prevention and disease management strategies
- Participates in the initial development, implementation, and ongoing revision of the PCP
- Communicates the beneficiary's progress and the effectiveness of the strategies and interventions to the Team Lead as outlined in the PCP

Supervision Requirements

Clinical supervision for the CST Staff is provided by the licensed Team Lead who has the knowledge, skills, and abilities required by the population served. The licensed clinician facilitates a weekly face-to-face team meeting to ensure that the planned support interventions are provided; to allow the CST Staff to briefly discuss the status of all beneficiaries receiving services; problem-solve emerging issues; and plan approaches to intervene and prevent crises. The Team Lead monitors the delivery of CST to ensure the interventions are provided effectively to help the beneficiary restore community, daily living, personal, social and specific tenancy skills including obtaining and maintaining his or her own housing and develop natural supports, manage their illness, and reduce crises. Additional supervision or support may be provided as a group or with individual CST Staff as needed to address specific concerns or challenges.

*Clinical and administrative supervision of CST is covered as an indirect cost and therefore, must not be billed separately

6.3 Program Requirements

A face-to-face functional assessment is required to gather information to assist with determining the scope and anticipated outcome of the service. CST providers must use a functional assessment tool, recommended by the LME-MCO or DHHS, that contains the following domains:

- a. Housing;
- b. Personal Care;
- c. Money Management;
- d. Safety;
- e. Transportation;
- f. Communication;
- g. Health Awareness;
- h. Leisure;
- i. Vocational or Educational; and
- j. Self-Advocacy/Rights

The functional assessment is administered during the initial 60-calendar days of treatment and up to every 90-calendar days thereafter.

- a. Development of a PCP through initial engagement with the beneficiary and promotion of the individual's active participation in their plan. This consists of assisting the beneficiary to identify their preferences, desired community social roles, activities, and relationships, potential community supports, their strengths and barriers to their recovery adaptations in behavior and restoration of skills to overcome barriers.
- b. Skills Development targeted at ONE or more of the following areas:
 1. the restoration of daily living skills (health, mental health and SUD; Focus on chronic illness education, money and benefits management, securing and maintaining housing or other living environment, personal responsibility, nutrition, menu planning and grocery shopping, personal hygiene and grooming).
 2. the restoration of appropriate social and role functioning in various community settings, communication and interpersonal relationships, the use of community services; role, rights, responsibilities of tenancy, and the development of appropriate personal and natural support networks;
 3. accessing and using appropriate mainstream medical, dental, mental health and SUD services;
 4. accessing, renewing, and using appropriate public entitlements and resources such as Social Security, Section 8, meeting requirements for securing and retaining affordable housing, transportation and food stamps;
 5. the restoration of wellness and use of recreational and leisure time and resources;
 6. skill training in maintaining relationships, self-advocacy and assertiveness in dealing with citizenship, legal, tenancy or other social and personal needs;
 7. skills of negotiating for accommodations related to their disabling condition and landlord, neighbor, employer relationships;
 8. the restoration of cognitive and behavior skills such as, the handling of emergencies, requesting reasonable accommodations, emergency preparedness and problem solving;
 9. wellness recovery focused on practicing stress management activities, managing chronic conditions, developing wellness and recovery plans, establishing and maintaining regular exercise, participating in spiritual or religious community; and
 10. the restoration of work and education readiness such as: improving communication skills, personal hygiene and dress, time management, other related skills preparing the beneficiary to take advantage of employment services or employment and educational opportunities.

Symptom Management and Recovery training and support. This consists of:

- a. Symptom monitoring and self-management of mental health and SUD symptoms, that consists of identifying and minimizing of the negative effects of psychiatric or SUD symptoms which interfere with the individual's daily living including securing and sustaining their living arrangements and assisting the beneficiary to identify and minimize their symptoms and potentially harmful behaviors;
- b. Medication management;
- c. Education and training on mental illness, SUDs, relapse identification, prevention and the promotion of recovery; and

- d. Interventions that are evidence-based practices demonstrating effectiveness as a treatment or intervention for specific problems. These consist of: (1) motivational enhancement for eliciting behavior changes by helping individuals explore and resolve their ambivalence and achieve lasting change for a range of problematic behaviors; (2) cognitive-behavioral and behavioral shaping interventions that replace undesirable, unhealthy or unproductive behaviors with more desirable and effective ones through positive or negative reinforcement and cognitive restructuring approaches; (3) evidence based practices for working with individuals with co-occurring mental health and substance use disorders; and (4) harm reduction and implementing practices or programs that address the adverse effects of drug use such as overdose, HIV, hepatitis C, addiction, and incarceration.

Crisis Intervention: Face-to-face, short term interventions with a beneficiary who is experiencing increased distress or an active state of crisis. Interventions and strategies consist of:

- a. Development and implementation of the beneficiary’s PCP comprehensive crisis plan, WRAP plan or Psychiatric Advance Directive;
- b. Brief, situational assessment;
- c. Verbal interventions to de-escalate the crisis;
- d. Interventions to mobilize support systems
- e. Relapse prevention planning
- f. Requesting assistance from and making referrals to alternative services at the appropriate level; and
- g. Assistance with addressing any other services or resources related issues, including medical, benefits, housing, or personal issues that may have occurred during the crisis.

Coordinating and managing services by:

- a. Providing oversight for the integrated implementation of goals, objectives and strategies identified in the beneficiary’s service agreement;
- b. Assuring stated measurable goals, objectives and strategies are met within established timeframes;
- c. Assuring all service activities such as collaborative consultation and guidance to other staff and agencies serving the beneficiary and family, as appropriate;
- d. Coordination to gain access and maintain housing, education, necessary rehabilitative and medical services, transportation, wellness and recovery services and benefits access; and
- e. Monitoring and follow up to determine if the services accessed have adequately met the beneficiary’s needs.

Training Requirements

| Time Frame | Training Required | Who | Total Minimum Hours Required |
|---------------------------|--|---|------------------------------|
| Within 30 calendar | <ul style="list-style-type: none"> ▪ 3 hours CST Service Definition Required Components ▪ 3 hours of Crisis Response | <ul style="list-style-type: none"> ▪ All Staff | 6 hours |

| Time Frame | Training Required | Who | Total Minimum Hours Required |
|--|---|---|--|
| <u>days</u> of hire to provide service | <ul style="list-style-type: none"> 3 hours of PCP Instructional Elements | <ul style="list-style-type: none"> CST Team Lead QPs responsible for PCP | 3 hours |
| Within 90 calendar days of hire to provide this service | <ul style="list-style-type: none"> 13 hours of Introductory Motivational Interviewing* (MI) (mandatory 2-day training) 15 hours of Permanent Supportive Housing Training 3 hours of Basics of Psychiatric Rehabilitation and Functional Assessments 3 hours of Trauma Informed Care 12 hours of Designated therapies, practices or models below specific to the population(s) to be served by each CST Team. Practices or models must be treatment focused models, not prevention: Cognitive Behavior Therapy: Trauma-Focused Therapy (For Example: Seeking Safety, TARGET, TREM, Prolonged Exposure Therapy for PTSD;) or Illness Management and Recovery (SAMHSA Toolkit http://mentalhealth.samhsa.gov/cmhs/CommunitySupport/toolkits/illness/default.asp). | <ul style="list-style-type: none"> All Staff CST Team Lead QP AP Licensed Substance Abuse Professional | 46 hours *12 hours or commensurate to the hours required to complete the evidenced based treatment model. |
| | <ul style="list-style-type: none"> 6 hours of Basic ASAM Criteria | <ul style="list-style-type: none"> CST Team Lead Licensed Substance Abuse Professional | 6 hours |
| Annually | <ul style="list-style-type: none"> Follow up training and ongoing continuing education required for fidelity to chosen modality*** (If no requirements are designated by developers of that modality, a minimum of 10 hours of continuing education in components of the selected modality must be completed.). | <ul style="list-style-type: none"> All CST Staff | 10 hours*** |

*Provider must demonstrate documentation and hours reflect completion of chosen evidence-based treatment model.

** Motivational Interviewing training must be provided by a Motivational Interviewing Network of Trainers (MINT) trainer.

***Modalities must be ONE of the following: Cognitive Behavioral Therapy, Trauma Focused Therapy, and Illness Management and Recovery (SAMHSA Toolkit).

Annual training for CST Staff shall be training that is appropriate for the population being served.

Trauma-focused therapy and Illness Management and Recovery training must be delivered by a trainer who meets the qualifications of the developer of the specific therapy, practice or model and meets the training standard of the specific therapy, practice or model. If no specific trainer qualifications are specified by the model, then the training must be delivered by a licensed professional.

The initial training requirements may be waived by the hiring agency if the team member can produce documentation certifying that training was completed no more than 24-months prior to hire date.

Licensed (or associate level licensed, under supervision) staff shall be trained in and provide the aspects of these practice(s) or model(s) that require licensure, such as individual therapy or other therapeutic interventions falling within the scope of practice. It is expected that licensed (or associate level licensed, under supervision) staff shall practice within their scope of practice.

Non-licensed staff (QPs, APs, PP, NCPSS) shall be trained in and provide only the aspects of these practice(s) or model(s) that do not require licensure and are within the scope of their education, training, and expertise. Non-licensed staff must practice under supervision per the policy. It is the responsibility of the licensed (or Associate Level licensed, under supervision) supervisor and the CABHA Clinical Director to ensure that the non-licensed staff practice within the scope of their education, training, and expertise and are not providing any services that require licensure.

All the follow up training, clinical supervision, or ongoing continuing education requirements for fidelity of the clinical model or EBP(s) must be followed.

Expected Outcomes

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

Expected outcomes are the following:

- a. increased ability to function in the major life domains (emotional, social, safety, housing, medical or health, educational, vocational, and legal) as identified in the PCP;
- b. reduced symptomatology;
- c. decreased frequency or intensity of crisis episodes;
- d. increased ability to function as demonstrated by community participation (time spent working, going to school, or engaging in social activities);
- e. increased ability to live as independently as possible, with natural and social supports;
- f. engagement in the recovery process;
- g. increased identification and self-management of triggers, cues, and symptoms;

- h. increased ability to function in the community and access financial entitlements, housing, work, and social opportunities;
- i. increased coping skills and social skills that mitigate life stresses resulting from the beneficiary's diagnostic and clinical needs;
- j. increased ability to use strategies and supportive interventions to maintain a stable living arrangement; and
- k. decreased criminal justice involvement related to the beneficiary's mental health or substance use disorder diagnosis.

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, DHHS division(s) or fiscal contractor(s).

8.0 Policy Implementation and History

Original Effective Date: July 1, 2010

History:

| Date | Section or Subsection Amended | Change |
|------------|--------------------------------|---|
| 11/01/2019 | All Sections and Attachment(s) | The existing Service definition, Community Support Team removed from policy 8A, to become a stand-alone clinical coverage policy, 8A-6, <i>Community Support Team</i> . |
| 11/01/2019 | Attachment A | Updated policy template language “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 | Attachment A | Added: Note: North Carolina Medicaid and North Carolina Health Choice will not reimburse for conversion therapy. |
| 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.” |

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)

Institutional (UB-04/837I 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 edition and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for code description, as it is no longer documented in the policy.

C. Code(s)

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

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

| HCPCS Code(s) | Billing Unit |
|---------------|---------------------|
| H2015 | 1 unit = 15 minutes |

Unlisted Procedure or Service

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

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

D. Modifiers

| Team Staffing Description | HCPCS Modifier 1 | HCPCS Modifier 2 |
|---|------------------|------------------|
| Licensed Team Lead | HT | HO |
| Licensed Clinical Addictions Specialist, Licensed Clinical Addictions Specialist-Associate, Certified Clinical Supervisor, or Certified Substance Abuse Counselor | HT | HF |
| Qualified Professional or Associate Professional | HT | HN |
| NC Peer Support Specialist | HT | UI |
| Paraprofessional | HT | HM |

E. Billing Units

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

LME-MCOs and provider agencies shall monitor utilization of service by conducting record reviews and internal audits of units of service billed. LME-MCOs shall assess their network providers' adherence to service guidelines to assure quality services for beneficiaries.

F. Place of Service

CST is a direct and indirect periodic rehabilitative service in which CST members provide medically necessary services and interventions that address the diagnostic and clinical needs of the beneficiary and help the beneficiary successfully transition to community living. CST members also arrange, coordinate, and monitor services on behalf of the beneficiary. CST provider shall deliver services in various environments, such as, primary private residences, schools, courts, homeless shelters, street locations, and other community settings.

Program services are primarily delivered face to face with the beneficiary and in locations outside the agency's facility. The aggregate services delivered by the credentialed provider site must be assessed and document annually by each credentialed provider site using the following quality assurance benchmarks:

- a. At least 75% of CST services must be delivered face-to-face by the team with the beneficiary. The remaining time may either be by phone or collateral contact; and
- b. At least 75% of staff time must be spent working outside of the agency's facility with or on behalf of the beneficiary.

CST also contains telephone time with the beneficiary and collateral contact with persons who assist the beneficiary in meeting the beneficiary's rehabilitation goals specified in the PCP. CST provides participation and ongoing clinical involvement in activities and meetings for the planning, development, implementation and revision of the beneficiary's PCP.

Providers that deliver CST shall provide "first responder" crisis response 24-hours a day, 7 days a week, 365 days a year, to a beneficiary of this service.

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/>

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