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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Note: Information in **Sections 1.0** through **8.0** of this policy supersedes information found in the attachments.

Related Clinical Coverage Policies

Refer to https://medicaid.ncdhhs.gov/ for the related coverage policies listed below:
8A-1, *Assertive Community Treatment (ACT) Program*
8B, *Inpatient Behavioral Health Services*
8C, *Outpatient Behavioral Health Services Provided by Direct-Enrolled Providers*
8D-1, *Psychiatric Residential Treatment Facilities for Children under the Age of 21*
8D-2, *Residential Treatment Services*

1.0 Description of the Procedure, Product, or Service

This document describes policies and procedures that direct-enrolled providers shall follow to receive reimbursement for covered enhanced benefit behavioral health services provided to eligible NC Medicaid (Medicaid) and North Carolina Health Choice (NCHC) beneficiaries. It sets forth the basic requirements for qualified providers to bill mental health and substance abuse services to Medicaid or NCHC.

Refer to **Subsection 7.3** for the authorities that set requirements for this policy.

1.1 Definitions

Refer to **Subsection 3.2 .1**(a), (b), (c), and (d).

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.

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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. Occasionally, an individual 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 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.)

b. NCHC

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 shall 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 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 Covered

3.2.1 Specific criteria covered by both Medicaid and NCHC

There must be a current diagnosis reflecting the need for treatment. All covered services must be medically necessary for meeting specific preventive, diagnostic, therapeutic, and rehabilitative needs of the beneficiary.

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

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

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 medical necessity criteria listed in **Section 3.0;**
c. the procedure, product, or service unnecessarily 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

None Apply.

4.2.2 Medicaid Additional Criteria Not Covered

None Apply.

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

Prior approval is required on the first day of service for all Enhanced Services, with the following exceptions as identified in the service definitions found in **Attachment D**.

a. Mobile Crisis Management;
b. Diagnostic Assessment;
c. Substance Abuse Intensive Outpatient Program (SAIOP); and
d. Substance Abuse Comprehensive Outpatient Treatment (SACOT).

5.2 Prior Approval Requirements

5.2.1 General

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

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

5.3 Utilization Management and Authorization of Covered Services

Refer to **Attachment D** for the specific service definition's utilization management and authorization requirements.

Utilization management must be performed by NC Medicaid's designated contractor or Local Management Entity-Managed Care Organization (LME-MCO).

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. They are required for each

individual service and may be written by a Medical Doctor (MD), Doctor of Osteopathic Medicine (DO), Licensed Psychologist, Nurse Practitioner (NP), or Physician Assistant (PA).

a. Backdating of service orders is not allowed. (Refer to **Attachment D, Service Definitions,** for the basic criteria to ensure medical necessity.)
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 shall not be able to bill Medicaid without a valid service order.

Service orders are valid for one year from the date of plan entered on a Person Centered Plan (PCP). Medical necessity must be reviewed, and services must be ordered at least annually, based on the Date of Plan. (Refer to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMHDDSAS) *Person-Centered Planning Instruction Manual* and the DMHDDSAS *Records Management and Documentation Manual* for additional information on service orders, signatures, and the date of plan.)

5.5 Service Summary

5.5.1 Medicaid Service Summary

Medicaid Service	Age	Must be Ordered By
Diagnostic Assessment	All ages	No Order Required
Assertive Community Treatment Team	Age 21+	MD DO Licensed psychologist [that is, a Health Services Provider—Psychologist (HSP-P)] NP PA
Community Support Team—Adults	Age 21+	
Day Treatment—Child and Adolescent	Age 5 through 20	
Intensive In-home Services	Age 3 through 20	
Mobile Crisis Management	All ages	
Multisystemic Therapy	Ages 7 through 17	
Partial Hospitalization	All ages	
Professional Treatment Services in Facility-Based Crisis Programs	Age 21+	
Psychosocial Rehabilitation	Age 21+	
Substance Abuse Comprehensive Outpatient Treatment Program	Age 21+	
Substance Abuse Intensive Outpatient Service	All ages	
Substance Abuse Medically Monitored Community Residential Treatment	Age 21+	
Substance Abuse Non-medical Community Residential Treatment	Age 21+	
Ambulatory Detoxification	Age 21+	
Non-hospital Medical Detoxification	Age 21+	

Medicaid Service	Age	Must be Ordered By
Medically Supervised or ADATC Detoxification Crisis Stabilization	Age 21+	
Outpatient Opioid Treatment	Age 21+	MD or DO

Note: For Medicaid beneficiaries under age 21 EPSDT provisions apply. For NCHC beneficiaries who are 18 years old they would be eligible for Medicaid services allowable to beneficiaries 18 years of age.

5.5.2 NCHC Service Summary

Health Choice Service	Age	Must be Ordered By
Diagnostic Assessment	All eligible ages	No Order Required
Day Treatment—Child and Adolescent	All eligible ages	MD DO Licensed psychologist [that is, a Health Services Provider—Psychologist (HSP-P)] NP PA
Intensive In-home Services	All eligible ages	
Mobile Crisis Management	All eligible ages	
Multisystemic Therapy	Ages 7 through 17	
Partial Hospitalization	All eligible ages	
Substance Abuse Intensive Outpatient Service	All eligible ages	
Ambulatory Detoxification	Age 18	
Outpatient Opioid Treatment	Age 18	MD, DO

5.6 Clinical or Professional Supervision

Covered services are provided to beneficiaries by agencies that are directly enrolled in the Medicaid and NCHC programs and that employ Licensed Professionals (LPs), Qualified Professionals (QPs), Associate Professionals (APs), and Paraprofessionals. Clinical or professional supervision must be provided according to the supervision and staffing requirements outlined in each service definition. Medically necessary services delivered by APs are delivered under the supervision and direction of the LP or QP. Medically necessary services delivered by Paraprofessionals are delivered under the supervision and direction of the LP, QP or, when the service definition does not specify a more stringent supervision requirement, an AP. Supervision shall be provided at the frequency and for the duration indicated in the individualized supervision plan created for each AP and Paraprofessional upon hire. Each supervision plan must be reviewed annually.

The Licensed Professional or QP personally works with beneficiary's families, and team members to develop an individualized PCP. The LP or QP meets with the beneficiaries receiving services throughout the course of treatment to monitor the services being delivered and to review the need for continued services. The supervising professional assumes professional responsibility for the services provided by staff who do not meet QP status and spends as much time as necessary directly supervising the staff member providing the service to ensure that the goals outlined on each PCP are being implemented and that beneficiaries are receiving services in a safe and efficient manner in accordance with accepted standards of practice.

The terms of employment with the directly enrolled provider agency must specify that each supervising professional is to provide adequate supervision for the APs, Paraprofessionals, and other staff in the agency who are assigned to him or her. The

provider agency shall ensure that supervisory ratios meet any requirements that are specified in the service definition, are reasonable and ethical, and provide adequate opportunity for the supervising professional to effectively supervise the staff member(s) assigned. Documentation must be kept on file to support the supervision provided to AP and Paraprofessional staff in the delivery of medically necessary services.

5.7 PCPs

Services covered by this policy require a PCP. Refer to the service definitions in **Attachment D,** the DMHDDSAS *Person-Centered Planning Instruction Manual,* and the DMHDDSAS *Records Management and Documentation Manual* for specific information.

The primary reference document for person-centered planning and PCPs is the DMHDDSAS *Person-Centered Planning Instruction Manual*. The guidance offered throughout **Subsection 5.7** is derived from it.

5.7.1 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 individual with the disability to assume an informed and in-command role for life planning and for treatment, service, and support options. The individual 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, such as family members, the legally responsible person, professionals, friends and others 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 PCP for the delivery of medically necessary services must be in place. The PCP must be completed at the time the beneficiary is admitted to a service. 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.

5.7.2 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 a new service.

Refer to the *Person-Centered Planning Instruction Manual* and the *Records Management and Documentation Manual* for more detailed information.

For Medicaid and NCHC beneficiaries who receive psychosocial rehabilitation services, the PCP shall be reviewed every six months.

5.8 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, including the service definitions in **Attachment D** and the DMHDDSAS *Records Management and Documentation Manual*.

5.8.1 Responsibility for Documentation

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

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

5.8.2 Contents of a Service Note

More than one intervention, activity, or goal may be reported in one service note, if applicable. Service notes unless otherwise noted in the service definition, must include all of the following:

a. **Date** of service provision;
b. **Name of service** provided (for example, Mobile Crisis Management);
c. **Type of contact** (face-to-face, phone call, collateral);
d. **Place of service,** when required by service definition;
e. **Purpose** of the contact as it relates to the goal(s) in the PCP;
f. **Description of the intervention** provided. Documentation of the intervention must accurately reflect treatment for the duration of time indicated. For case management–type services, a description of the case management activity fulfills this requirement;
g. **Duration** of service: Amount of time spent performing the intervention;
h. **Assessment of the effectiveness** of the intervention and the beneficiary's progress toward the beneficiary's goal. For case management–type services, a description of the result or outcome of the case management activity fulfills this requirement;
i. **Signature** and credentials or job title of the staff member who provided the service, as described in **Subsection 5.8.1; and**

j. **Each service note page must** be identified with the beneficiary's name Medicaid or NCHC identification number and record number.

5.8.3 Other Service Documentation Requirements

Frequency, format, and any other service-specific documentation requirements can be found in the service definitions in **Attachment D** or the DMHDDSAS *Records Management and Documentation Manual*. 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. Refer to **Attachment C** for additional documentation Best Practice guidelines.

6.0 Providers 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; 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

Qualified provider agencies must be credentialed by the LME-MCOs and directly enrolled with the Medicaid and NCHC program for each service they wish to provide. The credentialing process includes a service-specific checklist and adherence to all of the following:

a. Rules for Mental Health, Developmental Disability, and Substance Abuse Facilities and Services;
b. Confidentiality Rules;
c. Client Rights Rules in Community MHDDSA Services;
d. Records Management and Documentation Manual;
e. Implementation Updates to rules, revisions, and policy guidance; and
f. PCP Manual.

Within one year of Medicaid and NCHC enrollment, providers shall be nationally accredited by one of the accrediting bodies approved by the N.C. Department of Health and Human Services (DHHS). Staff members providing services shall have all required training as specified in each service definition. Employees and contractors shall meet the requirements specified (10A NCAC 27G .0104) for QP, AP, or Paraprofessional status and shall have the knowledge, skills and abilities required by the population and age to be served.

Provider numbers are assigned by NC Medicaid to qualified provider agencies that bill Medicaid or NCHC directly.

Competencies are documented along with supervision requirements to maintain that competency. This applies to QPs and APs (10A NCAC 27G .0203) and to Paraprofessionals (10A NCAC 27G .0204).

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

6.2 Provider Certifications

None Apply.

6.3 Staff Definitions

6.3.1 North Carolina General Statutes Requirements

6.3.1.1 Licensed/Certified Professionals Providing Services Under This Policy

Staff with the following classifications must be licensed or certified, as appropriate, according to North Carolina General Statutes and shall practice within the scope of practice defined by the applicable practice board.

a. Licensed Professional Counselor
b. Licensed Clinical Addiction Specialist
c. Certified Clinical Supervisor
d. Licensed Marriage and Family Therapist
e. Licensed Clinical Social Worker
f. Doctor of Osteopathy
g. Licensed Psychologist
h. Licensed Psychological Associate
i. Nurse Practitioner
j. Licensed Physician
k. Certified Clinical Nurse Specialist (only if certified as an advanced practice psychiatric clinical nurse specialist)
l. Certified Substance Abuse Counselor; and
m. Physician Assistant

6.3.2 North Carolina Administrative Code Requirements

The following staff may provide services according to10A NCAC 27G .0104—Staff Definitions:

a. Qualified Professional (QP)
b. Associate Professional (AP)
c. Paraprofessional

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, intellectual/developmental disabilities, and substance abuse services. The purpose of the Medicaid and NCHC 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 **Section 1.0** 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 findings 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 requests for withholdings from future payments should be sent to:

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

7.3 Authority

The following resources, and the rules, manuals, and statutes referenced in them, give the Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMHDDSAS) the authority to set the requirements included in this policy:

a. Rules for Mental Health, Developmental Disabilities and Substance Abuse Facilities and Services, Administrative Publication System Manuals (APSM)30-1
b. DMHDDSAS Records Management and Documentation Manual, APSM 45-2
c. DMHDDSAS Person-Centered Planning Instruction Manual

d. N.C. Mental Health, Developmental Disabilities, and Substance Abuse Laws, 2001 (G.S. 122-C)

8.0 Policy Implementation and Revision Information

Original Effective Date: July 1, 1989

Revision Information:

Date	Section Revised	Change
09/01/2005	Section 2.0	A special provision related to EPSDT was added.
12/01/2005	Subsection 2.2	The web address for DMA's EDPST policy instructions was added to this section.
01/01/2006	Subsection 8.1	Procedure code 90782 was end-dated and replaced with 90772.
01/01/2006	Attachment C	Procedure code 90782 was end-dated and replaced with 90772; 96100 was end-dated and replaced with 96101; 96115 was end-dated and replaced with 96116; and 96117 was end-dated and replaced with 96118.
07/01/2006	Policy Title	The title of the policy was changed.
07/01/2006	General Information	References to direct-enrolled residential treatment providers were deleted from the policy.
07/01/2006	Entire Policy	References to area programs were deleted throughout the policy.
07/01/2006	Section 1.0	The reference to the Service Records Manual for MHDDSAS Providers was deleted as one of the rules that provide DMHDDSAS the authority to set requirements for behavioral health services.
07/01/2006	Subsection 2.3	Information pertaining to services that were billed through an area program was deleted.
07/01/2006	Subsection 3.1	References to palliative care and case management including medical necessity criteria for case management were deleted from the policy.
07/01/2006	Subsection 3.2	This section, pertaining to the provision of mental health services through an area program, was deleted from the policy.
07/01/2006	Subsection 5.1	The statement that providers must have a policy regarding how the service orders are documented was deleted. The statement that an approved professional must order services was deleted. The statement that each provider must have a standing order for screening and evaluation services was deleted.
07/01/2006	Subsection 5.2	The Medicaid Services Summary table was updated to reflect who can order specific services.
07/01/2006	Subsection 5.3	This section, pertaining to service orders for retroactively eligible recipients, was deleted from the policy and replaced with a new section pertaining to clinical or professional supervision.

Date	Section Revised	Change
07/01/2006	Subsection 5.4	Information pertaining to the initial authorization for residential child treatment facility services, psychiatric residential facility services, outpatient services, and outpatient specialized therapies was deleted. Instructions pertaining to services that do not require authorization by an external reviewer were deleted. The rest of Section 5.0 was renumbered accordingly.
07/01/2006	Subsection 5.5.2	This section was updated to address the person-centered planning process.
07/01/2006	Subsection 5.5.3	The requirement that all PCPs must be reviewed at least annually was added.
07/01/2006	Subsection 5.6.1	The reference to the Service Records Manual was deleted.
07/01/2006	Subsection 5.6.4	Documentation requirements for case management services were deleted. The Medicaid Service Documentation Requirements table was updated to reflect the documentation requirements for the approved service definitions.
07/01/2006	Section 6.0	Information pertaining to the credentialing process was deleted.
07/01/2006	Subsection 6.1	The staff definition for qualified client record manager was deleted.
07/01/2006	Subsection 7.1	Information pertaining to annual audits was updated. This section pertaining to the Certification of Need for Institutional Care was deleted from the policy.
07/01/2006	Subsection 7.2	This section pertaining to therapeutic leave was deleted from the policy.
07/01/2006	Subsection 7.4	This section pertaining to the F2 stamp requirement was deleted from the policy.
07/01/2006	Subsection 7.5	This section pertaining to Criterion #5 was deleted from the policy.
07/01/2006	Subsection 7.6	This section pertaining to staffing for residential treatment services was deleted from the policy.
07/01/2006	Subsection 7.7	Information from Section 8.3 pertaining to appeal of service denials for non–medically necessary services was added to this section, which was renumbered to Section 7.2.
07/01/2006	Subsection 7.7.3	The portion of this section pertaining to the appeal of a service denial from an area mental health program by DMHDDSAS was deleted from the policy. The remainder of the information in this section (OAH hearings) was renumbered to Section 7.2.3
07/01/2006	Subsection 8.1	This section pertaining to who can bill CPT codes was deleted from the policy.
07/01/2006	Subsection 8.2	This section pertaining to what services can be billed was deleted from the policy.
07/01/2006	Subsection 8.3	Information pertaining to appeal of service denial for non–medically necessary services was moved to Section 7.7 and the section was renumbered to Section 8.1.
07/01/2006	Subsection 8.4	This section pertaining to billing for therapeutic leave was deleted from the policy.

Date	Section Revised	Change
07/01/2006	Attachment C	This attachment pertaining to CPT codes and billable services was deleted from the policy.
07/01/2006	Attachment D	The attachment pertaining to HCPCS codes was updated and renumbered to Attachment C.
07/01/2006	Attachment E	The service definitions listed were revised effective with date of approval by CMS and the attachment was renumbered to Attachment D.
12/01/2006	Subsection 2.2	The special provision related to EPSDT was revised.
12/01/2006	Sections 3.0 and 4.0	A note regarding EPSDT was added to these sections.
04/01/2007	Attachment D, Medicaid Billable Service	A section on Utilization Management and the first sentence under Service Exclusions or Limitations were added after having been inadvertently omitted.
04/01/2007	Attachment D, Partial Hospitalization	The minimum provision was corrected from 3 to 4 hours per day. This is a correction to an error, not a change in coverage.
04/01/2007	Subsection 2.2; Sections 3.0, and 4.0	EPSDT information was revised to clarify exceptions to policy limitations for recipients under 21 years of age.
06/11/2007	Subsection 6.2	Corrected title of Licensed Clinical Supervisor to Certified Clinical Supervisor.
06/11/2007	Attachment D	Revised service definitions for community supports (children and adults).
02/01/2008	Attachment D	Revised service definitions for community supports (children and adults).
01/01/2009	Former Att. D (now E)	Revised service definitions for adult and child community support services.
01/01/2009	General Information	Incorporated into Section 1.0.
01/01/2009	Section 1.0	Added DMHDDSAS Records Management and Documentation Manual, APSM 45-2 and DMHDDSAS Person-Centered Planning Instruction Manual as authorities.
01/01/2009	Former Subsection 2.2 and 2.3	Reversed the order (EPSDT information concludes the section).
01/01/2009	Subsection 3.1	Added standard general criteria for coverage.
01/01/2009	Subsection 4.1	Added standard general criteria for denying coverage.
01/01/2009	Subsection 5.2	Deleted “Supervision” column from table; added Doctors of Osteopathy (DOs) to the “Must Be Ordered By” column for all services.
01/01/2009	Subsection 5.5	Revised description of PCPs to reflect current practice.
01/01/2009	Former Subsections 5.6.1 and 5.6.2	Deleted “Purpose” title and stated the information in 5.6.1 directly under Section 5.6; renumbered Section 5.6.2 to 5.6.1.
01/01/2009	Former Subsection 5.6.3	Deleted section on documentation frequency.
01/01/2009	Former Subsection 5.6.4	Renumbered to 5.6.2 and renamed “Contents of a Service Note.”

Date	Section Revised	Change
01/01/2009	Subsection 5.6.3 (new)	Added section with references to other sources of information for frequency, format, and any other service-specific documentation requirements.
01/01/2009	Former Subsection 5.6.5	Deleted summary table of documentation requirements.
01/01/2009	Subsection 6.2	Divided into two subcategories. Section 6.2.1 is based on N.C. General Statutes definitions; Section 6.2.2 is based on N.C. Administrative Code definitions. Section 6.2.1 is further divided into direct-enrolled providers and others.
01/01/2009	Subsection 7.1 (new)	Added new standard section on compliance and renumbered subsequent headings in this section.
01/01/2009	Former Subsection 7.1 (now 7.2)	Added compliance review to title and discussion.
01/01/2009	Former Subsection 7.2 (now 7.3)	Expanded section on appeal rights to reflect current law. Specifically, added subsection 7.2.2 on Filing the Recipient Hearing Request Form; deleted subsections on Office of Administrative Hearings, Appeal of Service Denial from Other Mental Health Services, and Appeal of Service Reduction, Suspension, or Termination; and added subsection on services during the appeals process.
01/01/2009	Former Sections 8 & 9	Billing Guidelines was renamed "Claims-Related Information" and was moved to Attachment A; standard information and statements were added; subsequent attachments were renumbered; former Section 9.0 became Section 8.0.
06/11/2009	Attachment E	Revised the Utilization Management statements to match actual practice and the DMHDDSAS Web site.
08/01/2009	Attachment E	Added "Role of the Agency Licensed Professional" to service definitions for Community Support (both adults and children or adolescents).
04/01/2010	Attachment E	Updated Child & Adolescent Day Treatment Service Definition with effective date of 4/1/10. Changes include addition of .5 LP in staffing; mandated MOA with LEA; changed eligible age range; updated service description; mandated use of evidence based practice model.
04/01/2010	Attachment E	Added note before each service definition
01/01/2010	Attachment E	SACOT has 60 day pass-through before prior authorization is required.
01/01/2010	Attachment E	SAIOP has 30 day pass through before prior authorization is required.
01/01/2010	Attachment E	Mid-size ACT Team added.
03/01/2010	Attachment E	PSR may now do a weekly full service note.
04/01/2010	Attachment E	Child and Adolescent Day Treatment. MOA requirement removed, but MOA is suggested. Operating hours updated.
07/01/2010	Attachment E	Updated Intensive-In Home Service Definition with effective date of 7/1/10. Changes include updated service description, updated eligibility criteria, and updated staffing.

Date	Section Revised	Change
07/01/2010	All sections and attachment(s)	S.L. 2009-451, s. 10.31. (a) Transition of NCHC Program administrative oversight from the State Health Plan to DMA in the NC Department of Health and Human Services.
07/01/2010	Attachment E	Updated Community Support Team Service Definition with effective date of 7/1/10. Changes include updated service description, updated eligibility criteria, updated service limitations, and updated staffing to include a Licensed or Provisionally Licensed Team Leader.
01/01/2011	Attachment E	Updated the Staff Training Section of Intensive In-Home, Child and Adolescent Day Treatment, and Community Support Team Service Definitions. Removed Community Support - Adult and Community Support - Children service definitions. Inserted a new service definition titled Peer Support Services. Added clarification to the documentation requirements in service definition for Opioid Treatment.
02/15/2011	Sections 1.0, 2.0, 3.0, 4.0, 5.0, 7.0	Updated standard DMA template language
08/01/2011	Attachment E	Revision of Community Support Team to extend allowable time frame for services beyond six months if medically necessary as indicated by an independent assessment. Removal of language pertaining to Community Support Services. Removed the category board-eligible provisionally licensed professional. Provide a requirement of being CABHA in IIH and CST. Provisionally licensed LCAS as able to provide the various substance abuse services.
12/01/2012	All sections and attachment(s)	To comply with G.S. 108A-70.21(b). NCHC coverage shall be equivalent to coverage under Medicaid with some exceptions.
12/01/2012	All sections and attachment(s)	Merge Medicaid and NCHC current coverage into one policy.
12/01/2012	All sections and attachment(s)	Changed recipient to beneficiary per CMS guidelines.
12/01/2012	Attachment D	Attachment D deleted as the HCPCS codes were listed in Attachment A.
12/01/2012	Attachment E	Attachment E was renamed as Attachment D.
12/01/2012	All sections and attachment(s)	Changed patient, recipient, person, him, her, his/her, youth, child, individual, consumer to beneficiary, Provisionally licensed to Associate Level licensed as appropriate.
12/01/2012	Attachment D	Removed the Peer Support service definition and references to State Funded services (refer to DMH website for state funded policies).
04/01/2013	Section 1.0	Moved paragraph on authority to Section 7.3
04/01/2013	Section 5.0	Deleted: Prenatal and childbirth services are not covered.
04/01/2013	Section 5.6 and 6.1	Added NCHC to this section to clarify that NCHC beneficiaries must also comply with the supervision requirements of the service definitions.

Date	Section Revised	Change
04/01/2013	Attachment D	Partial Hospitalization - the section on Service Type was modified as follows: This is day or night service that shall be provided a minimum of four hours per day, five days per week, and 12 months a year (exclusive of transportation time), excluding legal or governing body designated holidays.
08/01/2013	Attachment D	Under the Department of Justice agreement, Assertive Community Treatment was revised and updated to match the evidenced-based model and comply with model fidelity as measured by the TMACT.
08/01/2014	All Sections and Attachments	Reviewed policy grammar, readability, typographical accuracy, and format. Policy amended as needed to correct, without affecting coverage.
08/01/2014	All Sections and Attachments	Updated: DSM-IV to DSM-5 language, American Society for Addiction Medicine language pertaining to substance use disorder, 2013 CPT codes, language pertaining to intellectual/ developmental disabilities, as well as other technical, non-substantive, and clarifying language/grammar changes.
08/01/2015	Attachment D	Assertive Community Treatment (ACT) service definition removed from policy as it will be covered under stand-alone policy 8A-1, Assertive Community Treatment (ACT) Program
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.
10/01/2016	Attachment D	SAIOP and SACOT - updated Utilization Management section to change rollover of unmanaged visits from calendar year to state fiscal year.
04/01/2017	SAIOP and SACOT	SAIOP and SACOT – updated the staffing section allowing supervision from both an LCAS or CCS and revising the supervision language so that SAIOP and SACOT were consistent.
04/01/2017	Attachment D	Intensive In Home Services- revised staffing ratio from 1 Team to 8 Families to 1 Team to 12 Families, as directed by 2014 Legislative action and approved by CMS January 5, 2017.
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.
06/15/2019	Attachment D	Multisystemic Therapy – removed limit on billable units in 24-hour period. Ambulatory Detoxification – removed NCHC eligibility. Effective date 04/01/2019

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)

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.

Claims submitted to Medicare have specific coding requirements that are substantially different from the requirements for billing Medicaid. Specifically, diagnosis coding is required on all claims to Medicare. The Centers for Medicare and Medicaid Services (CMS) recognizes only the International Classification of Diseases, Tenth Revisions, Clinical Modification (ICD-10-CM) and Procedural Coding System (PCS) codes. CMS does not recognize any diagnosis codes in the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5), or any subsequent editions of this reference material.

For further information about Medicare, refer to Palmetto GBA Medicare (online at http://www.palmettogba.com/palmetto/palmetto.nsf/DocsCat/Home).

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.

For providers using institutional claims, providers shall bill the applicable revenue code(s). For providers utilizing professional claims, providers shall select the most specific billing code(s) that accurately describes the service(s) provided.

Mobile Crisis Management (Medicaid and NCHC)

HCPCS Code	Billing Unit
H2011	1 unit =15 minutes

Diagnostic Assessment (Medicaid and NCHC)

HCPCS Code	Billing Unit
T1023	1 unit =1 event

Intensive In-Home Services (Medicaid and NCHC)

HCPCS Code	Billing Unit
H2022	1 unit =1 day

Multisystemic Therapy (Medicaid and NCHC)

HCPCS Code	Billing Unit
H2033	1 unit =15 minutes

Community Support Team—Adults (Medicaid Only)

HCPCS Code	Bill with Modifier	Billing Unit
H2015	HT – denotes individual	1 unit =15 minutes

Assertive Community Treatment Team (Medicaid and NCHC)

HCPCS Code	Billing Unit
H0040	1 unit =1 event

Psychosocial Rehabilitation (Medicaid Only)

HCPCS Code	Billing Unit
H2017	1 unit =15 minutes

Child and Adolescent Day Treatment (Medicaid and NCHC)

HCPCS Code	Bill with Modifier	Billing Unit
H2012	HA	1 unit =1 hour

Partial Hospitalization (Medicaid and NCHC)

HCPCS Code	Billing Unit
H0035	1 unit =1 event

Professional Treatment Services in Facility-Based Crisis Programs – Adult (Medicaid Only)

HCPCS Code	Billing Unit
S9484	1 unit = 1 hour

Substance Abuse Intensive Outpatient Program (Medicaid and NCHC)

HCPCS Code	Billing Unit
H0015	1 unit = 1 event per day (3 hours minimum)

Substance Abuse Comprehensive Outpatient Treatment (Medicaid Only)

HCPCS Code	Billing Unit
H2035	1 unit =1 hour

Substance Abuse Non-Medical Community Residential Treatment—Adult (Medicaid Only)

HCPCS Code	Bill with Modifier	Billing Unit
H0012	HB	1 unit = 1 day not to exceed more than 30 days in a 12-month period

Substance Abuse Medically Monitored Community Residential Treatment (Medicaid Only)

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

Ambulatory Detoxification (Medicaid and NCHC)

HCPCS Code	Billing Unit
H0014	1 unit = 15 minutes

Non-Hospital Medical Detoxification (Medicaid Only)

HCPCS Code	Billing Unit
H0010	1 unit = 1 day not to exceed more than 30 days in a 12-month period

Medically Supervised Detoxification Crisis Stabilization (Medicaid Only)

HCPCS Code	Billing Unit
H2036	1 unit = 1 day not to exceed more than 30 days in a 12-month period

Opioid Treatment (Medicaid and NCHC)

HCPCS Code	Billing Unit
H0020	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. Refer to **Section C** above.

E. Billing Units

Provider(s) shall report the appropriate procedure code(s) used which determines the billing unit(s).

F. Place of Service

Places of service shall vary depending on the specific service rendered. They include the following: community settings such as primary private residence, school, shelters, work locations, and hospital emergency rooms; licensed substance abuse settings; and licensed crisis settings.

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.

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 <u>examples of goals</u> 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.

Attachment D: Service Definitions

Mobile Crisis Management (MHDDSA): Medicaid and NCHC Billable Service

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

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

Provider Requirements
Mobile Crisis Management services must be delivered by a team of practitioners employed by a mental health, substance abuse or intellectual and developmental disability provider organization that meets the provider qualification policies and procedures established by the Division of Mental Health (DMH). These policies and procedures set forth the administrative, financial, clinical, quality improvement, and information services infrastructure necessary to provide services. Provider organizations shall demonstrate that they meet these standards by being credentialed by the LME-MCO. Within three years of enrollment as a provider, the organization shall have achieved national accreditation. The organization must be established as a legally recognized entity in the United States and qualified or registered to do business as a corporate entity in the State of North Carolina.

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

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

a. a minimum of one year's experience in providing crisis management services in the following settings: assertive outreach, assertive community treatment, emergency department or other service providing 24-hours-a-day, 7-days-a-week, response in emergent or urgent situations

AND

b. 20 hours of training in appropriate crisis intervention strategies within the first 90 days of employment.

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

Service Type and Setting

Mobile Crisis Management is a direct and periodic service that is available at all times, 24-hours-a-day, 7-days-a-week, 365-days-a-year. It is a "second level" service, in that other services must be billed before Crisis Management, as appropriate and if there is a choice. For example, if the beneficiaries outpatient clinician stabilized his or her crisis, the outpatient billing code shall be used, not crisis management. If a Community Support Team worker responds and stabilizes his or her crisis, the Community Support Team billing code shall be used.

Units shall be billed in 15-minute increments.

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

a. Team providing this service shall provide at least 80% of their units face-to-face with beneficiaries of this service.
b. If a face-to-face assessment is required, this assessment must be delivered in the least restrictive environment and provided in or as close as possible to a beneficiary's home, in the beneficiary's natural setting, school, work, local emergency room, etc. This response must be mobile. The result of this assessment must identify the appropriate crisis stabilization intervention.

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

Program Requirements

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

Mobile Crisis Management services must be capable of addressing all psychiatric, substance use disorder, and intellectual and developmental disability crises for all ages to help restore (at a minimum) a beneficiary to his or her previous level of functioning.

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

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

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

Utilization management shall be performed by NC Medicaid's designated contractor or LME-MCO.

Eligibility Criteria
The beneficiary is eligible for this service when the following criteria are met:

a. the beneficiary or family are experiencing an acute, immediate crisis as determined by a crisis rating scale specified by DMH;

AND

b. the beneficiary or family has insufficient or severely limited resources or skills necessary to cope with the immediate crisis.

OR

c. the beneficiary or family members evidences impairment of judgment, impulse control, cognitive or perceptual disabilities;

OR

d. the beneficiary is intoxicated or in withdrawal, in need of substance use disorder treatment and unable to access services without immediate assistance.

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

Continued Service Criteria
The beneficiary is eligible to continue this service if the crisis has not been resolved or his or her crisis situation has not been stabilized, which may include placement in a facility-based crisis unit or other appropriate residential placement.

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

The Beneficiary's crisis has been stabilized and his or her need for ongoing treatment or supports has been assessed. If the beneficiary has continuing treatment or support needs, a linkage to ongoing treatment or supports has been made.

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

Documentation Requirements
The minimum standard is a daily full service note that includes the:

a. beneficiary's name;
b. beneficiary's Medicaid or NCHC identification number;
c. date of service;
d. purpose of contact;
e. description of the provider's interventions;
f. time spent performing the interventions;
g. effectiveness of the intervention; and
h. signature of the staff providing the service.

Treatment logs or preprinted check sheets are not sufficient to provide the necessary documentation. For a beneficiary new to the public system, Mobile Crisis Management shall develop a crisis plan before discharge.

Service Exclusions
Services that may not be concurrently provided with Mobile Crisis Management include the following:

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

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

Diagnostic Assessment (MHDDSA): Medicaid and NCHC Billable Service

Service Definition and Required Components
A Diagnostic Assessment is an intensive clinical and functional face-to-face evaluation of a beneficiary's mental health, intellectual and developmental disability, or substance use condition. The assessment results in the issuance of a Diagnostic Assessment report with a recommendation regarding whether the beneficiary meets target population criteria and includes a recommendation for Enhanced Benefit services that provides the basis for the development of the PCP. For substance use-focused Diagnostic Assessment, the designated diagnostic tool specified by DMH (e.g., Substance Use Disorders Diagnostic Schedule (SUDDS) IV, Addiction Severity Index (ASI), Substance Abuse Subtle Screening Inventory (SASSI) for specific substance use disorder benefit plan populations (i.e., Work First, Driving While Intoxicated (DWI), etc. must be used. In addition, any elements included in this service definition that are not covered by the tool must be completed.

Elements of the Diagnostic Assessment
The Diagnostic Assessment must include all of the following elements:

a. a chronological general health and behavioral health history (includes both mental health and substance use) of the beneficiary's symptoms, treatment, treatment response and attitudes about treatment over time, emphasizing factors that have contributed to or inhibited previous recovery efforts;
b. biological, psychological, familial, social, developmental and environmental dimensions and identified strengths and weaknesses in each area;
c. a description of the presenting problems, including source of distress, precipitating events, associated problems or symptoms, recent progressions; and current medications;
d. a strengths or problem summary which addresses risk of harm, functional status, co-morbidity, recovery environment, and treatment and recovery history;
e. diagnoses from the DSM-5, or any subsequent editions of this reference material, including mental health, substance use disorder and or intellectual/developmental disability as well as physical health conditions and functional impairment;
f. evidence of an interdisciplinary team progress note that documents the team's review and discussion of the assessment;
g. a recommendation regarding target population eligibility; and
h. evidence of beneficiary participation including families, or when applicable, guardians or other caregivers

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

Provider Requirements
Diagnostic Assessments must be conducted by practitioners employed by a mental health, substance abuse, or intellectual and developmental disability provider meeting the provider qualification policies, procedures, and standards established by DMH and the requirements of 10A NCAC 27G. These policies and procedures set forth the administrative, financial, clinical, quality improvement, and information services infrastructure necessary to provide services. Provider organizations must demonstrate that they meet these standards by being credentialed by the LME-MCO. Within three years of enrollment as a

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

Staffing Requirements
The Diagnostic Assessment team must include at least two QPs, according to 10A NCAC 27G .0104, both of whom are licensed or certified clinicians. One of the team members must be a QP whose professional licensure or certification authorizes the practitioner to diagnose mental illnesses or addictive disorders. One team member must be an MD, DO, nurse practitioner, physician assistant, or licensed psychologist. For substance use-focused Diagnostic Assessment, the team must include a CCS or LCAS. For a beneficiary with intellectual and developmental disabilities, the team must include a Master's level QP with at least two years of experience with individuals with intellectual and developmental disabilities.

Service Type and Setting
A Diagnostic Assessment is a direct periodic service that can be provided in any location.*

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

Program Requirements
An initial Diagnostic Assessment may be performed by a Diagnostic Assessment team for each beneficiary being considered for receipt of services in the mental health, developmental disabilities, or substance abuse Enhanced Benefit package.

Utilization Management
A beneficiary may receive one Diagnostic Assessment per year. An assessment equals one event. For beneficiaries eligible for Enhanced Benefit services, referral and utilization management by the LME-MCO (Medicaid) or by NC Medicaid's designated contractor (NCHC) for Diagnostic Assessment is required. Additional events require prior authorization and utilization management from the designated contractor or LME-MCO.

Eligibility Criteria

The beneficiary is eligible for this service when either of the following criteria are met:

a. there is a known or suspected mental health, substance use disorder, intellectual or developmental disability diagnosis;

OR

b. initial screening or triage information indicates a need for additional mental health, substance use disorder, intellectual, or developmental disabilities treatment or supports.

Continued Service Criteria
Not applicable.

Discharge Criteria
Not applicable.

Expected Outcomes
A Diagnostic Assessment determines whether the beneficiary is appropriate for and can benefit from mental health, intellectual disability, developmental disability, or substance abuse services based on the beneficiary's diagnosis, presenting problems, and treatment and recovery goals. It also evaluates the beneficiary's level of readiness and motivation to engage in treatment. Results from a Diagnostic Assessment include an interpretation of the assessment information, appropriate case formulation, an order for immediate needs and the development of PCP. For beneficiaries with a substance use disorder diagnosis, a Diagnostic Assessment recommends a level of placement using The American Society of Addiction Medicine (AASAM) Criteria.

Documentation Requirements
The Diagnostic Assessment report must include the elements described above under "Elements of the Diagnostic Assessment."

Service Exclusions and Limitations
A Diagnostic Assessment shall not be billed on the same day as Assertive Community Treatment Team, Intensive In-Home, Multisystemic Therapy or Community Support Team services. If psychological testing or specialized assessments are indicated, they are billed separately using appropriate CPT codes for psychological, developmental, or neuropsychological testing.

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

Intensive In-Home Services:
Medicaid and NCHC Billable Service

Service Definition and Required Components

The Intensive In-Home (IIH) service is a team approach designed to address the identified needs of children and adolescents who, due to serious and chronic symptoms of an emotional, behavioral, or substance use disorder, are unable to remain stable in the community without intensive interventions. This service may only be provided to beneficiaries through age 20. This medically necessary service directly addresses the beneficiary's mental health or substance use disorder diagnostic and clinical needs. The needs are evidenced by the presence of a diagnosable mental, behavioral, or emotional disturbance (as defined by DSM-5, or any subsequent editions of this reference material), with documentation of symptoms and effects reflected in the Comprehensive Clinical Assessment and the Person-Centered Plan (PCP). This team provides a variety of clinical rehabilitative interventions available 24 hours per day, 7 days per week, 365 days per year.

This is a time-limited, intensive child and family intervention based on the clinical needs of the beneficiary. The service is intended to accomplish the following:

a. reduce presenting psychiatric or substance use disorder symptoms;
b. provide first responder intervention to diffuse current crisis;
c. ensure linkage to community services and resources; and
d. prevent out of home placement for the beneficiary.

IIH services are authorized for one individual child in the family. The parent or caregiver must be an active participant in the treatment. The team provides individualized services that are developed in full partnership with the family. Effective engagement, including cultural sensitivity, is essential in providing services in the family's living environment. Services are generally more intensive at the beginning of treatment and decrease over time as the beneficiary's skills develop.

This team service includes a variety of interventions that are available 24 hours per day, 7 days per week, 365 days per year. Services are delivered by the IIH staff who maintain contact and intervene as one organizational unit. IIH services are provided through a team approach; however, discrete interventions may be delivered by any one or more team members as clinically indicated. Not all team members are required to provide direct intervention to each beneficiary on the caseload. The Team Leader must provide direct clinical interventions with each beneficiary. The team approach involves structured, face-to-face, scheduled therapeutic interventions to provide support and guidance across multiple functional domains including emotional, medical and health. This service is not delivered in a group setting.

IIH services are delivered to children and adolescents, primarily in their living environments, with a family focus, and IHH services include but are not limited to the following interventions as clinically indicated:

a. individual and family therapy;
b. substance use disorder treatment interventions;
c. developing and implementing a home-based behavioral support plan with the beneficiary and the beneficiary's caregivers;
d. psychoeducation imparts information about the beneficiary's diagnosis, condition, and treatment to the beneficiary, family, caregivers, or other individuals involved with the beneficiary's care;

e. intensive case management includes the following:
    1. assessment;
    2. planning;
    3. linkage and referral to paid and natural supports; and
    4. monitoring and follow up.
f. arrangements for psychological and psychiatric evaluations; and
g. crisis management.

The IIH Team shall provide "first responder" crisis response, as indicated in the PCP, 24-hours-a-day, 7-days-a-week, 365-days-a-year, to beneficiaries of this service.

In partnership with the beneficiary, the beneficiary's family, and the legally responsible person, as appropriate, the licensed or QP is responsible for convening the Child and Family Team, which is the vehicle for the person-centered planning process. The licensed or QP is responsible for monitoring and documenting the status of the beneficiary's progress and the effectiveness of the strategies and interventions outlined in the PCP. The licensed or QP consults with identified medical (such as primary care and psychiatric) and non-medical providers (e.g., the county department of social services [DSS], school, the Department of Juvenile Justice and Delinquency Prevention [DJJDP]), engages community and natural supports, and includes their input in the person-centered planning process.

A signed service order shall be completed by a physician, licensed psychologist, PA, or NP according to his or her scope of practice and shall be accompanied by other required documentation as outlined elsewhere in this policy (NC Medicaid Clinical Coverage Policy 8A, *Enhanced Mental Health and Substance Abuse Services*). Each service order shall be signed and dated by the authorizing professional and shall indicate the *date* on which the service was ordered. A service order shall 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 shall be based on a comprehensive clinical assessment of the beneficiary's needs.

Provider Requirements

IIH services shall be delivered by practitioners 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 NC Medicaid;
c. meet the provider qualification policies, procedures, and standards established by the Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMHDDSAS); and
d. fulfill the requirements of 10A NCAC 27G.

These policies and procedures set forth the administrative, financial, clinical, quality improvement, and information services infrastructure necessary to provide services. Provider organizations shall demonstrate that they meet these standards by being credentialed by the Local Management Entity (LME). As part of the endorsement, the provider must notify the LME-MCO of the therapies, practices, or models that the provider has chosen to implement. Additionally, within one year of enrollment as a provider with NC Medicaid, the organization shall achieve national accreditation with at least one of the designated accrediting agencies. (Providers who were enrolled prior to July 1, 2008, shall have achieved national accreditation within three years of their enrollment date.) The organization shall be established as a legally constituted entity capable of meeting all of the requirements of the Provider Endorsement, Medicaid Enrollment Agreement, Medicaid Bulletins, and service implementation standards.

For Medicaid or NCHC services, the organization is responsible for obtaining prior authorization from Medicaid's approved vendor for medically necessary services identified in the PCP. The IIH service provider organization shall comply with all applicable federal and state requirements. This includes, but is not limited to, DHHS statutes, rules, policies, and Implementation Updates; Medicaid Bulletins; and other published instruction.

Staffing Requirements

All treatment shall be focused on, and for the benefit of, the eligible beneficiary of IIH services. The service model requires that IIH staff provide 24-hour-a-day coverage, 7-days-a-week, 365-days-a-year. This service model is delivered by an IIH team comprised of one full-time equivalent (FTE) team leader and at least two additional full-time equivalent positions as follows:

a. one FTE team leader who is a licensed professional who has the knowledge, skills, and abilities required by the population and age to be served (may be filled by no more than two individuals). An associate level professional actively seeking licensure 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;

AND

b. one FTE QP who has the knowledge, skills, and abilities required by the population and age to be served (may be filled by no more than two individuals);

AND

c. one FTE QP or AP who has the knowledge, skills, and abilities required by the population and age to be served (may be filled by no more than two individuals).

For IIH services focused on substance use disorder interventions, the team shall include at least one certified clinical supervisor (CCS), licensed or associate level licensed clinical addiction specialist (LCAS), or certified substance abuse counselor (CSAC) as a member of the IIH team.

All staff providing Intensive In-Home Services to children and families must have a minimum of one (1) year documented experience with this population.

No IIH team member who is actively fulfilling an IIH team role may contribute to the staffing ratio required for another service during that time. When fulfilling the responsibilities of IIH services, the staff member shall be fully available to respond in the community.

The team-to-family ratio shall not exceed 1:12 for each IIH team.

The team leader is responsible for the following:

a. providing individual and family therapy for each beneficiary served by the team;
b. designating the appropriate team staff such that specialized clinical expertise is applied as clinically indicated for each beneficiary;
c. providing and coordinating the assessment and reassessment of the beneficiary's clinical needs;
d. providing clinical expertise and guidance to the IIH team members in the team's interventions with the beneficiary; and
e. providing the clinical supervision of all members of the team for the provision of this service. An individual supervision plan is required for all IIH team members exclusive of the Team Leader.

Licensed professional or qualified professional has responsibility for the following:

a. coordinates and oversees the initial and ongoing assessment activities;
b. convening the Child and Family Team for person-centered planning;
c. completing the initial development and ongoing revision of the PCP and ensuring its implementation;
d. consulting with identified medical (for example, primary care and psychiatric) and non-medical (for example, DSS, school, DJJDP) providers, engaging community and natural supports, and including their input in the person-centered planning process;
e. ensuring linkage to the most clinically appropriate and effective services including arranging for psychological and psychiatric evaluations;
f. providing and coordinating behavioral health services and other interventions for the beneficiary or other family members with other licensed professionals and Child and Family Team members; and
g. monitoring and documenting the status of the beneficiary's progress and the effectiveness of the strategies and interventions outlined in the PCP.

All IIH staff have responsibility for the following under the direction of the team leader:

a. Participating in the person-centered planning process;
b. Assisting with implementing a home-based behavioral support plan with the beneficiary and the beneficiary's caregivers as indicated in the PCP;
c. Providing psychoeducation as indicated in the PCP;
d. Assisting the team leader in monitoring and evaluating the effectiveness of interventions, as evidenced by symptom reduction and progress toward goals identified in the PCP;
e. Assisting with crisis interventions; and
f. Assisting the team leader in consulting with identified providers, engaging community and natural supports, and including their input in the person-centered planning process.

All members of the IIH services team shall be supervised by the team leader. Persons who meet the requirements specified for QP or AP status according to 10A NCAC 27G .0104 and who have the knowledge, skills, and abilities required by the population and age to be served may deliver IIH services.

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

Note: Supervision of IIH staff is covered as an indirect cost and therefore must not be billed separately an IIH service.

Staff Training
The following are the requirements for training staff in IIH.

All IIH Team Staff

a. Within 30 days of hire to provide IIH services, all staff shall complete the following training requirements:
   1. 3 hours of training in the IIH service definition required components;
   2. 3 hours of crisis response training; and
   3. 3 hours of PCP Instructional Elements (required for only IIH Team Leaders and IIH QP staff responsible for PCP) training;

AND

b. Within 90 days of hire to provide this service, or by June 30, 2011 for staff who were currently working as an IIH team member as of January 1,2011, all IIH staff shall complete the following training requirements:

   IIH staff must complete 24 hours* of training (a minimum of 3 days) in one of the designated therapies, practices or models below specific to the population(s) to be served by each IIH Team. The designated therapies, practices or models are as follows:
   1. Cognitive Behavior Therapy;
   2. Trauma-Focused Therapy (For Example: Seeking Safety, Trauma Focused CBT, Real Life Heroes); or
   3. Family Therapy (For Example: Brief Strategic Family Therapy, Multidimensional Family Therapy, Family Behavior Therapy, Child Parent Psychotherapy, or Family Centered Treatment).
      A. Practices or models must be treatment focused, not prevention focused.
      B. Each practice or model chosen must specifically address the treatment needs of the population to be served by each IIH.
      C. Cognitive Behavior Therapy training must be delivered by a licensed professional.
      D. Trauma-focused therapy and family therapy 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.

* Licensed professionals (LP) who have documented evidence of post graduate training in the chosen qualifying practice (identified in this clinical coverage policy) dated no earlier than March 20, 2006 may count those training hours toward the 24 hour requirement. It is the responsibility of the LP to have clearly documented evidence of the hours and type of training received.

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 of licensed professionals. It is expected that licensed (or associate level licensed, under supervision) staff shall practice within their scope of practice.

Non-licensed staff [QPs and APs] 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 according to the service definition. It is the responsibility of the licensed (or associate level licensed, under supervision) supervisor and the Critical Access Behavioral Health Agency (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 follow up training, clinical supervision, or ongoing continuing education requirements for fidelity of the clinical model or EBP(s) must be followed.

AND

c. On an annual basis, follow up training and ongoing continuing education for fidelity to the chosen modality (Cognitive Behavioral Therapy, Trauma Focused Therapy, Family Therapy) is required. If no requirements have been designated by the developers of that modality, a minimum of 10 hours of continuing education in components of the selected modality must be completed annually.

IIH Team Leaders

a. In addition to the training required for all IIH staff, IIH team leaders, within 90 days of hire to provide this service, or by March 31, 2011 for staff who were currently working as an IIH Team member as of January 1, 2011, shall complete the following training requirements:
   1. 13 hours of Introductory Motivational Interviewing (MI) training by a MINT Trainer** (mandatory 2-day training);
   2. 11 hours of Introduction to System of Care Training; and
   3. 12 hours of Person Centered Thinking (PCT) training from a Learning Community for Person Centered Practices certified PCT trainer.
      A. All new hires to IIH must complete the full 12 hour training.
      B. Staff who previously worked in IIH for another agency and had six (6) hours of PCT training under the old requirement shall have to meet the 12 hour requirement when moving to a new company.
      C. The 12 hour PCT training must be portable if an employee changes jobs any time after completing the 12 hour requirement, as long as there is documentation of such training in the new employer's personnel records.
      D. Staff who previously worked in IIH within the same agency and had six (6) hours of PCT training under the old requirement may complete the additional six (6) hour PCT or Recovery training curriculum when available as an alternative to the full 12 hour training; if not, then the full 12 hour training must be completed.

AND

b. Within 90 days of hire to provide this service, or by June 30, 2011 for staff who were currently working as an IIH Team member as of January 1, 2011, all IIH Team Leaders shall complete all supervisory level training required by the developer of the designated therapy, practice or model. If no specific supervisory level training exists for the designated therapy, practice, or model, then all IIH Team Leaders must complete a minimum of 12 hours of clinical supervision training.

All Non-Supervisory IIH Staff (QPs and APs)

In addition to the training required for all IIH staff, non-supervisory IIH staff, within 90 days of hire to provide this service, or by June 30, 2011 for staff who were currently working as an IIH Team member as of January 1, 2011, shall complete the following training requirements:

a. 13 hours of Introductory Motivational Interviewing (MI) training by a MINT Trainer** (mandatory 2-day training);
b. 11 hours of Introduction to System of Care Training; and

c. 12 hours of Person Centered Thinking training from a Learning Community for Person Centered Practices certified PCT trainer.
   1. All new hires to IIH must complete the full 12 hour training.
   2. Staff who previously worked in IIH for another agency and had six (6) hours of PCT training under the old requirement shall have to meet the 12 hour requirement when moving to a new company.
   3. The 12 hour PCT training must be portable if an employee changes jobs any time after completing the 12 hour requirement, as long as there is documentation of such training in the new employer's personnel records.
   4. Staff who previously worked in IIH within the same agency and had six (6) hours of PCT training under the old requirement may complete the additional six (6) hour PCT or Recovery training curriculum when available as an alternative to the full 12 hour training; if not, then the full 12 hour training must be completed.

**Note: Motivational Interviewing training must be provided by a Motivational Interviewing Network of Trainers (MINT) trainer (www.motivationalinterview.org).

Motivational Interviewing and all selected therapies, practices and models must be designated in the provider's program description. All staff shall be trained in Motivational Interviewing as well as the other practice(s) or model(s) identified above and chosen by the provider. All training shall be specific to the role of each staff member and specific to the population served.

The following table summarizes the training requirements for the IIH service.

Time Frame	Training Required	Who	Total Minimum Hours Required
Within **30 days** of hire to provide service	▪ 3 hours IIH service definition required components ▪ 3 hours of crisis response	▪ All Staff	6 hours
	▪ 3 hours of PCP Instructional Elements	▪ IIH Team Leaders ▪ QPs responsible for PCP	3 hours
Within **90 days** of hire to provide this service, **or** by **March 31, 2011** for staff members of existing providers	▪ 13 hours of Introductory Motivational Interviewing* (MI) (mandatory 2-day training) ▪ 12 hours of Person Centered Thinking ▪ 11 hours Introduction to SOC	▪ IIH Team Leaders	36 hours
Within **90 days** of hire to provide this service, **or** by **June 30, 2011** for staff members of existing providers	▪ 13 hours of Introductory Motivational Interviewing* (MI) (mandatory 2-day training) ▪ 12 hours of Person Centered Thinking ▪ 11 hours Introduction to SOC	▪ All Non-Supervisory IIH Team Staff	36 hours

Time Frame	Training Required	Who	Total Minimum Hours Required
	▪ To ensure the core fundamental elements of training specific to the modality** selected by the agency for the provision of services are implemented a minimum of 24 hours of the selected modality must be completed.	▪ All IIH Staff	24 hours
	▪ All supervisory level training required by the developer of the designated therapy, practice or model with a minimum of 12 hours must be completed.	▪ IIH Team Leaders	12 hours
Annually	▪ 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.).	▪ All IIH Staff	10 hours**

* 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 Family Therapy.

Total hours of training for the IIH staff:

a. IIH Staff other than Team Leader and QPs responsible for PCPs – **42 hrs plus the required hours of training for the selected model;**
b. QPs responsible for the PCP – **45 hours plus the required hours of training for the selected model;**
c. Team Leader – **45 hours plus the required hours of training for the selected model as well as the supervisory training requirement;**

AND

d. Annually, all IIH staff must have a **minimum of 10 hours** of training (**more** if fidelity to the model requires it).

Service Type and Setting

IIH is a direct and indirect, periodic, rehabilitative service in which the team members provide medically necessary services and interventions that address the diagnostic and clinical needs of the beneficiary. Additionally, the team provides interventions with the family and caregivers on behalf of and directed for the benefit of the beneficiary as well as plans, links, and monitors services on behalf of the beneficiary. This service is provided in any location. IIH providers shall deliver services in various environments, such as homes, schools, court, homeless shelters, libraries, street locations, and other community settings.

***Note:** For all services, federal Medicaid regulations shall deny Medicaid or NCHC payment for services delivered to inmates of public correctional institutions, secure juvenile detention centers, or to beneficiaries in facilities that have more than 16 beds and that are classified as institutions of mental diseases.

The IIH Team shall provide "first responder" crisis response, as indicated in the PCP, 24-hours-a-day, 7-days-a-week, 365-days-a-year, to beneficiaries of this service.

IIH also includes telephone time with the beneficiary and the beneficiary's family or caregivers, as well as collateral contact with persons who assist the beneficiary in meeting the beneficiary's rehabilitation goals specified in the PCP. IIH includes participation and ongoing clinical involvement with the Child and Family Team and meetings for the planning, development, implementation, and revision of the beneficiary's PCP.

Program Requirements

For IIH beneficiaries, all aspects of the delivery of this service occurring per date of service shall equal one per diem event of a two hour minimum. It is the expectation that service frequency shall decrease over time: at least 12 face-to-face contacts per beneficiary are required in the first month, and at least 6 face-to face contacts per beneficiary per month are required in the second and third months of IIH services. The IIH service varies in intensity to meet the changing needs of beneficiaries, families, and caregivers; to assist them in the home and community settings; and to provide a sufficient level of service as an alternative to the beneficiary's need for a higher level of care.

The IIH team works together as an organized, coordinated unit under the direct supervision of the team leader. The team meets at least weekly to ensure that the planned interventions are implemented by the appropriate staff members and to discuss beneficiary's progress toward goals as identified in the PCP.

This service is billed per diem, with a 2-hour minimum. That is, when the total contact time per date of service meets or exceeds 2 hours, it is a billable event. Based on the percentages listed below, the 2 hours may include:

a. direct clinical interventions as identified in the PCP; or
b. case management interventions (face-to-face, telephone time, and collateral contacts).

Services are delivered face-to-face with the beneficiary, family, and caregivers and in locations outside the agency's facility. Each provider agency must assess and document at least annually the aggregate services delivered at each site using both of the following quality assurance benchmarks:

a. at least 60% of the contacts shall occur face-to-face with the beneficiary, family, and caregivers. The remaining units may be either telephone or collateral contacts; and
b. at least 60% of staff time shall be spent working outside of the agency's facility, with or on behalf of the beneficiaries.

At any point while the beneficiary is receiving IIH services, IIH staff shall link the beneficiary to an alternative service when clinically indicated and functionally appropriate for the needs of the beneficiary and family as determined by the Child and Family Team. A full service note is required to document the activities that led to the referral.

It is incumbent upon the IIH provider agency as a professional entity to research and implement evidence-based practices appropriate to this service definition.

Eligibility Criteria

The beneficiary is eligible for this service when all of the following criteria are met:

a. there is a mental health or substance use disorder 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. based on the current comprehensive clinical assessment, this service was indicated and outpatient treatment services were considered or previously attempted, but were found to be inappropriate or not effective;
c. the beneficiary has current or past history of symptoms or behaviors indicating the need for a crisis intervention as evidenced by suicidal or homicidal ideation, physical aggression toward others, self-injurious behavior, serious risk taking behavior (running away, sexual aggression, sexually reactive behavior, or substance use);
d. the beneficiary's symptoms and behaviors are unmanageable at home, school, or in other community settings due to the deterioration of the beneficiary's mental health or substance use disorder condition, requiring intensive, coordinated clinical interventions;
e. the beneficiary is at imminent risk of out-of-home placement based on the beneficiary's current mental health or substance use disorder clinical symptomatology, or is currently in an out-of-home placement and a return home is imminent; and
f. there is no evidence to support that alternative interventions would be equally or more effective, based on North Carolina community practice standards (Best Practice Guidelines of the American Academy of Child and Adolescent Psychiatry, American Psychiatric Association, American Society of Addiction Medicine).

Entrance Process

The process for a beneficiary to enter this service includes a comprehensive clinical assessment that demonstrates medical necessity shall 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 part of the current comprehensive clinical assessment. Relevant diagnostic information shall be obtained and included in the PCP.

For Medicaid or NCHC funded IIH services, a signed service order shall be completed by a physician, licensed psychologist, physician assistant, or nurse practitioner according to his or her scope of practice. Each service order shall be signed and dated by the authorizing professional and shall indicate the *date* on which the service was ordered. A service order shall 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 shall be based on a comprehensive clinical assessment of the beneficiary's needs.

Prior authorization is required on the first day of this service.

Prior authorization by the Medicaid or NCHC approved vendor is required for Medicaid or NCHC funded IIH services,. To request the initial authorization, submit the PCP with signatures and the required authorization request form to the Medicaid or NCHC approved vendor. In addition, submit a completed LME-MCO Consumer Admission and Discharge Form to the LME-MCO.

Medicaid or NCHC may cover up to 60 days for the initial authorization period, based on medical

necessity.

After the initial authorization has been obtained, the team leader shall convene the Child and Family Team, in partnership with the beneficiary and the beneficiary's family, for the purpose of further developing the PCP.

Continued Service Criteria
The beneficiary is eligible to continue this service 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 out-of-home placement, based on current clinical assessment, history, and 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 premorbid level of functioning, are possible; or
d. The beneficiary fails to make progress, or demonstrates regression, in meeting goals through the interventions outlined in the PCP. The beneficiary's diagnosis should be reassessed to identify any unrecognized co-occurring disorders, and interventions or treatment recommendations shall be revised based on the findings. This includes consideration of alternative or additional services.

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

a. The beneficiary has achieved goals and is no longer in need of IIH services;
b. 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;
c. The beneficiary is not making progress or is regressing, and all reasonable strategies and interventions have been exhausted, indicating a need for more intensive services;
d. The beneficiary or legally responsible person no longer wishes to receive IIH services; or
e. The beneficiary, based on presentation and failure to show improvement despite modifications in the PCP, requires a more appropriate best practice treatment modality based on North Carolina community practice standards (for example, National Institute of Drug Abuse, American Psychiatric Association).

In addition, a completed LME-MCO Consumer Admission and Discharge Form shall be submitted to the LME-MCO.

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

Expected Clinical Outcomes

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

Expected clinical outcomes include but are not limited to the following:

a. Decrease in the frequency or intensity of crisis episodes;
b. Reduction in symptomatology;
c. Beneficiary and family or caregivers' engagement in the recovery process;
d. Improved beneficiary functioning in the home, school and community settings;
e. Ability of the beneficiary and family or caregiver to better identify and manage triggers, cues, and symptoms;
f. Beneficiary's sustained improvement in developmentally appropriate functioning in specified life domains;
g. Beneficiary's utilization increased coping skills and social skills that mitigate life stresses resulting from the beneficiary's diagnostic and clinical needs;
h. Reduction of symptoms and behaviors that interfere with the beneficiary's daily living, such as negative effects of the substance use disorder or dependence, psychiatric symptoms, or both;
i. Decrease in delinquent behaviors when present; and
j. Increased use of available natural and social supports by the beneficiary and family or caregivers.

Documentation Requirements

Refer to NC Medicaid Clinical Coverage Policies and the DMHDDSAS *Records Management and Documentation Manual* for a complete listing of documentation requirements.

For this service, one of the documentation requirements is a full service note for each contact or intervention (such as family counseling, individual counseling, case management, crisis response) for each date of service, written and signed by the person(s) who provided the service, which includes the following:

a. Beneficiary's name;
b. Medicaid or NCHC identification number;
c. Service Record Number;
d. Service provided (for example, IIH services);
e. Date of service;
f. Place of service;
g. Type of contact (face-to-face, telephone call, collateral);
h. Purpose of the contact;
i. Description of the provider's interventions;
j. Amount of time spent performing the intervention;
k. Description of the effectiveness of the interventions in meeting the beneficiary's specified goals as outlined in the PCP; and
l. Signature and credentials of the staff member(s) providing the service

A documented discharge plan shall be discussed with the beneficiary and included in the service record.

In addition, a completed LME-MCO Consumer Admission and Discharge Form shall be submitted to the LME-MCO.

Utilization Management

Services are based upon a finding of medical necessity, shall be directly related to the beneficiary's diagnostic and clinical needs, and are expected to achieve the specific rehabilitative goals specified in the

beneficiary's PCP. Medical necessity is determined by North Carolina community practice standards as verified by independent Medicaid consultants for Medicaid or NCHC funded services.

Medically necessary services are authorized in the most cost-efficient mode, as long as the treatment that is made available is similarly efficacious to services requested by the beneficiary's physician, therapist, or other licensed practitioner. Typically, a medically necessary service shall be generally recognized as an accepted method of medical practice or treatment. Each case is reviewed individually to determine if the requested service meets the criteria outlined under EPSDT.

No more than one beneficiary in the home may receive IIH services during any active authorization period.

For Medicaid or NCHC, prior authorization by the Medicaid or NCHC approved vendor is required according to published policy.

The Medicaid or NCHC approved vendor or the LME-MCO shall evaluate the request to determine if medical necessity supports more or less intensive services.

Medicaid or NCHC may cover up to 60 days for the initial authorization period based on the medical necessity documented in the beneficiary's PCP, the authorization request form, and supporting documentation. Submit the reauthorization request before the initial authorization expires. Medicaid and NCHC cover up to 60 days for reauthorization based on the medical necessity documented in the required PCP, the authorization request form, and supporting documentation.

If continued IIH services are needed at the end of the initial authorization period, submit the PCP and a new request for authorization reflecting the appropriate level of care and service to the Medicaid or NCHC approved vendor for Medicaid or NCHC services. This must occur before the authorization expires.

This service is billed per diem, with a 2-hour minimum. That is, when the total contact time per date meets or exceeds 2 hours, it is a billable event. The 2 hours may include both direct and indirect interventions (face-to-face, telephone time, and collateral contacts), based on the percentages listed in Program Requirements.

Service Exclusions and Limitations
A beneficiary may receive IIH services from only one IIH service provider organization during any active authorization period for this service.

The following are not billable under this service:

a. Transportation time (this is factored in the rate);
b. Any habilitation activities;
c. Any social or recreational activities (or the supervision thereof); or
d. Clinical and administrative supervision of staff, including team meetings (this is factored in the rate).

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

IIH services cannot be provided during the same authorization period as the following services:

a. Multisystemic Therapy;
b. Day Treatment;
c. individual, group and family therapy;
d. Substance Abuse Intensive Outpatient Program;
e. child residential treatment services Level II Program Type through Level IV;
f. Psychiatric Residential Treatment Facility (PRTF); or
g. substance abuse residential services.

Note: For Medicaid beneficiaries under the age of 21, additional products, services, or procedures may be requested even if they do not appear in the N.C. State Plan or when coverage is limited to those over 21 years of age. Service limitations on scope, amount, or frequency described in the coverage policy may not apply if the product, service, or procedure is medically necessary. [See **Subsection 2.2.1, EPSDT Special Provision,** in this policy (Clinical Coverage Policy 8A, *Enhanced Mental Health and Substance Abuse Services*).]

Multisystemic Therapy (MST): Medicaid and NCHC Billable Service

Service Definition and Required Components

Multisystemic Therapy (MST) is a program designed for youth generally between the ages 7 through 17 who:

a. have antisocial, aggressive or violent behaviors;
b. are at risk of out-of-home placement due to delinquency;
c. adjudicated youth returning from out-of-home placement;
d. chronic or violent juvenile offenders; or
e. youth with serious emotional disturbances or a substance use disorder and their families.

MST provides an intensive model of treatment based on empirical data and evidence-based interventions that target specific behaviors with individualized behavioral interventions. The purpose of this program is to keep youth in the home by delivering an intensive therapy to the family within the home. Services are provided through a team approach to beneficiaries and their families.

Services include:

a. an initial assessment to identify the focus of the MST intervention;
b. individual therapeutic interventions with the beneficiary and family;
c. peer intervention;
d. case management; and
e. crisis stabilization.

Specialized therapeutic and rehabilitative interventions are available to address special areas such as:

a. a substance use disorder;
b. sexual abuse;
c. sex offending; and
d. domestic violence.

Services are available in-home, at school, and in other community settings. The duration of MST intervention is 3 to 5 months. MST involves families and other systems such as the school, probation officers, extended families, and community connections.

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

This team approach is structured face-to-face therapeutic interventions to provide support and guidance in all areas of functional domains:

a. adaptive;
b. communication;
c. psychosocial;
d. problem solving; and
e. behavior management.

The service promotes the family's capacity to monitor and manage the beneficiary's behavior.

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

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

MST providers must have the ability to deliver services in various environments, such as homes, schools, homeless shelters, street locations, etc. Organizations that provide MST must provide "first responder" crisis response on a 24-hours-a-day, 7-days-a-week, 365-days-a-year, basis to beneficiaries who are receiving this service.

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

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

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

Clinical Requirements
For registered beneficiaries, a minimum of 12 contacts must occur within the first month. For the second and third months of MST, an average of 6 contacts must occur each month. It is the expectation that service frequency shall be titrated over the last 2 months.

Units must be billed in 15-minute increments.

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

a. A minimum of 50% of the contacts occur face-to-face with the beneficiary or family. The remaining units may either be phone or collateral contacts; and
b. A minimum of 60% of staff time must be spent working outside of the agency's facility, with or on behalf of beneficiaries.

Utilization Management
Authorization by the statewide vendor is required. The amount, duration, and frequency of the service must be included in an beneficiary's PCP. The initial authorization for services may not exceed 30 days. Reauthorization for services may not exceed 120 days and is so documented in the PCP and service record.

Utilization management must be performed by NC Medicaid's designated contractor or LME-MCO.

No more than 480 units of services can be provided to a beneficiary in a 3-month period unless specific authorization for exceeding this limit is approved.

Eligibility Criteria

The beneficiary is eligible for this service when all of the following criteria are met:
a. there is a mental health or substance use disorder diagnosis present, other than a sole diagnosis of intellectual and developmental disability;
b. the beneficiary must be between the ages of 7 through 17;
c. the beneficiary displays willful behavioral misconduct (e.g., theft, property destruction, assault, truancy or substance use or juvenile sex offense), when in conjunction with other adjudicated delinquent behaviors;
d. the beneficiary is at imminent risk of out-of-home placement or is currently in out-of-home placement due to delinquency and reunification is imminent within 30 days of referral; and
e. the beneficiary has a caregiver that is willing to assume long term parenting role and caregiver who is willing to participate with service providers for the duration of the treatment.

Continued Service Criteria
The beneficiary is eligible to continue this service 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 history, or the tenuous nature of the functional gains, or any one of the following apply:
a. beneficiary continues to exhibit willful behavioral misconduct;

AND

b. there is a reasonable expectation that the beneficiary shall continue to make progress in reaching overarching goals identified in MST in the first 4 weeks;

OR

c. beneficiary is not making progress; the PCP must be modified to identify more effective interventions;

OR

d. beneficiary is regressing; the PCP must be modified to identify more effective interventions.

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

The beneficiary's level of functioning has improved with respect to the goals outlined in the PCP, or no longer benefits from this service. The decision shall be based on one of the following:

a. beneficiary has achieved 75% of the PCP goals, discharge to a lower level of care is indicated;
b. beneficiary is not making progress or is regressing, and all realistic treatment options within this modality have been exhausted;
c. the beneficiary or family requests discharge and is not imminently dangerous to self or others; or
d. the beneficiary requires a higher level of care (i.e., inpatient hospitalization or PRTF).

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

Documentation Requirements

The minimum standard is a daily full service note that includes:

a. the beneficiary's name;
b. Medicaid or NCHC identification number;
c. date of service;
d. purpose of contact;
e. describes the provider's intervention;
f. time spent performing the intervention;
g. effectiveness of interventions; and
h. signature of the staff providing the service.

Expected Outcomes

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

Service Exclusions and Limitations

A beneficiary may receive MST services from only one MST provider organization at a time.

MST services may not be billed for beneficiaries who are receiving:

a. Intensive In-Home Services;
b. Day Treatment;
c. Hourly Respite;
d. individual, group or family therapy;
e. SAIOP;
f. child residential Level II–IV; or
g. substance abuse residential services.

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

Community Support Team (CST) (MHSA): Medicaid Billable Service

Service Definition and Required Components

Community Support Team (CST) services consist of community-based mental health and substance abuse rehabilitation services and necessary supports provided through a team approach to assist adults* in achieving rehabilitative and recovery goals. It is intended for individuals with mental illness, substance use disorders, or both who have complex and extensive treatment needs. The individual's clinical needs are evidenced by the presence of a diagnosable mental illness, substance use disorder (as defined by the DSM-5, or any subsequent editions of this reference material), or both, with symptoms and effects documented in the comprehensive clinical assessment and the PCP.

***Note:** The age at which a beneficiary is considered an "adult" is determined by the funding source. Medicaid-funded services for adults begin at age 21. Medicaid beneficiaries under the age of 21 may be eligible for adult services under EPSDT.

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:

a. reduce presenting psychiatric or substance use disorder symptoms and promote symptom stability;
b. restore the beneficiary's community living and interpersonal skills;
c. provide first responder intervention to deescalate the current crisis; and
d. ensure linkage to community services and resources.

This team service includes a variety of interventions that are available 24-hours-a-day, 7-days-a-week, 365-days-a-year, and are 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 as clinically indicated. Not all team members are required to provide direct intervention to each beneficiary on the caseload. The team leader must provide direct clinical interventions with each beneficiary. The team approach involves structured, face-to-face, scheduled therapeutic interventions to provide support and guidance in all areas of functioning in life domains: emotional, social, safety, housing, medical and health, educational, vocational, and legal.

The CST licensed professional or associate level licensed professional team leader drives the delivery of this rehabilitative service. In partnership with the beneficiary, the assigned CST QP identified as the person responsible for the PCP has ongoing clinical responsibility for developing and revising the PCP.

Under the direction of the team leader, CST services are delivered to beneficiaries, with a team approach, primarily in their living environments and include but are not limited to the following interventions as clinically indicated:

a. Individual therapy;
b. Behavioral interventions such as modeling, behavior modification, behavior rehearsal;
c. Substance use disorder treatment interventions;
d. Development of relapse prevention and disease management strategies to support recovery;
e. Psychoeducation for the beneficiary, families, caregivers, or other individuals involved with the beneficiary about the beneficiary's diagnosis, symptoms, and treatment;
f. Psychoeducation regarding the identification and self-management of the prescribed medication regimen, with documented communication to prescribing practitioner(s);

g. Intensive case management;
    1. assessment
    2. planning
    3. linkage and referral to paid and natural supports
    4. monitoring and follow up
h. Arranging for psychological and psychiatric evaluations; and
i. Crisis management, including crisis planning and prevention

For Medicaid-funded CST services, a signed service order shall be completed by a physician, licensed psychologist, physician assistant, or nurse practitioner according to his or her scope of practice and shall be accompanied by other required documentation as outlined elsewhere in this policy (NC Medicaid Clinical Coverage Policy 8A, *Enhanced Mental Health and Substance Abuse Services*). Each service order shall be signed and dated by the authorizing professional and shall indicate the *date* on which the service was ordered. A service order shall be in place *prior to* or on the day that the service is initially provided in
order to bill Medicaid for the service. The service order shall be based on a comprehensive clinical assessment of the beneficiary's needs.

Provider Requirements

CST services shall be delivered by practitioners employed by mental health or substance abuse provider organizations that:

a. are currently certified as a Critical Access Behavioral Healthcare Agency (CABHA) according to 10A NCAC 22P;
b. meet the provider qualification policies, procedures, and standards established by NC Medicaid;
c. meet the provider qualification policies, procedures, and standards established by the Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMHDDSAS); and
d. fulfill the requirements of 10A NCAC 27G.

These policies and procedures set forth the administrative, financial, clinical, quality improvement, and information services infrastructure necessary to provide services. Provider organizations shall demonstrate that they meet these standards by being credentialed by the Local Management Entity (LME). As part of the endorsement, the provider must notify the LME-MCO of the therapies, practices, or models that the provider has chosen to implement. Additionally, within one year of enrollment as a provider with NC Medicaid, the organization shall achieve national accreditation with at least one of the designated accrediting agencies. (Providers who were enrolled prior to July 1, 2008, shall have achieved national accreditation within three years of their enrollment date.) The organization shall be established as a legally constituted entity capable of meeting all of the requirements of the Provider Endorsement, Medicaid Enrollment Agreement, Medicaid Bulletins, and service implementation standards.

For Medicaid services, the organization is responsible for obtaining prior authorization from Medicaid's approved vendor for medically necessary services identified in the PCP. The CST provider organization shall comply with all applicable federal and state requirements. This includes but is not limited to North Carolina Department of Health and Human Services (DHHS) statutes, rules, policies, and Implementation Updates; Medicaid Bulletins; and other published instruction.

Staffing Requirements

CST shall be comprised of three full-time staff positions as follows:

a. One full-time equivalent (FTE) team leader who is a licensed professional who has the knowledge, skills, and abilities required by the population and age to be served (may be filled by no more than two individuals). An associate level licensed professional actively seeking licensure 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.
b. One FTE QP who has the knowledge, skills, and abilities required by the population and age to be served (may be filled by no more than two individuals).
c. One FTE who is a QP, AP, paraprofessional, or certified peer support specialist, and who has the knowledge, skills, and abilities required by the population and age to be served (may be filled by no more than two individuals).

For CST focused on substance use disorder interventions, the team shall include at least one certified clinical supervisor (CCS), licensed or associate level licensed clinical addiction specialist (LCAS), or certified substance abuse counselor (CSAC) as a member of the team.

The team leader shall meet the requirements specified for licensed or associate level licensed status according to 10A NCAC 27G. 0104 and have the knowledge, skills, and abilities required by the population and age to be served. Persons who meet the requirements specified for QP, AP, or Paraprofessional status according to 10A NCAC 27G .0104 and who have the knowledge, skills, and abilities required by the population and age to be served may deliver CST services.

The **Certified Peer Support Specialist** shall be an individual who is or has been a beneficiary of mental health or substance abuse services and is committed to his or her own personal recovery. A certified peer support specialist is a fully integrated team member who draws from his or her own experiences and knowledge gained as a beneficiary to provide individualized interventions to beneficiaries of CST services. The certified peer support specialist validates the beneficiary experiences and provides guidance and encouragement in taking responsibility for and actively participating in their own recovery. Certified peer support specialists also provide essential expertise and consultation to the entire team to promote a culture in which each individual's point of view and preferences are recognized, understood, respected, and integrated into treatment, rehabilitation, and community self-help activities.

Note: Supervision of CST staff is covered as an indirect cost and therefore must not be billed separately as CST services.

The CST maintains a maximum caseload of 45 beneficiaries per team. The beneficiary-to-staff ratio is no more than 15:1. The team caseload shall be determined by the level of acuity and the needs of the beneficiaries served. CST is designed to provide services through a team approach, and not individual staff caseloads. Factors to consider in determining the number of beneficiaries to be served include but are not limited to the needs of special populations (persons who are homeless, those involved in the judicial system, etc.), the intensity of the needs of the beneficiaries served, individual needs requiring services during evening and weekend hours, and geographical areas covered by the team.

The following charts set forth the additional activities included in this service definition. These activities reflect the appropriate scopes of practice for the CST staff identified below.

Community Support Team
Team Leader
• 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 coordinating 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 Leader • 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

Team Leader or QP
• Provides psychoeducation as indicated in the PCP • Assists with crisis interventions • Assists the Team Leader with behavioral and substance use disorder treatment interventions • Assists with the development of relapse prevention and disease management strategies • Coordinates and oversees the initial and ongoing assessment activities • Develops the initial PCP and its ongoing revisions and ensures its implementation • Consults with identified medical (for example, 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

(charts continue next page)

AP, QP, or Team Leader
• Provides psychoeducation as indicated in the PCP • Assists with crisis interventions • Assists the team leader 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 leader as outlined in the PCP

Paraprofessional
• Provides psychoeducation as indicated in the PCP • Assists with crisis interventions • Assists the team leader 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 leader 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 the beneficiary's legal rights within the community

All staff providing CST services shall have a minimum of 1 year of documented experience with the adult mental health or substance use disorder population to be served. (Exception: A certified peer support specialist is not required to demonstrate 1 year of documented experience in working with the adult mental health or substance use disorder population, as his or her personal experience in mental health or substance abuse services fulfills that requirement.)

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

Staff Training
The following are the requirements for training staff in CST.

All CST Staff

All CST staff shall be trained according to the following training schedule:

a. Within 30 days of hire to provide CST services, all staff shall complete the following training requirements:
   1. 3 hours of training in the CST service definition required components;
   2. 3 hours of crisis response training; and
   3. 3 hours of PCP Instructional Elements training (required for only CST Team Leaders and CST QP staff responsible for PCP).

b. Within 90 days of hire to provide this service, or by June 30, 2011 for staff who were currently working as an CST Team member as of January 1, 2011, all CST staff shall complete the following training requirements:
   1. CST staff must complete 24 hours* of training (a minimum of 3 days) in one of the designated therapies, practices or models below specific to the population(s) to be served by each CST Team:
      The designated therapies, practices or models are as follows:
      A. Cognitive Behavior Therapy:
      B. Trauma-Focused Therapy (For Example: Seeking Safety, TARGET, TREM, Prolonged Exposure Therapy for PTSD:) or
      C. Illness Management and Recovery (SAMHSA Toolkit http://mentalhealth.samhsa.gov/cmhs/CommunitySupport/toolkits/illness/default.asp).
         i. Practices or models must be treatment focused models, not prevention or education focused models.
         ii. Each practice or model chosen must specifically address the treatment needs of the population to be served by each CST.
         iii. Cognitive Behavior Therapy training must be delivered by a licensed professional.
         iv. 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.

* Licensed professionals (LP) who have documented evidence of post graduate training in the chosen qualifying practice (identified in this clinical coverage policy) dated no earlier than March 20, 2006 may count those training hours toward the 24 hour requirement. It is the responsibility of the LP to have clearly documented evidence of the hours and type of training received.

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 of licensed professionals. It is expected that licensed (or associate level licensed, under supervision) staff shall practice within their scope of practice.

Non-licensed staff [QPs, APs, Peer Support Specialists, and Paraprofessionals] 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 shall practice under supervision according to the service definition. 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 follow up training, clinical supervision, or ongoing continuing education requirements for fidelity of the clinical model or EBP(s) must be followed.

c. On an annual basis, follow up training and ongoing continuing education for fidelity to chosen modality (Cognitive Behavioral Therapy, Trauma Focused Therapy, and Illness Management and Recovery (SAMHSA Toolkit) is required. If no requirements have been designated by the developers of that modality, a minimum of 10 hours of continuing education in components of the selected modality must be completed annually.

CST Team Leaders

All CST Team Leaders shall receive the following training in addition to that required for all CST staff:

a. In addition to the training required for all CST staff, CST Team Leaders, within **90 days** of hire to provide this service, **or** by **March 31, 2011** for staff who were currently working as a CST Team member as of January 1, 2011, shall completed the following training requirements:
   1. 13 hours of Introductory Motivational Interviewing (MI) training by a MINT Trainer** (mandatory 2-day training).
   2. 12 hours of Person Centered Thinking (PCT) training from a Learning Community for Person Centered Practices certified PCT trainer.
      A. All new hires to CST must complete the full 12 hour training.
      B. Staff who previously worked in CST for another agency and had six (6) hours of PCT training under the old requirement shall have to meet the 12 hour requirement when moving to a new company.
      C. The 12 hour PCT training shall be portable if an employee changes jobs any time after completing the 12 hour requirement, as long as there is documentation of such training in the new employer's personnel records.
      D. Staff who previously worked in CST within the same agency and had six (6) hours of PCT training under the old requirement may complete the additional six (6) hour PCT or Recovery training curriculum when available as an alternative to the full 12 hour training; if not, then the full 12 hour training must be completed.

b. Within 90 days of hire to provide this service, or by June 30, 2011 for staff who were currently working as a CST Team member as of January 1, 2011, all CST team leaders shall complete all supervisory level training required by the developer of the designated therapy, practice or model. If no specific supervisory level training exists for the designated therapy, practice, or model, then all CST team leaders must complete a minimum of 12 hours of clinical supervision training.

All Non-Supervisory CST Staff (QPs, APs, Paraprofessionals and Certified Peer Support Specialists)

In addition to the training required for all CST staff, non-supervisory CST staff, within 90 days of hire to provide this service, or by June 30, 2011 for staff who were currently working as a CST Team member as of January 1, 2011, shall complete the following training requirements:

a. 13 hours of Introductory Motivational Interviewing* (MI) training (mandatory 2-day training)
b. 12 hours of Person Centered Thinking (PCT) training from a Learning Community for Person Centered Practices certified PCT trainer.
    1. All new hires to CST must complete the full 12 hour training.
    2. Staff who previously worked in CST for another agency and had six (6) hours of PCT training under the old requirement shall have to meet the 12 hour requirement when moving to a new company.
    3. The 12 hour PCT training shall be portable if an employee changes jobs any time after completing the 12 hour requirement, as long as there is documentation of such training in the new employer's personnel records.
    4. Staff who previously worked in CST within the same agency and had six (6) hours of PCT training under the old requirement may complete the additional six (6) hour PCT or Recovery training curriculum when available as an alternative to the full 12 hour training; if not, then the full 12 hour training must be completed.

**Note: Motivational Interviewing training must be provided by a Motivational Interviewing Network of Trainers (MINT) trainer (www.motivationalinterview.org).

Motivational Interviewing and all selected therapies, practices and models must be designated in the provider's program description. All staff shall be trained in Motivational Interviewing as well as the other practice(s) or model(s) identified above and chosen by the provider. All training shall be specific to the role of each staff member and specific to the population served.

Time Frame	Training Required	Who	Total Minimum Hours Required
Within **30 days** of hire to provide service	▪ 3 hours CST service definition required components ▪ 3 hours of crisis response	▪ All Staff	6 hours
	▪ 3 hours of PCP Instructional Elements	▪ CST Team Leaders ▪ QPs responsible for PCP	3 hours
Within **90 days** of hire to provide this service, **or** by **March 31, 2011**, for staff members of existing providers	▪ 13 hours of Introductory Motivational Interviewing* (MI) (mandatory 2-day training) ▪ 12 hours of Person Centered Thinking	▪ CST Team Leaders	25 hours
Within **90 days** of hire to provide this service, **or** by **June**	▪ 13 hours of Introductory Motivational Interviewing* (MI) (mandatory 2-day training)	▪ All Non-Supervisory CST Team Staff	25 hours

Time Frame	Training Required	Who	Total Minimum Hours Required
30, 2011, for staff members of existing providers	▪ 12 hours of Person Centered Thinking		
	▪ To ensure the core fundamental elements of training specific to the modality** selected by the agency for the provision of services are implemented a minimum of 24 hours of the selected modality must be completed.	▪ All CST Staff	24 hours
	▪ All supervisory level training required by the developer of the designated therapy, practice or model with a minimum of 12 hours must be completed.	▪ CST Team Leaders	12 hours
Annually	▪ 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.).	▪ All CST Staff	10 hours**

* 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).

Total hours of training for the CST staff:

a. CST Staff other than the Team Leader and QPs responsible for PCPs – **31 hours plus required hours for selected model**
b. QPs responsible for the PCP – **34 hours plus required hours for selected model**
c. Team Leader – **34 hours plus required hours for selected model and supervisory training requirement**

AND

d. Annually, all CST staff must have a **minimum of 10 hours** of training (**more** if fidelity to the model requires it)

Service Type and Setting

CST is a direct and indirect periodic rehabilitative service in which the CST members provide medically necessary services and interventions that address the diagnostic and clinical needs of the beneficiary and also arrange, coordinate, and monitor services on behalf of the beneficiary. This service is provided in any location. CST providers shall deliver services in various environments, such as homes, schools, courts, homeless shelters, street locations, libraries, and other community settings.

***Note:** For all services, federal Medicaid regulations shall deny Medicaid payment for services delivered to inmates of public correctional institutions, secure detention centers, or to patients in facilities that have more than 16 beds and that are classified as institutions of mental diseases.

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

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

Program Requirements

The CST works together as an organized, coordinated unit under the direct supervision of the team leader. The team meets at least weekly to ensure that the planned interventions are implemented by the appropriate staff members and to discuss beneficiary's progress toward goals as identified in the PCP.

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. During a beneficiary's first month of service, the CST shall provide at least eight (8) contacts. In subsequent months, CST services are provided at least once a week.

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 in an attempt to locate and engage the beneficiary to continue the beneficiary's treatment be 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.

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

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

Units are billed in 15-minute increments.

Eligibility Criteria

The beneficiary is eligible for this service when the following criteria are met:

a. 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.

AND

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

AND

c. For beneficiaries with a primary substance use disorder diagnosis, the American Society for Addiction Medicine Criteria is met.

AND

d. Four or more of the following conditions related to the diagnosis are present:
    1. High use of acute psychiatric hospitals or crisis or emergency services, including but not limited to mobile crisis management, in-clinic or crisis residential (2 or more admissions in a year), extended hospital stay (30 days within the past year), or psychiatric emergency services;
    2. History of difficulty using traditional services (missing office appointments, difficulty maintaining medication schedules, etc.);
    3. Intermittently medication refractory (not achieving full response to medication or sustained reduction of symptoms) or difficulty maintaining compliance with taking medication;
    4. Co-occurring diagnoses of a substance use disorder (ASAM—any level of care) and mental illness;
    5. Legal issues (conditional release for non-violent offense; history of failures to show in court, etc.) related to the beneficiary's mental or substance use disorder diagnosis;
    6. Homeless or at high risk of homelessness due to residential instability resulting from the beneficiary's mental health or substance use disorder diagnosis;
    7. Clinical evidence of suicidal gestures, persistent ideation, or both in past 3 months;
    8. Ongoing inappropriate public behavior in the community within the last 3 months;
    9. Within the past 6 months, physical aggression, intense verbal aggression, or both toward self or others (due to symptoms associated with diagnosis) sufficient to create functional problems in the home, community, school, job, etc; or
    10. A less intense level of care has been tried and found to be ineffective for the clinical needs of the beneficiary.

AND

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

Entrance Process

A comprehensive clinical assessment that demonstrates medical necessity shall 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 utilized as a part of the current comprehensive clinical assessment. Relevant diagnostic information shall be obtained and be included in the PCP.

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

Prior authorization is required on the first day of this service.

For Medicaid-funded CST services, prior authorization by the Medicaid-approved vendor is required. To request the initial authorization, submit the PCP with signatures and the required authorization request form to the Medicaid-approved vendor. In addition, submit a completed LME-MCO Consumer Admission and Discharge Form to the LME-MCO.

Medicaid funded services may cover up to 60 days for the initial authorization period based on medical necessity.

Continued Service Criteria

The beneficiary is eligible to continue this service if:

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

AND

ANY of the following applies:

b. The beneficiary has achieved current PCP goals, and additional goals are indicated as evidenced by documented symptoms;

c. The beneficiary is making satisfactory progress toward meeting goals and there is documentation that supports that continuation of this service shall be effective in addressing the goals outlined in the PCP;

d. 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 level of functioning, are possible; or

e. The beneficiary fails to make progress, demonstrates regression, or both in meeting goals through the interventions outlined in the PCP. The beneficiary's diagnosis should be reassessed to identify any unrecognized co-occurring disorders, and treatment recommendations shall be revised based on the findings. This includes the consideration of alternative or additional services.

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 is not making progress or is regressing and all reasonable strategies and interventions have been exhausted, indicating a need for more intensive services;
d. The beneficiary or legally responsible person no longer wishes to receive CST services; or
e. The beneficiary, based on presentation and failure to show improvement, despite modifications in the PCP, requires a more appropriate best practice treatment modality based on North Carolina community practice standards (for example, National Institute of Drug Abuse, American Psychiatric Association).

Expected Clinical Outcomes

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

Expected outcomes include but are not limited to 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; or
k. decreased criminal justice involvement related to the beneficiary's mental health or substance use disorder diagnosis

Documentation Requirements

Refer to NC Medicaid Clinical Coverage Policies and the DMHDDSAS *Records Management and Documentation Manual* for a complete listing of documentation requirements.

For this service, one of the documentation requirements is a full service note for each contact or intervention (such as individual counseling, case management, crisis response), for each date of service, written and signed by the person(s) who provided the service, that includes the following:

a. Beneficiary's name;
b. Service record number;
c. Medicaid identification number;
d. Service provided (for example, CST);
e. Date of service;
f. Place of service;
g. Type of contact (face-to-face, telephone call, collateral);
h. Purpose of the contact;
i. Description of the provider's interventions;
j. Amount of time spent performing the interventions;
k. Description of the effectiveness of the interventions in meeting the beneficiary's specified goals as outlined in the PCP; and
l. Signature and credentials of the staff member(s) providing the service (for paraprofessionals, position is required in lieu of credentials with staff signature).

A documented discharge plan shall be discussed with the beneficiary and included in the service record.

In addition, a completed LME-MCO Consumer Admission and Discharge Form shall be submitted to the LME-MCO.

Utilization Management

Services are based upon a finding of medical necessity, shall be directly related to the beneficiary's diagnostic and clinical needs, and are expected to achieve the specific rehabilitative goals specified in the beneficiary's PCP. Medical necessity is determined by North Carolina community practice standards as verified by independent Medicaid consultants.

Medically necessary services are authorized in the most cost-efficient 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 shall be generally recognized as an accepted method of medical practice or treatment. Each case is reviewed individually to determine if the requested service meets the criteria outlined under EPSDT.

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

The Medicaid-approved vendor or the LME-MCO shall evaluate the request to determine if medical necessity supports more or less intensive services.

Medicaid may cover up to 60 days for the initial authorization period, based on the medical necessity documented in the beneficiary's PCP, the authorization request form, and supporting documentation. Reauthorization requests shall be submitted before the initial authorization expires. Medicaid may cover up to 60 days for reauthorization, based on the medical necessity documented in the PCP, the authorization request form, and supporting documentation.

If continued CST services are needed at the end of the initial authorization period, the PCP and a new request for authorization reflecting the appropriate level of care and service shall be submitted to the Medicaid-approved vendor for Medicaid services. This should occur before the authorization expires.

Effective August 1, 2010, no more than 128 units (32 hours) of service per 60 calendar day period may be authorized for a beneficiary. CST services are not intended to remain at this level of intensity for the long term. Services shall not be authorized for more than six months per calendar year. Any request for an exception to this six month limit must be accompanied by a comprehensive clinical assessment completed by an independent licensed professional and an updated PCP with new service order signed by an MD, Licensed Psychologist, NP or PA. The Clinical Assessment must meet the requirements as specified in IU #36 and clearly document medical necessity as defined in the continued service criteria in this policy.

The independent licensed mental health professional must meet the criteria included in 10A NCAC 27G .0104 and must not be employed by the agency providing the Community Support Team service or have any financial or other interest in the agency providing the Community Support Team service.

Units are billed in 15-minute increments.

Service Exclusions and Limitations

A beneficiary may receive CST services from only one CST provider organization during any active authorization period for this service.

The following are not billable under this service:

a. transportation time (this is factored in the rate);
b. habilitation activities;
c. social or recreational activities (or the supervision thereof); and
d. clinical and administrative supervision of staff (this is factored in the rate).

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

CST services may be provided for beneficiaries residing in adult mental health residential facilities: independent living; supervised living low or moderate; and group living low, moderate, or high. CST services may not be provided for beneficiaries residing in a nursing home facility.

CST services may be billed in accordance with the authorization for services during the same authorization period as Psychosocial Rehabilitation services based on medical necessity.

For the purposes 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 QP, CST services may be provided by the QP and billed for a maximum of 8 units for the first and last 30-day periods for beneficiaries who are authorized to receive the following service:

a. Assertive Community Team Treatment

For the purposes of helping a beneficiary transition to and from a service (facilitating an admission to a service, discharge planning, or both), providing coordination during the provision of a service, and ensuring that the service provider works directly with the CST QP, CST services may be provided by the QP and billed for a maximum of eight units for each 30-day period for beneficiaries who are authorized to receive one of the following services:

a. Substance Abuse Intensive Outpatient Program; or
b. Substance Abuse Comprehensive Outpatient Treatment.

Note: The provider of these services becomes responsible for the PCP and all other clinical home responsibilities.

To help a beneficiary transition to and from a service (facilitating an admission to a service, discharge planning, or both), provide coordination during the provision of a service, and ensure the service provider works directly with the CST QP, CST services may be provided by the QP and billed in accordance with the authorization for services during the same authorization period, for the following services based on medical necessity:

a. all detoxification services;
b. professional Treatment Services in Facility-Based Crisis Programs;
c. partial Hospitalization;
d. substance Abuse Medically Monitored Community Residential Treatment; or
e. substance Abuse Non-Medically Monitored Community Residential Treatment.

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

Psychosocial Rehabilitation: Medicaid Billable Service

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

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

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

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

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

Provider Requirements
Psychosocial Rehabilitation services must be delivered by a mental health provider organization that meets the provider qualification policies, procedures, and standards established by the Division of Mental Health (DMH) and the requirements of 10A NCAC 27G. These policies and procedures set forth the administrative, financial, quality improvement, and information services infrastructure necessary to provide services. Provider organizations must demonstrate that they meet these standards by being credentialed by the LME-MCO. Within three years of enrollment as a provider, the organization must have achieved national accreditation. The organization must be established as a legally recognized entity in the United States and qualified or registered to do business as a corporate entity in the State of North Carolina.

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

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

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

If the PSR provider organization also provides Supported Employment or Transitional Employment, these services are to be reported separately including reporting of separate costs.

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

Utilization Management
Authorization by NC Medicaid's designated contractor or LME-MCO is required. The amount, duration, and frequency of services must be included in a beneficiary's PCP, and authorized on or before the day services are to be provided. Initial authorization for services must not exceed 90 days. Reauthorization must not exceed 180 days and be so documented in the service record.

Utilization management must be performed by NC Medicaid's designated contractor or LME-MCO.

Eligibility Criteria

The beneficiary is eligible for this service when all of the following criteria are met:

a. there is a mental health diagnosis present;
b. Level of Care Criteria are met;
c. The beneficiary has impaired role functioning that adversely affects at least two of the following:
    1. employment;
    2. management of financial affairs;
    3. ability to procure needed public support services;
    4. appropriateness of social behavior; or
    5. activities of daily living.
d. The beneficiary's level of functioning may indicate a need for psychosocial rehabilitation if the beneficiary has unmet needs related to recovery and regaining the skills and experience needed to maintain personal care, meal preparation, housing, or to access social, vocational and recreational opportunities in the community.

Continued Service Criteria
The beneficiary is eligible to continue this service 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 history, or the tenuous nature of the functional gains, or any one of the following apply:

a. beneficiary has achieved initial rehabilitation goals in the PCP goals and continued services are needed in order to achieve additional goals;
b. beneficiary is making satisfactory progress toward meeting rehabilitation goals;
c. beneficiary is making some progress, but the specific interventions need to be modified so that greater gains, which are consistent with the beneficiary's rehabilitation goals are possible or can be achieved;
d. beneficiary is not making progress; the rehabilitation goals must be modified to identify more effective interventions; or
e. beneficiary is regressing; the PCP must be modified to identify more effective interventions.

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

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

a. beneficiary has achieved rehabilitation goals, discharge to a lower level of care is indicated;
b. beneficiary is not making progress, or is regressing and all realistic treatment options with this modality have been exhausted; or
c. beneficiary requires a more intensive level of care or service.

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

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

Documentation Requirements
Minimum standard is a full weekly service note.

Service Exclusions
PSR cannot be provided during the same authorization period with the following services: Partial Hospitalization and ACT.

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

Child and Adolescent Day Treatment (MHSA): Medicaid and NCHC Billable Service

Service Definition and Required Components

Day Treatment is a structured treatment service in a licensed facility, for children or adolescents and their families, that builds on strengths and addresses identified needs. This medically necessary service directly addresses the beneficiary's diagnostic and clinical needs, which are evidenced by the presence of a diagnosable mental, behavioral, or emotional disturbance (as defined by the DSM-5, or any subsequent editions of this reference material), with symptoms and effects documented in a comprehensive clinical assessment and the PCP.

This service is designed to serve children who, as a result of their mental health or substance use disorder treatment needs, are unable to benefit from participation in academic or vocational services at a developmentally appropriate level in a traditional school or work setting. The provider implements therapeutic interventions that are coordinated with the beneficiary's academic or vocational services available through enrollment in an educational setting. A Memorandum of Agreement (MOA) between the Day Treatment provider, the Local Management Entity (LME), the Local Education Agency (LEA) (or private or charter school) is highly encouraged. The purpose of an MOA is to ensure that all relevant parties (LEA, LME-MCO, provider) understand and support the primary purpose of the Day Treatment service definition which is to serve children who, as a result of their mental health or substance use disorder treatment needs, are unable to benefit from participation in academic or vocational services at a developmentally appropriate level in a traditional school or work setting.

These interventions are designed to reduce symptoms, improve behavioral functioning, increase the individual's ability to cope with and relate to others, promote recovery, and enhance the beneficiary's capacity to function in an educational setting, or to be maintained in community based services. It is available for children 5 to 17 years of age (20 or younger for those who are eligible for Medicaid and age 6-18 for those eligible for NCHC). Day Treatment must address the age, behavior, and developmental functioning of each beneficiary to ensure safety, health and appropriate treatment interventions within the program milieu.

Day Treatment provides mental health or substance use disorder interventions in the context of a therapeutic treatment milieu. This service is focused on providing clinical interventions and service to support the beneficiary in achieving functional gains that support the beneficiary's integration in educational or vocational settings, is developmentally appropriate, is culturally relevant and sensitive, and is child and family centered. Each Child and Adolescent Day Treatment provider must follow a clearly identified clinical model(s) or evidence-based treatment(s) consistent with best practice. The selected model(s) must be specified and described in the provider's program description. The clinical model(s) or Evidence-Based Practices (EBPs) should be expected to produce positive outcomes for this population.

The selected clinical model(s) or EBP(s) must address the clinical needs of each beneficiary, and those needs shall be identified in the comprehensive clinical assessment and documented in the PCP. All criteria (program, staffing, clinical and other) for the Day Treatment service definition and all criteria for the chosen clinical model(s) or EBP(s) must be followed. Where there is any incongruence between the service definition and the clinical model(s) or EBP(s), the more stringent requirements must be met.

Providers of Day Treatment must have completed the required certification or licensure of the selected model(s) (as required by the developer of the clinical model or EBP) and must document ongoing supervision and compliance within the terms of the clinical model(s) or EBP(s) to assure model fidelity.

All staff participating in the delivery of the clinical model(s) or EBP(s) shall complete the training requirements of that practice within the first 30 days of each staff member's date of employment to provide this service. This is in addition to the 20 hours of staff training that are minimally required for the delivery of the Day Treatment. All follow up training or ongoing continuing education requirements for fidelity of the clinical model(s) or EBP(s) must be followed.

Intensive services are designed to reduce symptoms and improve level of social, emotional, or behavioral functioning including but not limited to:

a. functioning in an appropriate educational setting;
b. maintaining residence with a family or community based non-institutional setting (foster home, Therapeutic Family Services); and
c. maintaining appropriate role functioning in community settings.

Day Treatment implements developmentally appropriate direct preventive and therapeutic interventions to accomplish the goals of the PCP, as related to the mental health or substance use disorder diagnosis. These interventions include, but are not limited to, the following:

a. development of skills and replacement behaviors which can be practiced, applied, and continually addressed with treatment staff in a therapeutic and educational environment;
b. monitoring of psychiatric symptoms in coordination with the appropriate medical care provider;
c. identification and self-management of symptoms or behaviors;
d. development or improvement of social and relational skills;
e. enhancement of communication and problem-solving skills;
f. relapse prevention and disease management strategies;
g. individual, group and family counseling;
h. provision of strengths-based positive behavior supports; and
i. psycho-education, and training of family, unpaid caregivers, or others who have a legitimate role in addressing the needs identified in the PCP.

Note: Psycho-education services and training furnished to family members or caregivers must be provided to, or directed exclusively toward the treatment of, the eligible beneficiary. Psycho-education imparts information to children, families, caregivers, or other individuals involved with the beneficiary's care. Psycho-education helps explain the beneficiary's diagnosis, condition, and treatment for the express purpose of fostering developmentally appropriate coping skills. These skills will support recovery and encourage problem solving strategies for managing issues posed by the beneficiary's condition. Psycho-educational activities are performed to benefit and help the beneficiary develop appropriate coping skills for handling problems resulting from their condition. The goal of psycho-education is to reduce symptoms, improve functioning, and meet the goals outlined in the PCP.

In partnership with the beneficiary, the beneficiary's family, the legally responsible person (as applicable), and other service providers, a Child and Adolescent Day Treatment QP is responsible for convening the Child and Family Team, which is the vehicle for the person-centered planning process. The Child and Family Team comprises those persons relevant to the beneficiary's successful achievement of service goals including, but not limited to, family members, mentors, school personnel, primary medical care provider, and members of the community who may provide support, structure, and services for the beneficiary. The Day Treatment provider works with other behavioral health service providers, as well as with identified medical (including primary care and psychiatric) and non-medical providers (for example, the county department of social services, school, the Department of Juvenile Justice and Delinquency Prevention), engages community and natural supports, and includes their input in the person-centered planning process. A Day Treatment QP is responsible for developing, implementing, and monitoring the PCP, which shall include a crisis plan. The Day Treatment provider is also responsible for documenting the status of the beneficiary's progress and the effectiveness of the strategies and interventions outlined in the PCP.

As part of the crisis plan of the PCP, the Day Treatment provider shall coordinate with the LME and beneficiaries of this service to assign and ensure "first responder" coverage and crisis response, as indicated in the PCP, 24-hours-a-day, 7-days-a-week, 365-days-a-year.

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

a. assessing the beneficiary's needs for comprehensive services;
b. convening Child and Family Team meetings to coordinate the provision of multiple services and the development of, and revisions to, the PCP;
c. developing and implementing the PCP;
d. linking the beneficiary or family to needed services and supports (such as medical or psychiatric consultations);
e. monitoring the provision of services and supports;
f. assessing the outcomes of services and supports; and
g. collaborating with other medical and treatment providers.

For Medicaid or NCHC funded Day Treatment services, a signed service order shall be completed by a physician, licensed psychologist, physician assistant, or nurse practitioner according to his or her scope of practice and shall be accompanied by other required documentation as outlined elsewhere in this policy. Each service order shall be signed and dated by the authorizing professional and shall indicate the date on which the service was ordered. A service order shall 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 shall be based on a comprehensive clinical assessment of the beneficiary's needs.

Provider Requirements

Day Treatment services shall be delivered by practitioners employed by mental health or substance abuse provider organizations that:

a. meet the provider qualification policies, procedures, and standards established by NC Medicaid;
b. meet the provider qualification policies, procedures, and standards established by the Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMHDDSAS);
c. fulfill the requirements of 10A NCAC 27G; and
d. are currently certified as a Critical Access Behavioral Healthcare Agency (CABHA) according to 10A NCAC 22P.

These policies and procedures set forth the administrative, financial, clinical, quality improvement, and

information services infrastructure necessary to provide services. Provider organizations shall demonstrate that they meet these standards by being credentialed by the LME-MCO. Additionally, within one year of enrollment as a provider with NC Medicaid, the organization shall achieve national accreditation with at least one of the designated accrediting agencies. (Providers who were enrolled prior to July 1, 2008, shall have achieved national accreditation within three years of their enrollment date.) The organization shall be established as a legally constituted entity capable of meeting all of the requirements of the Provider Endorsement, Medicaid Enrollment Agreement, Medicaid Bulletins, and service implementation standards.

For Medicaid or NCHC services, the organization is responsible for obtaining authorization for medically necessary services identified in the PCP from NC Medicaid's designated contractor or LME-MCO. The Day Treatment provider organization shall comply with all applicable federal and state requirements. This includes but is not limited to DHHS statutes, rules, policies, and Implementation Updates; Medicaid Bulletins; and other published instruction.

A facility providing Day Treatment services shall be licensed under 10A NCAC 27G .1400 or 10A NCAC 27G .3700.

Staffing Requirements
All staff working in a Day Treatment Program must have the knowledge, skills and abilities required by the population and age to be served.

This service is delivered by the following staff:

a. One (1) full time program director who meets the requirements specified for a QP (preferably Master's level or a licensed professional), has a minimum of two years experience in child and adolescent mental health or substance abuse treatment services, and who must be actively involved in program development, implementation, and service delivery. This individual may serve as one of the QPs in the Day Treatment Program staffing ratio.

b. A minimum of one (1) FTE QP, per six children, who has the knowledge, skills, and abilities required by the population and age to be served, who must be actively involved in service delivery (for example, a program with four beneficiaries needs one FTE QP, a program with seven beneficiaries needs two FTE QPs), and a program with 19 beneficiaries needs 4 FTE QPs).

c. A minimum of one (1) additional FTE (QP, AP, or Paraprofessional) for every 18 enrolled beneficiaries beginning with the 18th enrolled beneficiary (for example, a program with 17 beneficiaries does not need the additional FTE; a program with 21 beneficiaries needs one additional FTE; and a program with 36 beneficiaries needs two additional FTEs) .

d. A minimum of a .5 of a full time dedicated licensed professional for every 18 enrolled beneficiaries. This individual must be actively involved in service delivery. An associate level licensed professional who fills this position must be fully licensed within 30 months from the effective date of this policy. For associate level licensed professionals hired after the effective date of this policy, the 30-month timeline begins at date of hire. For substance use disorder focused programs, the licensed professional must be an LCAS (For example, a program with 10 beneficiaries needs one .5 LP; a program with 19 beneficiaries needs one full time LP).

Although the licensed professional is in addition to the program's QP to beneficiary ratio, he or she may serve, as needed, as one of the two staff when children are present.

A minimum ratio of one QP to every six (6) children is required to be present, with a minimum of two (2) staff present with children at all times. The exception is when only one beneficiary is in the program, in which case only one (1) staff member is required to be present. The staffing configuration must be adequate to anticipate and meet the needs of the beneficiaries receiving this service.

If, for additional staffing purposes, the program includes persons who meet the requirements specified for AP or paraprofessional status according to 10A NCAC 27G .0104, supervision must be provided according to supervision requirements specified in 10A NCAC 27G .0204 and according to licensure requirements of the appropriate discipline.

Staff Training

Within 30 calendar days of hire to provide Day Treatment service all staff shall complete the following training requirements:

a. 3 hours of training in the Day Treatment service definition required components;
b. 3 hours of crisis response training;
c. 11 hours Introduction to System of Care (SOC) training;
d. Required training specific to the selected clinical model(s) or evidence-based treatment(s); and
e. 3 hours of PCP Instructional Elements (required for only Day Treatment QP staff responsible for the PCP) training.

Within **90 calendar days** of hire to provide this service, all Day Treatment staff shall complete the following training requirements:

a. 12 hours of Person Centered Thinking [PCT] training from a Learning Community for Person Centered Practices certified PCT trainer.
    1. All new hires to Day Treatment must complete the full 12 hour training
    2. Staff who previously worked in Day Treatment for another agency and had six (6) hours of PCT training under the old requirement shall have to meet the 12 hour requirement when moving to a new company.
    3. The 12 hour PCT training shall be portable if an employee changes jobs any time after completing the 12 hour requirement, as long as there is documentation of such training in the new employer's personnel records.
    4. Staff who previously worked in Day Treatment within the same agency and had six (6) hours of PCT training under the old requirement may complete the additional six (6) hour PCT or Recovery training curriculum if not, then the full 12 hour training must be completed.

Time Frame	Training Required	Who	Total Minimum Hours Required
Effective April 1, 2010:			
Within **30 days** of hire to provide service	▪ 3 hours Day Treatment service definition required components ▪ 3 hours of crisis response ▪ 11 hours Introduction to SOC* ▪ 6 hours of Person Centered Thinking	▪ All Day Treatment Staff	23 hours
	▪ Required training specific to the selected clinical model(s) or evidence-based treatment(s)**	▪ All Day Treatment Staff	To be determined by model selected**
	▪ 3 hours of PCP Instructional Elements	▪ Day Treatment QP staff responsible for PCP	3 hours
***Effective January 1, 2011:**			
Within **90 days** of hire to provide this service, **or** by **June 30, 2011** for staff members of existing providers	▪ 12 hours of Person Centered Thinking	▪ All Day Treatment Staff	12 hours

* Day Treatment staff who have documentation of having received the required number of Introduction to SOC training hours within the past three years dating back to January 1, 2007, shall be deemed to have met this requirement.

** The training hours for the selected clinical model(s) or evidence-based treatment(s) must be based on the requirements of the selected clinical model(s) or evidence-based treatment(s).

***All staff shall be required to complete the new 12 hours of Person Centered Thinking training addressed in Implementation Update # 73.

Total hours of training for the Day Treatment staff (as of 4/1/10):

e. Day Treatment Staff other than the QPs responsible for PCPs – **23 hours plus the additional training hours on the selected clinical model(s) or evidence-based treatment(s)**

f. QPs responsible for the PCP – **26 hours plus the additional training hours on the selected clinical model(s) or evidence-based treatment(s)**

Service Type and Setting
A facility providing Day Treatment services shall be licensed under 10A NCAC 27G .1400 or 10A NCAC 27G .3700.

This is a day or night service that shall be available year round for a minimum of three hours a day during all days of operation. During the school year, the Day Treatment Program must operate each day that the schools in the local education agency, private or charter school, are in operation, and the Day Treatment operating hours shall cover at least the range of hours that the LEAs, private or charter schools operate. Day treatment programs may **not** operate as simply after-school programs.

Day Treatment may include time spent off site in places that are related to achieving service goals such as normalizing community activities that facilitate transition or integration with their school setting, visiting a local place of business to file an application for part time employment.

As part of the crisis plan of the PCP, the Day Treatment provider shall coordinate with the Local Management Entity and beneficiary to assign and ensure "first responder" coverage and crisis response, as indicated in the PCP, 24-hours-a-day, 7-days-a-week, 365-days-a-year, to beneficiaries of this service.

Day Treatment shall be provided in a licensed facility separate from the beneficiary's residence.

This is a facility based service and is provided in a licensed and structured program setting appropriate for the developmental age of children and adolescents. No more than 25% of treatment services for an individual per agency work week may take place outside of the licensed facility. This shall be documented and tracked by the provider for each beneficiary.

Program Requirements

Each Child and Adolescent Day Treatment provider must follow a clearly identified clinical model consistent with best practice. This model must be specified and described in the provider's program description. This clinical model should be expected to produce positive outcomes for this population.

The Day Treatment Program staff collaborates with the school and other service providers prior to admission and throughout service duration. The roles of Day Treatment staff and educational or academic staff are established through the MOA (if applicable) among the Day Treatment provider, the Local Management Entity, and the Local Education Agency (or private or charter school as applicable). If no MOA exists, providers must establish written policy which defines these roles. Designation of educational instruction and treatment interventions is determined based on staff function, credentials of staff, the beneficiary's PCP, and the IEP or 504 plan. Educational instruction is not billable as Day Treatment. The therapeutic milieu should reflect integrated rehabilitative treatment and educational instruction.

Day Treatment is time limited and services are titrated based on the transition plan in the PCP. Transition and discharge planning begins at admission and must be documented in the PCP.

While Day Treatment addresses the mental health or substance use disorder symptoms related to functioning in an educational setting, family involvement and partnership is a critical component of treatment as clinically indicated.

Eligibility Criteria
Children 5 through 17 (20 or younger for those who are eligible for Medicaid and age 6-17 for those eligible for NCHC) are eligible for this service when all of the following criteria are met:

a. there is a mental health or substance use disorder diagnosis (as defined by the DSM-5, or any subsequent editions of this reference material), other than a sole diagnosis of an intellectual and developmental disability;
b. for children with a substance use disorder diagnosis, The ASAM Criteria are met for Level 2.1;
c. both of the following shall apply:
    1. evidence that less restrictive mental health or substance abuse rehabilitative services in the educational setting have been unsuccessful as evidenced by documentation from the school (e.g., Functional Behavioral Assessment, Functional Behavioral Plan, Individual Education Plan, 504 Plan, behavior plans); and
    2. the beneficiary exhibits behavior resulting in significant school disruption or significant social withdrawal.
d. the beneficiary is experiencing mental health or substance use disorder symptoms (not solely those related to an individual's diagnosis of intellectual and developmental disability) related to his or her diagnosis that severely impair functional ability in an educational setting which may include vocational education; and
e. there is no evidence to support that alternative interventions would be equally or more effective, based on North Carolina community practice standards (Best Practice Guidelines of the American Academy of Child and Adolescent Psychiatry, American Psychiatric Association, American Society of Addiction Medicine).

Entrance Process
A comprehensive clinical assessment that demonstrates medical necessity shall 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 part of the current comprehensive clinical assessment. Relevant diagnostic information shall be obtained and included in the PCP.

For Medicaid or NCHC funded Day Treatment services, a signed service order shall be completed by a physician, licensed psychologist, physician assistant, or nurse practitioner according to his or her scope of practice and shall be accompanied by other required documentation as outlined elsewhere in this policy. Each service order shall be signed and dated by the authorizing professional and shall indicate the date on which the service was ordered. A service order shall be in place prior to or on the date that the service is initially provided in order to bill Medicaid or NCHC for the service. The service order shall be based on a comprehensive clinical assessment of the beneficiary's needs.

Prior authorization is required prior to or on the first date of this service.

For Medicaid or NCHC funded Day Treatment services, prior authorization by NC Medicaid's designated contractor or LME-MCO is required. To request the initial authorization, the Day Treatment provider must submit the PCP with signatures and the required authorization request form to the Medicaid or

NCHC approved vendor.
Medicaid or NCHC may cover up to 60 days for the initial authorization period, based on medical necessity documented in the beneficiary's PCP, the authorization request form, and supporting documentation. Requests for reauthorization may be submitted by the Day Treatment Program provider.

In partnership with the beneficiary, the beneficiary's family, the legally responsible person (as applicable), and other service providers, a Child and Adolescent Day Treatment QP is responsible for convening the Child and Family Team monthly.

Continued Service Criteria
The beneficiary is eligible to continue this service 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 unable to function in an appropriate educational setting, based on ongoing assessments, history, and the tenuous nature of the functional gains.

AND

One of the following applies. The beneficiary:

a. has achieved current PCP goals, and additional goals are indicated as evidenced by documented symptoms;
b. 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. 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 level of functioning, are possible; or
d. fails to make progress, or demonstrates regression, in meeting goals through the interventions outlined in the PCP. The beneficiary's diagnosis shall be reassessed to identify any unrecognized co-occurring disorders, and interventions or treatment recommendations shall be revised based on the findings. This includes consideration of alternative or additional services.

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

a. the beneficiary has achieved goals and is no longer in need of Day Treatment services;
b. the beneficiary's level of functioning has improved with respect to the goals outlined in the PCP, inclusive of a plan to transition to a lower level of care or appropriate educational setting;
c. the beneficiary is not making progress or is regressing, and all reasonable strategies and interventions have been exhausted, indicating a need for more intensive services;
d. the beneficiary or legally responsible person no longer wishes to receive Day Treatment services;
e. the beneficiary, based on presentation and failure to show improvement despite modifications in the PCP, requires a more appropriate best practice treatment modality based on North Carolina community practice standards (for example, National Institute of Drug Abuse, American Psychiatric Association).

In addition, 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 legally responsible person about their appeal rights in accordance with the Department's beneficiary notices procedure.

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

Expected clinical outcomes may include, but are not limited to the following:

a. improved social, emotional, or behavioral functioning in an appropriate educational setting;
b. integration or reintegration into an appropriate educational or vocational setting;
c. reduced mental health or substance use disorder symptomatology;
d. improvement of behavior, anger management, or developmentally appropriate coping skills;
e. development or improvement of social and relational skills;
f. enhancement of communication and problem-solving skills;
g. increased identification and self-management of triggers, cues, and symptoms and decreased frequency or intensity of crisis episodes;
h. engagement in the recovery process, for children with substance use disorders,
i. reduction of negative effects of substance use disorder or psychiatric symptoms that interfere with the beneficiary's daily living
j. maintaining residence with a family or community based non-institutional setting (foster home, therapeutic family services);
k. reduction in behaviors that require juvenile justice involvement; or
l. increased use of available natural and social supports

Documentation Requirements
Refer to NC Medicaid Clinical Coverage Policies, located on NC Medicaid's website at https://medicaid.ncdhhs.gov/, and the DMHDDSAS *Records Management and Documentation Manual* for a complete listing of documentation requirements.

For this service, the minimum documentation requirement is a full service note for each date of service, written and signed by at least one of the persons who provided the service. The note shall include the following:

a. beneficiary's name;
b. service record number;
c. Medicaid or NCHC identification number;
d. service provided (for example, Day Treatment services);
e. date of service;
f. place of service;
g. other staff involved in the provision of the service;
h. type of contact (face-to-face, telephone call, collateral);
i. purpose of the contact;
j. description of the provider's interventions;
k. amount of time spent performing the interventions;
l. description of the effectiveness of the interventions in meeting the beneficiary's specified goals as outlined in the PCP; and
m. signature and credentials of the staff member(s) providing the service (for paraprofessionals, position is required in lieu of credentials with staff signature).

A documented discharge plan shall be developed with the beneficiary, family or caregiver, and Child and Family Team and included in the service record.

In addition, a completed LME-MCO Consumer Admission and Discharge Form must be submitted to the LME-MCO.

Utilization Management
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 specified in the beneficiary's PCP. Medical necessity is determined by North Carolina community practice standards as verified by independent Medicaid or NCHC consultants for Medicaid or NCHC funded services.

Medically necessary services are authorized in the most cost-efficient mode, as long as the treatment that is made available is similarly efficacious to services requested by the beneficiary's physician, therapist, or other licensed practitioner. Typically, a medically necessary service must be generally recognized as an accepted method of medical practice or treatment. Each case is reviewed individually to determine if the requested service meets the criteria outlined under EPSDT.

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

The Medicaid or NCHC approved vendor or the LME-MCO shall evaluate the request to determine if medical necessity supports more or less intensive services.

Medicaid, NCHC, or State funds may cover up to 60 days for the initial authorization period based on the medical necessity documented in the beneficiary's PCP, the authorization request form, and supporting documentation. Submit the reauthorization request before the initial authorization expires. Medicaid and NCHC funded services cover up to 60 days for reauthorization based on the medical necessity documented in the required PCP, the authorization request form, and supporting documentation.

If continued Day Treatment services are needed at the end of the initial authorization period, the Day Treatment provider must submit the PCP and a new request for authorization reflecting the appropriate level of care and service to the Medicaid or NCHC approved vendor for Medicaid or NCHC services. This must occur before the authorization expires.

Services are billed in one hour increments.

Service Exclusions and Limitations
The beneficiary may receive Day Treatment services from only one Day Treatment provider organization during any active authorization period for this service.

The following are not billable under this service:

a. transportation time (this is factored in the rate);
b. any habilitation activities;
c. child care;
d. any social or recreational activities (or the supervision thereof);
e. clinical and administrative supervision of staff (this is factored in the rate); or

f. educational instruction.

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

Day Treatment services may not be provided during the same authorization period as the following services:

a. Intensive In-Home Services;
b. Multisystemic Therapy;
c. Individual, group and family therapy;
d. Substance Abuse Intensive Outpatient Program;
e. Child Residential Treatment services–Levels II (Program Type) through IV;
f. Psychiatric Residential Treatment Facility (PRTF);
g. Substance abuse residential services; or
h. Inpatient hospitalization.

Day Treatment shall be provided in a licensed facility separate from the beneficiary's residence.

Note: For beneficiaries under the age of 21, additional products, services, or procedures may be requested even if they do not appear in the N.C. State Plan or when coverage is limited to those over 21 years of age. Service limitations on scope, amount, or frequency described in the coverage policy may not apply if the product, service, or procedure is medically necessary. Refer to **Subsection 2.2.1, EPSDT Special Provision.**

Partial Hospitalization: Medicaid and NCHC Billable Service

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

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

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

Cognitive and Behavioral Skill Acquisition
Partial Hospitalization includes interventions that address functional deficits associated with affective or cognitive problems or the beneficiary's diagnostic conditions. This may include training in community living, and specific coping skills, and medication management. This assistance allows beneficiaries to develop their strengths and establish peer and community relationships.

Service Type
This is day or night service that shall be provided a minimum of 4 hours per day, 5 days per week, and 12 months a year (exclusive of transportation time), excluding legal or governing body designated holidays.

Service standards and licensure requirements are outlined in10A NCAC 27G .1100. Utilization management must be performed by NC Medicaid's designated contractor or LME-MCO.

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

Service Delivery Setting
Partial Hospitalization is provided in a licensed facility that offers a structured, therapeutic program under the direction of a physician that may or may not be hospital based.

Utilization Management
Authorization by NC Medicaid's designated contractor or LME-MCO is required. The amount, duration, and frequency of the service must be included in a beneficiary's Person-Centered Plan. Initial authorization shall not exceed seven calendar days. Reauthorization shall not exceed seven calendar days. All utilization review activity shall be documented in the Provider's Service Plan.

Utilization management must be performed by NC Medicaid's designated contractor or LME-MCO.

Eligibility Criteria

The beneficiary is eligible for this service when all of the following criteria are met:

a. Beneficiary must have a mental health or substance use disorder diagnosis;
b. Level of Care Criteria;
c. The beneficiary is experiencing difficulties in at least one of the following areas:
    1. Functional impairment, crisis intervention, diversion, aftercare needs, or at risk for placement outside the natural home setting;

       AND

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

Service Order Requirement
A physician, doctoral level licensed psychologist, psychiatric nurse practitioners, psychiatric clinical nurse specialist within their scope of practice can order this service. The service must be ordered prior to or on the day the service is initiated.

Continuation or Utilization Review Criteria
The desired outcome or level of functioning has not been restored, improved, or sustained over the time frame outlined in the beneficiary's service plan or the beneficiary continues to be at risk for relapse based on history or the tenuous nature of the functional gains or ANY of the following applies:

a. beneficiary has achieved initial service plan goals and additional goals are indicated;
b. beneficiary is making satisfactory progress toward meeting goals;
c. beneficiary is making some progress, but the service plan (specific interventions) need to be modified so that greater gains which are consistent with the beneficiary's premorbid level of functioning are possible or can be achieved;
d. beneficiary is not making progress; the service plan must be modified to identify more effective interventions; or

e. beneficiary is regressing; the service plan must be modified to identify more effective interventions.

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

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

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

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

Service Maintenance Criteria
If the beneficiary is functioning effectively with this service and discharge would otherwise be indicated, PH must be maintained when it can be reasonably anticipated that regression is likely to occur if the service is withdrawn. The decision shall be based on ANY of the following:

a. past history of regression in the absence of PH is documented in the beneficiary record; or
b. the presence of a DSM-5 (or any subsequent editions of this reference material) diagnosis that would necessitate a disability management approach.

In the event, there are epidemiological sound expectations that symptoms will persist and that ongoing treatment interventions are needed to sustain functional gains.

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

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

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

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

Professional Treatment Services in Facility-Based Crisis Program

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

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

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

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

Service Type
This is a 24-hour service that is offered seven days a week.

Resiliency or Environmental Intervention
This service assists the beneficiary with remaining in the community and receiving treatment interventions at an intensive level without the structure of an inpatient setting. This structured program assesses, monitors, and stabilizes acute symptoms 24-hours-a-day.

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

Eligibility Criteria

The beneficiary is eligible for this service when all of the following are met:

a. There is a mental health or substance use disorder diagnosis present or the beneficiary has a condition that may be defined as a intellectual and developmental disability as defined in GS 122C-3 (12a);

b. Level of Care Criteria, Level D NC-SNAP (NC Supports or Needs Assessment Profile) or The ASAM Criteria;
c. The beneficiary is experiencing difficulties in at least one of the following areas:
    1. functional impairment,
    2. crisis intervention, diversion, or after-care needs, or
    3. at risk for placement outside of the natural home setting; and
d. The beneficiary's level of functioning has not been restored or improved and may indicate a need for clinical interventions in a natural setting if any one of the following apply:
    4. unable to remain in family or community setting due to symptoms associated with diagnosis, therefore being at risk for out of home placement, hospitalization, or institutionalization;
    5. intensive, verbal and limited physical aggression due to symptoms associated with diagnosis, which are sufficient to create functional problems in a community setting; or
    6. at risk of exclusion from services, placement or significant community support systems as a result of functional behavioral problems associated with diagnosis.

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

Continuation or Utilization Review
The desired outcome or level of functioning has not been restored, improved or sustained over the time frame outlined in the beneficiary's service plan or the beneficiary continues to be at risk for relapse based on history or the tenuous nature of the functional gains or **any one of the following** applies:
a. beneficiary has achieved initial service plan goals and additional goals are indicated;
b. beneficiary is making satisfactory progress toward meeting goals;
c. beneficiary is making some progress, but the service plan (specific interventions) need to be modified so that greater gains, which are consistent with the beneficiary's premorbid level of functioning, are possible or can be achieved;
d. beneficiary is not making progress; the service plan must be modified to identify more effective interventions; or
e. beneficiary is regressing; the service plan must be modified to identify more effective interventions.

AND
Utilization review by NC Medicaid's designated contractor or LME-MCO must be conducted after the first 7 days (112 units). Initial authorization shall not exceed 8 days (128 units). All utilization review activity shall be documented in the Provider's Service Plan.

Units are billed in 1-hour increments up to 16 hours in a 24-hour period. This is a short-term service that cannot be provided for more than 30 days in a 12-month period.

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

Beneficiary's level of functioning has improved with respect to the goals outlined in the service plan, inclusive of a transition plan to step-down or no longer benefits or has the ability to function at this level of care and ANY of the following apply:
a. beneficiary has achieved goals, discharge to a lower level of care is indicated; or
b. beneficiary is not making progress or is regressing and all realistic treatment options with this modality have been exhausted.

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

Service Maintenance Criteria
If the beneficiary is functioning effectively with this service and discharge would otherwise be indicated, Facility-based crisis service must be maintained when it can be reasonably anticipated that regression is likely to occur if the service is withdrawn. The decision shall be based on ANY of the following:

a. past history of regression in the absence of facility based crisis service is documented in the service record; or
b. in the event there are epidemiologically sound expectations that symptoms will persist and that ongoing treatment interventions are needed to sustain functional gains, the nature of the beneficiary's DSM-5 (or any subsequent editions of this reference material) diagnosis necessitates a disability management approach.

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

Provider Requirement and Supervision
This is a 24-hour service that is offered seven days a week, with a staff to beneficiary ratio that ensures the health and safety of beneficiaries served in the community and compliance with 10A NCAC 27E Seclusion, Restraint and Isolation Time Out. At no time shall staff to beneficiary ratio be less than 1:6 for adults with a mental health disorder and 1:9 for adults with a substance use disorder.

Documentation Requirements
The minimum documentation is a daily service note per shift.

Substance Abuse Services

Medicaid Billable Service
Diagnostic Assessment
See Diagnostic Assessment (MHDDSA) service.

Mobile Crisis Management
See Mobile Crisis Management (MHDDSA) service.

Community Support Team—Adult
See Community Support Team—Adult (MHSA).

Substance Abuse Intensive Outpatient Program: Medicaid and NCHC Billable Service

Level 2.1 Intensive Outpatient Services ASAM Criteria

Service Definition and Required Components

Substance Abuse Intensive Outpatient Program (SAIOP) means structured individual and group addiction activities and services that are provided at an outpatient program designed to assist adult and adolescent beneficiaries to begin recovery and learn skills for recovery maintenance. The program is offered at least 3 hours a day, at least 3 days a week, with no more than 2 consecutive days between offered services, and distinguishes between those beneficiaries needing no more than 19 hours of structured services per week (ASAM Level 2.1). The beneficiary must be in attendance for a minimum of 3 hours a day in order to bill this service. SAIOP services shall include a structured program consisting of, but not limited to, the following services:

a. Individual counseling and support;
b. Group counseling and support;
c. Family counseling, training or support;
d. Biochemical assays to identify recent drug use (e.g. urine drug screens);
e. Strategies for relapse prevention to include community and social support systems in treatment;
f. Life skills;
g. Crisis contingency planning;
h. Disease Management; and
i. Treatment support activities that have been adapted or specifically designed for beneficiaries with physical disabilities; or beneficiaries with co-occurring disorders of mental illness and substance use; or an intellectual and developmental disability and substance use disorder.

SAIOP can be designed for homogenous groups of beneficiaries e.g., pregnant women, and women and their children; individuals with co-occurring mental health and substance use disorders; individuals with human immunodeficiency virus (HIV); or individuals with similar cognitive levels of functioning. Group counseling shall be provided each day SAIOP services are offered.

SAIOP includes:

a. case management to arrange, link or integrate multiple services; and
b. assessment and reassessment of the beneficiary's need for services.

SAIOP services also:

a. inform the beneficiary about benefits, community resources, and services;
b. assist the beneficiary in accessing benefits and services;
c. arrange for the beneficiary to receive benefits and services; and
d. monitor the provision of services.

Beneficiaries may be residents of their own home, a substitute home, or a group care setting; however, the SAIOP must be provided in a setting separate from the beneficiary's residence. The program is provided over a period of several weeks or months.

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

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

Organizations that provide SAIOP must provide "first responder" crisis response on a 24-hours-a-day, 7-days-a-week, 365-days-a-year basis, to beneficiaries who are receiving this service

Staffing Requirements
Persons who meet the requirements specified for CCS, LCAS, LCAS-A, and CSAC under Article 5C may deliver SAIOP. The program must be under the clinical supervision of a CCS or a LCAS who is on site a minimum of 50% of the hours the service is in operation. Services may also be provided by staff who meet the requirements specified for QP or AP status for Substance Abuse according to 10A NCAC 27G .0104, under the supervision of a CCS or LCAS. The maximum face-to-face staff-to-beneficiary ratio is not more than 12 adult beneficiaries to 1 QP based on an average daily attendance. The ratio for adolescents shall be 1:6. Paraprofessional level providers who meet the requirements for Paraprofessional status according to 10A NCAC 27G .0104 and who have the knowledge, skills, and abilities required for the population and age to be services may deliver SAIOP, under the supervision of a CCS or LCAS. Paraprofessional level providers may not provide services in lieu of on-site service provision by a CCS, LCAS, LCAS-A, CSAC, or QP.

Service Type and Setting
Facility licensed under 10A NCAC 27G .4400.

Program Requirements
See Service Definition and Required Components.

Utilization Management
The initial 30 calendar days of treatment do not require a prior authorization. Services provided after this initial 30-day "pass-through" period require authorization from the Medicaid or NCHC approved vendor. This pass-through is available only once per treatment episode and only once per state fiscal year. The amount, duration, and frequency of SAIOP Service must be included in a beneficiary's authorized PCP. Services may not be delivered less frequently than the structured program set forth in the service description above.

Reauthorization shall not exceed 60 calendar days. Under exceptional circumstances, one additional reauthorization up to 2 weeks can be approved. This service is billed with a minimum of three hours per day as an event. All utilization review activity shall be documented in the Service Record.

Eligibility Criteria

The beneficiary is eligible for this service when ALL of the following criteria are met:
a. there is a substance use disorder diagnosis present; and
b. the beneficiary meets ASAM Level 2.1 criteria.

Continued Service Criteria
The beneficiary is eligible to continue this service 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 history or the tenuous nature of the functional gains or **any one of the follow**ing applies. The beneficiary:

a. has achieved positive life outcomes that support stable and ongoing recovery, and additional goals are indicated;
b. is making satisfactory progress toward meeting goals;
c. is making some progress, but the PCP (specific interventions) needs to be modified so that greater gains, which are consistent with the beneficiary's premorbid level of functioning, are possible or can be achieved;
d. is not making progress; the PCP must be modified to identify more effective interventions; or
e. is regressing; the PCP must be modified to identify more effective interventions.

Expected Outcomes
The expected outcome of SAIOP is abstinence.
Secondary outcomes include:

a. sustained improvement in health and psychosocial functioning;
b. reduction in any psychiatric symptoms (if present),;
c. reduction in public health or safety concerns; and
d. reduction in the risk of relapse as evidenced by improvement in empirically supported modifiable relapse risk factors.

Documentation Requirements
The minimum standard is a daily full service note for each day of SAIOP that includes:

a. the beneficiary's name;
b. Medicaid or NCHC identification number;
c. date of service;
d. purpose of contact;
e. describes the provider's interventions, the time spent performing the intervention, the effectiveness of interventions; and
f. the signature and credentials of the staff providing the service. A documented discharge plan shall be discussed with the beneficiary and included in the record.

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

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, or no longer benefits, or has the ability to function at this level of care and **any of the following** apply. The beneficiary:

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

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

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

Substance Abuse Comprehensive Outpatient Treatment Program: Medicaid Billable Service

Level 2.5 Partial Hospitalization ASAM Criteria

Service Definition and Required Components
Substance Abuse Comprehensive Outpatient Treatment (SACOT) program means a periodic service that is a time-limited, multi-faceted approach treatment service for adults who require structure and support to achieve and sustain recovery.

SACOT Program is a service emphasizing:
a. reduction in use of substances or continued abstinence;
b. the negative consequences of substance use;
c. development of social support network and necessary lifestyle changes;
d. educational skills;
e. vocational skills leading to work activity by reducing substance use as a barrier to employment;
f. social and interpersonal skills;
g. improved family functioning;
h. the understanding of addictive disease; and
i. the continued commitment to a recovery and maintenance program.

These services are provided during day and evening hours to enable beneficiaries to maintain residence in their community, continue to work or go to school, and to be a part of their family life. The following types of services are included in the SACOT Program:
a. individual counseling and support;
b. group counseling and support;
c. family counseling, training or support;
d. biochemical assays to identify recent drug use (e.g., urine drug screens);
e. strategies for relapse prevention to include community and social support systems in treatment;
f. life skills;
g. crisis contingency planning;
h. disease management; and
i. treatment support activities that have been adapted or specifically designed for beneficiaries with physical disabilities; or beneficiaries with co-occurring disorders of mental illness and substance use; or an intellectual and developmental disability and substance use disorder.

SACOT programs can be designed for homogenous groups of beneficiaries, including:
a. beneficiaries being detoxed on an outpatient basis;
b. beneficiaries with chronic relapse issues;
c. pregnant women, and women and their children;
d. beneficiaries with co-occurring mental health and substance use disorders;
e. beneficiaries with HIV; or
f. beneficiaries with similar cognitive levels of functioning.

SACOT includes case management to arrange, link or integrate multiple services as well as assessment and reassessment of the beneficiary's need for services. SACOT services also:
a. inform the beneficiary about benefits, community resources, and services;
b. assist the beneficiary in accessing benefits and services;
c. arrange for the beneficiary to receive benefits and services; and

d. monitor the provision of services.

Beneficiaries may be residents of their own home, a substitute home, or a group care setting; however, the SACOT Program must be provided in a setting separate from the beneficiary's residence.

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

This service must operate at least 20 hours per week and offer a minimum of 4 hours of scheduled services per day, with availability at least 5 days per week with no more than 2 consecutive days without services available. The beneficiary must be in attendance for a minimum of 4 hours a day in order to this for this service. Group counseling services must be offered each day the program operates. Services must be available during both day and evening hours.

A SACOT Program may have variable lengths of stay and reduce each beneficiary's frequency of attendance as recovery becomes established and the beneficiary can resume more and more usual life obligations. The program conducts random drug screening and uses the results of these tests as part of a comprehensive assessment of participants' progress toward goals and for Person - Centered Planning.

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

Organizations that provide SACOT must provide "first responder" crisis response on a 24-hours-a-day, 7-days-a-week, 365-days-a-year basis, to beneficiaries who are receiving this service.

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

Consultation Services
Beneficiaries must have ready access to psychiatric assessment and treatment services when warranted by the presence of symptoms indicating co-occurring substance use and mental health disorders (e.g. major depression, schizophrenia, borderline personality disorder). These services shall be delivered by

psychiatrists who meet requirements as specified in NCAC 27G .0104. The providers shall be familiar with the SACOT Program treatment plan for each beneficiary seen in consultation, shall have access to SACOT Program treatment records for the beneficiary, and shall be able to consult by phone or in person with the CCS, LCAS or CSAC providing SACOT Program services.

Service Type and Setting
Facility licensed in accordance with **10A NCAC 27G .4500**.

Program Requirements
Refer to Service Definition and Required Components.

Utilization Management
The initial 60 calendar days of treatment do not require a prior authorization. Services provided after this initial 60-day "pass-through" period require authorization from the Medicaid or NCHC approved vendor. This pass-through is available only once per treatment episode and only once per state fiscal year. The amount, duration, and frequency of SACOT Service must be included in a beneficiary's authorized PCP. Services may not be delivered less frequently than the structured program set forth in the service description above.

Reauthorization shall not exceed 60 calendar days. This service is billed with a minimum of four hours per day billed in hourly increments. Utilization management must be performed by NC Medicaid's designated contractor or LME-MCO. All utilization review activity shall be documented in the Service Record.

Eligibility Criteria

The beneficiary is eligible for this service when the following criteria are met:

a. there is a substance use disorder diagnosis present;

AND

b. the beneficiary meets ASAM Level 2.5 criteria.

Continued Service Criteria
The beneficiary is eligible to continue this service 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 history or the tenuous nature of the functional gains or any one of the following applies:

a. beneficiary has achieved initial PCP goals and continued service at this level is needed to meet additional goals;
b. beneficiary is making satisfactory progress toward meeting goal;.
c. beneficiary is making some progress, but the PCP (specific interventions) needs to be modified so that greater gains, which are consistent with the beneficiary's premorbid level of functioning, are possible or can be achieved;
d. beneficiary is not making progress; the PCP must be modified to identify more effective interventions; or
e. beneficiary is regressing; the PCP must be modified to identify more effective interventions.

AND

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

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

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

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

Expected Outcomes
The expected outcome is abstinence.

Secondary outcomes include:

a. sustained improvement in health and psychosocial functioning;
b. reduction in any psychiatric symptoms (if present);
c. reduction in public health or safety concerns; and
d. and a reduction in the risk of relapse as evidenced by improvement in empirically-supported modifiable relapse risk factors.

For beneficiaries with co-occurring mental health and substance use disorders, improved functioning is the expected outcome.

Documentation Requirements
The minimum standard is a daily full service note for each day of SACOT that includes:

a. beneficiary's name;
b. Medicaid identification number;
c. date of service;
d. purpose of contact;
e. description of the provider's interventions, the time spent performing the intervention, the effectiveness of interventions; and
f. signature and credentials of the staff providing the service.

A documented discharge plan shall be discussed with the beneficiary and included in the record

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

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

Substance Abuse Non-Medical Community Residential Treatment: Medicaid Billable Service

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

Level 3.5 Clinically Managed High-Intensity Residential Services

Service Definition and Required Components
Non-medical Community Residential Treatment (NMCRT) is a 24-hour residential recovery program professionally supervised residential facility that provides trained staff who:

a. work intensively with adults with substance use disorders; and
b. provide or have the potential to provide primary care for their minor children.

This is a rehabilitation facility, without 24 hour per day medical nursing or monitoring, where a planned program of professionally directed evaluation, care and treatment for the restoration of functioning for beneficiaries with an addiction disorder.

These programs shall include:

a. assessment;
b. referral;
c. individual and group therapy;
d. family therapy;
e. recovery skills training;
f. disease management;
g. symptom monitoring;
h. monitoring medications and self management of symptoms;
i. aftercare; and
j. follow-up and access to preventive and primary health care including psychiatric care.

The facility may utilize services from another facility providing psychiatric or medical services.

Services shall;

a. promote development of a social network supportive of recovery;
b. enhance the understanding of addiction;
c. promote successful involvement in regular productive activity (such as school or work);
d. enhance personal responsibility; and
e. promote successful reintegration into community living.

Services shall be designed to provide a safe and healthy environment for beneficiaries and their children.

Program staff shall;

a. arrange, link or integrate multiple services as well as assessment and reassessment of the beneficiary's need for services;
b. inform the beneficiary about benefits, community resources, and services;
c. assist the beneficiary in accessing benefits and services;
d. arrange for the beneficiary to receive benefits and services; and
e. monitor the provision of services.

For programs providing services to beneficiaries with their children in residence or pregnant women: Each adult shall also receive in accordance with their PCP:

a. training in therapeutic parenting skills;
b. basic independent living skills;
c. child supervision;
d. one-on-one interventions with the community to develop interpersonal and community coping skills, including adaptation to school and work environments; and
e. therapeutic mentoring.

In addition, their children shall receive services in accordance with 10A NCAC 27G .4100.

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

Provider Requirements

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

Organizations that provide NMCRT must provide "first responder" crisis response on a 24-hours-a-day 7-days-a-week 365-days-a-year basis, to beneficiaries receiving this service.

Staffing Requirements

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

Service Type and Setting

Programs for pregnant women or individuals with children in residence shall be licensed under 10A NCAC 27G .4100 for residential recovery programs.

Program Requirements

Refer to the Service Definition and Required Components, and 10A NCAC 27G .4100 for residential recovery programs.

Utilization Management
Authorization by NC Medicaid's designated contractor or LME-MCO is required. This service must be included in the beneficiary's PCP. Initial authorization shall not exceed 10 days. Reauthorization shall not exceed 10 days. All utilization review activity shall be documented in the Provider's Service Plan.

Utilization management must be performed by NC Medicaid's designated contractor or LME-MCO.

Eligibility Criteria

The beneficiary is eligible for this service when ALL of the following criteria are met:

a. There is a substance use disorder diagnosis present; and
b. Meets ASAM Level 3.5 criteria.

Continued Service Criteria
The beneficiary is eligible to continue this service 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 history or the tenuous nature of the functional gains, or **ANY one of the following** applies:

a. beneficiary has achieved initial PCP goals and requires this service in order to meet additional goals;
b. beneficiary is making satisfactory progress toward meeting goals;
c. beneficiary is making some progress, but the PCP (specific interventions) needs to be modified so that greater gains, which are consistent with the beneficiary's pre-morbid level of functioning, are possible or can be achieved;
d. beneficiary is not making progress; the PCP must be modified to identify more effective interventions; or
e. beneficiary is regressing; the PCP must be modified to identify more effective interventions.

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

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

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

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

Expected Outcomes
The expected outcome is abstinence.

Secondary outcomes include:

a. sustained improvement in health and psychosocial functioning;

b. reduction in any psychiatric symptoms (if present);
c. reduction in public health or safety concerns;
d. a reduction in the risk of relapse as evidenced by improvement in empirically-supported modifiable relapse risk factors; and
e. additionally, for Residential Recovery Programs, improved parenting is an expected outcome.

Documentation Requirements
The minimum standard is a full daily note that includes:
a. beneficiary's name;
b. Medicaid identification number;
c. date of service;
d. purpose of contact;
e. a description of the provider's interventions;
f. the time spent performing the intervention;
g. the effectiveness of interventions; and
h. signature and credentials of the staff providing the service.

Residential Recovery Programs for women and children shall also provide documentation of all services provided to the children in the program. Goals for parent-child interaction shall be established and progress towards meeting these goals shall be documented in the parent's service record. A documented discharge plan discussed with the beneficiary is included in the record.

Service Exclusions and Limitations
Non-Medical Community Residential Treatment cannot be billed the same day as any other mental health or substance abuse services **except** group living moderate. This is a short-term service that can only be billed for 30 days in a 12 month period.

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

Substance Abuse Medically Monitored Community Residential Treatment: Medicaid Billable Service

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

Level 3.7 Medically Monitored Intensive Inpatient Services

Service Definition and Required Components
Medically Monitored Community Residential Treatment (MMCRT) is a non-hospital rehabilitation facility for adults, with 24-hour-a-day medical or nursing monitoring, where a planned program of professionally directed evaluation, care and treatment for the restoration of functioning for beneficiaries with alcohol and other drug problems or addiction occurs.

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

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

Organizations that provide NMCRT must provide “first responder” crisis response on a 24-hours-a-day, 7 days-a-week, 365-days-a-year basis, to the beneficiaries who are receiving this service.

Staffing Requirements
Medically Monitored Community Residential Treatment is staffed by physicians who are available 24-hours-a-day by telephone and who conduct assessments within 24 hours of admission. A registered nurse is available to conduct a nursing assessment on admission and oversee the monitoring of a beneficiary’s progress and medication administration on an hourly basis. Persons who meet the requirements specified for CCS, LCAS, LCAS-A, and CSAC under Article 5C may deliver MMCRT. The program must be under the clinical supervision of a LCAS or CCS who is on site a minimum of 8 hours per day when the service is in operation and available by phone 24-hours-a-day. Services may also be provided by staff who meet the requirements specified for QP or AP status in Substance Abuse according to 10A NCAC 27G .0104, under the supervision of a LCAS or CCS. Paraprofessional level providers who meet the requirements for paraprofessional status according to 10A NCAC 27G .0104 and who have the knowledge, skills, and abilities required by the population and age to be served may deliver MMCRT, under the supervision of a LCAS or CCS. Paraprofessional level providers may not provide services in lieu of on-site service provision to beneficiaries receiving this service by a QP, CCS, LCAS, LCAS-A, or CSAC.

Service Type and Setting
Facility licensed under 10A NCAC 27G .3400.

Program Requirements
Refer to the Service Definition and Required Components.

Utilization Management
Authorization by NC Medicaid's designated contractor or LME-MCO is required. The amount and duration of the service must be included in the beneficiary's authorized PCP. Initial authorization shall not exceed 10 days. Reauthorization shall not exceed 10 days. All utilization review activity shall be documented in the Provider's Service Plan. This is a short-term service that cannot exceed more than 30 days in a 12-month period.

Eligibility Criteria

The beneficiary is eligible for this service when ALL of the following criteria are met:
a. there is a substance use disorder diagnosis present; and
b. the beneficiary meets ASAM Level 3.7 criteria.

Continued Service Criteria
The beneficiary is eligible to continue this service 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 history or the tenuous nature of the functional gains or ANY of the following applies:
a. beneficiary has achieved positive life outcomes that supports stable and ongoing recovery and services need to be continued to meet additional goals;
b. beneficiary is making satisfactory progress toward meeting treatment goals;
c. beneficiary is making some progress, but the PCP (specific interventions) needs to be modified so that greater gains, which are consistent with the beneficiary's premorbid level of functioning, are possible or can be achieved;
d. beneficiary is not making progress; the PCP must be modified to identify more effective interventions; or
e. beneficiary is regressing; the PCP must be modified to identify more effective interventions.

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

Beneficiary's level of functioning has improved with respect to the goals outlined in the PCP, inclusive of a transition plan to step down, or no longer benefits, or has the ability to function at this level of care and ANY of the following apply:
a. beneficiary has achieved positive life outcomes that support stable and ongoing recovery;
b. beneficiary is not making progress, or is regressing and all realistic treatment options have been exhausted indicating a need for more intensive services; or
c. beneficiary no longer wishes to receive MMCRT services. (Note that although a beneficiary may no longer wish to receive MMCRT services, the beneficiary must still be provided with discharge recommendations that are intended to help the beneficiary meet expected outcomes).

Expected Outcomes
The expected outcome is abstinence.

Secondary outcomes include:
a. sustained improvement in health and psychosocial functioning;
b. reduction in any psychiatric symptoms (if present);reduction in public health or safety concerns; and
c. a reduction in the risk of relapse as evidenced by improvement in empirically-supported modifiable relapse risk factors.

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

Documentation Requirements
The minimum standard is a daily full service note that includes:
a. beneficiary's name;
b. Medicaid identification number;
c. date of service;
d. purpose of contact;
e. description of the provider's intervention(s);
f. time spent performing the intervention(s);
g. effectiveness of intervention(s), and
h. signature and credentials of the staff providing the service.

A discharge plan shall be discussed with the beneficiary and included in the record.

Service Exclusions and Limitations
This service cannot be billed the same day as any other mental health or substance abuse service except CST or ACT.

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

Detoxification Services
Ambulatory Detoxification:
Medicaid Billable Service

Level 1-WM: Ambulatory Withdrawal Management without Extended On-Site Monitoring

Service Definition and Required Components
Ambulatory Detoxification is an organized outpatient service delivered by trained clinicians who provide medically supervised evaluation, detoxification and referral services according to a predetermined schedule. Such services are provided in regularly scheduled sessions. The services are designed to treat the beneficiary's level of clinical severity and to achieve safe and comfortable withdrawal from mood-altering drugs (including alcohol) and to effectively facilitate the beneficiary's transition into ongoing treatment and recovery.

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

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

Staffing Requirements
Ambulatory Detoxification is staffed by physicians, who are available 24-hours-a-day by telephone and who conduct an assessment within 24 hours of admission. A registered nurse must be available to conduct a nursing assessment on admission and oversee the monitoring of a beneficiary's progress and medication. Appropriately licensed and credentialed staff are available to administer medications in accordance with physician orders and the services of counselors are available. Services must be provided by staff who meet the requirements specified for QP or AP status for Substance Abuse according to 10A NCAC 27G .0104, under the supervision of a LCAS or CCS.

Service Type and Setting
Facility licensed under 10A NCAC 27G .3300.

Eligibility Criteria

The beneficiary is eligible for this service when all of the following criteria are met:
a. there is a substance use disorder diagnosis present; and
b. the beneficiary meets ASAM Level I-WM criteria.

Utilization Management
Authorization by NC Medicaid's designated contractor or LME-MCO is required. This service must be included in a beneficiary's PCP. Initial authorization is limited to seven days. Reauthorization is limited to a maximum of three days as there is a 10-day maximum for this service.

Utilization management must be performed by NC Medicaid's designated contractor or LME-MCO.

Continued Service and Discharge Criteria
The beneficiary continues in Ambulatory Detoxification until **ANY of the following** criteria are met:

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

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

Documentation Requirements
The minimum standard is a daily full service note for each day of Ambulatory Detoxification that includes:

a. beneficiary name;
b. Medicaid identification number;
c. date of service;
d. purpose of contact;
e. a description of the provider's interventions;
f. time spent performing the intervention;
g. effectiveness of interventions; and
h. signatures and credentials of staff providing the service.

Detoxification rating scale tables e.g., Clinical Institute Withdrawal Assessment-Alcohol, Revised (CIWA-AR) and flow sheets (which include tabulation of vital signs) are used as needed, and a discharge plan which has been discussed with the beneficiary is also documented prior to discharge.

Service Exclusions
Cannot be billed the same day as any other service except for Substance Abuse Comprehensive Outpatient Treatment (SACOT).

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

Non-Hospital Medical Detoxification: Medicaid Billable Service

Level 3.7-WM: Medically Monitored Inpatient Withdrawal Management

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

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

Provider Requirements
Non-Hospital Medical Detoxification must be delivered by practitioners employed by a substance abuse provider organization that meet the provider qualification policies and procedures established by DMH. These policies and procedures set forth the administrative, financial, clinical, quality improvement, and information services infrastructure necessary to provide services. Provider organizations must demonstrate that they meet these standards by being credentialed by LME-MCO. Within three years of enrollment as a provider, the organization must have achieved national accreditation. The organization must be established as a legally recognized entity in the United States and qualified or registered to do business as a corporate entity in the State of North Carolina.

Staffing Requirements
Non-Hospital Medical Detoxification is staffed by physicians, who are available 24-hours-a-day by telephone and who conducts an assessment within 24 hours of admission. A registered nurse is available to conduct a nursing assessment on admission and oversee the monitoring of a beneficiary's progress and medication administration. The level of nursing care is appropriate to the severity of beneficiary needs based on the clinical protocols of the program. Appropriately licensed and credentialed staff are available to administer medications in accordance with physician orders. Persons who meet the requirements specified for CCS, LCAS, LCAS-A, and CSAC under Article 5C may deliver a planned regimen of 24-hour evaluation, care and treatment services for beneficiaries engaged in Non-Hospital Medical Detoxification. The planned regimen of 24-hour evaluation, care and treatment services must be under the clinical supervision of a CCS or LCAS who is available by phone 24-hours-a-day. The planned regimen of 24-hour evaluation, care and treatment services for beneficiaries engaged in Non-Hospital Medical Detoxification must be provided by staff who meet the requirements specified for QP or AP status in Substance Abuse according to 10A NCAC 27G .0104, under the supervision of a LCAS or CCS. Paraprofessional level providers who meet the requirements for paraprofessional status according to 10A NCAC 27G .0104 and who have the knowledge, skills, and abilities required by the population and age to be served may deliver the planned regimen of 24-hour evaluation, care and treatment services for beneficiaries engaged in Medically Monitored Detoxification, under the supervision of a LCAS or CCS. Paraprofessional level providers may not provide services in lieu of on-site service provision to beneficiaries by a QP, CCS, LCAS, LCAS-A, or CSAC.

Service Type and Setting
Facility licensed under 10A NCAC 27G .3100.

Eligibility Criteria

The beneficiary is eligible for this service when all of the following criteria are met:
a. there is a substance use disorder diagnosis present; and
b. meets ASAM Level 3.7-WM criteria.

Utilization Management
Authorization by NC Medicaid's designated contractor or LME-MCO is required. This service must be included in a beneficiary's PCP. Initial authorization shall not exceed 10 days. Reauthorization shall not exceed 10 days. All utilization review activity shall be documented in the Provider's Service Plan.

Utilization management must be performed by NC Medicaid's designated contractor or LME-MCO.

Continued Service and Discharge Criteria
The beneficiary continues in Non-Hospital Medical Detoxification until **ANY of the following** criteria are met:
a. withdrawal signs and symptoms are sufficiently resolved the beneficiary can be safely managed at a less intensive level of care; or
b. the signs or symptoms of withdrawal have failed to respond to treatment and have intensified such that transfer to a more intensive level of detoxification service is indicated.

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

Documentation Requirements
The minimum standard is a full daily note that includes:
a. beneficiary name;
b. Medicaid or NCHC identification number;
c. date of service;
d. purpose of contact;
e. a description of the provider's interventions;
f. time spent performing the intervention;
g. effectiveness of interventions; and
h. signatures and credentials of staff providing the service.

Detoxification rating scale tables [e.g., Clinical Institute Withdrawal Assessment-Alcohol, Revised (CIWA-AR)] and flow sheets (includes tabulation of vital signs) are used as needed. A discharge plan, which has been discussed with the beneficiary, is also included in the record.

Service Exclusions
This service cannot be billed the same day as any other mental health or substance abuse service **except** CST and ACT. This is a short-term service that cannot be billed for more than 30 days in a short-term period.

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

Medically Supervised or ADATC Detoxification Crisis Stabilization: Medicaid Billable Service

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

Level 3.9-WM: Medically Supervised Detoxification Crisis Stabilization (NC)

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

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

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

Staffing Requirements
Medically Supervised or ADATC Detoxification Crisis Stabilization are staffed by physicians and psychiatrists, who are available 24-hours-a-day by telephone and who conduct assessments within 24 hours of admission. A registered nurse is available to conduct a nursing assessment on admission and oversee the monitoring of a beneficiary's progress and medication administration on an hourly basis. Appropriately licensed and credentialed staff are available to administer medications in accordance with physician orders. Persons who meet the requirements specified for CCS, LCAS, LCAS-A, and CSAC under Article 5C may deliver a planned regimen of 24-hour evaluation, care and treatment services for beneficiaries engaged in Medically Supervised or ADATC Detoxification Crisis Stabilization. The planned regimen of 24-hour evaluation, care and treatment services must be under the clinical supervision of a CCS or LCAS who is who is available by phone 24-hours-a-day. The planned regimen of 24-hour evaluation, care and treatment services for beneficiaries engaged in Medically Supervised or ADATC Detoxification Crisis Stabilization must be provided by staff who meet the requirements specified for QP or AP status for Substance Abuse according to 10A NCAC 27G .0104, under the supervision of a LCAS or CCS.

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

Service Type and Setting
(Licensure TBD)

Eligibility Criteria

The beneficiary is eligible for this service when all of the following criteria are met:
a. there is a substance use disorder diagnosis present; and
b. meets ASAM Level 3.9-WM criteria (NC).

Utilization Management
Authorization by NC Medicaid's designated contractor or LME-MCO is required after the first eight hours of admission. This service must be included in a beneficiary's PCP. Initial authorization is limited to five days.

Utilization management must be performed by NC Medicaid's designated contractor or LME-MCO.

Continued Service and Discharge Criteria
The beneficiary continues in Medically Supervised or ADATC Detoxification Crisis Stabilization until **ANY of the following** criteria are met:
a. withdrawal signs and symptoms are sufficiently resolved that the beneficiary can be safely managed at a less intensive level of care;
b. the signs or symptoms of withdrawal have failed to respond to treatment and have intensified such that transfer to a more intensive level of detoxification service is indicated;
c. the addition of other clinical services are indicated.

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

Documentation Requirements
The minimum standard is a full daily note that includes:
a. beneficiary name;
b. Medicaid or NCHC identification number;
c. date of service;
d. purpose of contact;
e. a description of the provider's interventions;
f. time spent performing the intervention;
g. effectiveness of interventions; and
h. signatures and credentials of staff providing the service

In addition, detoxification rating scale tables [e.g., Clinical Institute Withdrawal Assessment-Alcohol, Revised (CIWA-AR)] and flow sheets (includes tabulation of vital signs) are used as needed. A discharge plan, which has been discussed with the beneficiary, is also included in the record.

Service Exclusions
This service cannot be billed the same day as any other mental health or substance abuse service except CST and ACT. This is a short-term service that cannot be billed for more than 30 days in a 12-month period.

Outpatient Opioid Treatment: Medicaid and NCHC Billable Service

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

Guidelines

a. Services in this type include methadone or buprenorphine administration for:
    1. Treatment; **OR**
    2. Maintenance.
b. Only direct face-to-face time with beneficiary to be reported.
c. Staff travel time to be reported separately.
d. Preparation and documentation time NOT reported.

Payment Unit

One daily unit.

Therapeutic Relationship and Intervention

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

Structure of Daily Living

Not applicable.

Cognitive and Behavioral Skill Acquisition

Not applicable.

Service Type

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

Resiliency and Environment Intervention

Not applicable.

Service Delivery Setting

This service must be provided at a licensed Outpatient Treatment Program under 10A NCAC 27G .3600.

Eligibility Criteria

The beneficiary is eligible for this service when all of the following criteria are met:

a. A DSM-5 (or any subsequent editions of this reference material) diagnosis of a severe Opioid Use Disorder;
b. American Society for Addiction Medicine (ASAM) for Opioid Treatment Services (OTS) level of care is met; and
c. service is a part of an aftercare planning process (time-limited step down or transitioning) and is required to avoid returning to a higher, more restrictive level of service.

Service Order Requirement

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

Continued Service and Utilization Review Criteria

The beneficiary is eligible to continue this service if the desired outcome or level of functioning has not been restored, improved or sustained over the time frame outlined in the beneficiary's service plan or the beneficiary continues to be at risk for relapse based on history or the tenuous nature of the functional gains; **OR**

The beneficiary meets any of the specifications listed in The ASAM Criteria for Dimension 5 Relapse, Continued Use or Continued Problem Potential for Opioid Treatment Services.

Authorization by NC Medicaid's designated contractor or LME-MCO is required.

Initial authorization shall not exceed 60 days. Reauthorization shall not exceed 180 days. All utilization review activity shall be documented in the Provider's Service Plan.

Discharge Criteria

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

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

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

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

Service Maintenance Criteria

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

a. history of regression in the absence of Opioid Treatment is documented in the beneficiary record; or
b. presence of a DSM-5 (or any subsequent editions of this reference material) diagnosis that would necessitate a disability management approach, in the event that there is epidemiological sound expectations that symptoms will persist and that on going treatment interventions are needed to sustain functional gains.

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

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

Documentation Requirements
A Medication Administration Record (MAR) shall be utilized to document each administration or dispensing of methadone. In addition, a modified service note shall be written at least weekly, or per date of service if the beneficiary receives the service less frequently than weekly.

Note: In addition to the above requirements, a modified service note is required for any and all significant events, changes in status, or situations outside the scope of medication administration.

A documented discharge plan shall be discussed with the beneficiary and included in the service record. In addition, a completed LME-MCO Consumer Admission and Discharge Form shall be submitted to the LME-MCO.

Refer to the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services' (DMHDDSAS) Records Management and Documentation Manual for a complete listing of documentation requirements.