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NC Division of Medical Assistance
Medicaid and Health Choice
Psychiatric Rehabilitation
Clinical Coverage Policy No: 8A-4
(Psychosocial Rehabilitation)

DRAFT

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1.0 Description of the Procedure, Product, or Service

Psychiatric Rehabilitation (Psychosocial Rehabilitation) is a rehabilitative service in a licensed facility designed to assist adults (age 18 and older) with psychiatric disabilities to restore their ability to live successfully in the community. Psychiatric Rehabilitation (PR) focuses on restoration of skills which allow the beneficiary to live independently, manage their illness and reestablish their community roles. PR’s therapeutic goal centers on improving and fostering sustainability within the life domains of emotional, social, safety, housing, medical and health, educational, vocational and legal so that the skills can be practiced within the community.

PR is a strengths-based service founded on the principles of recovery. Using individualized interventions, PR services support the acquisition of skills that:

a. promote self-determination;

b. increase the use of natural and community supports;

c. promote beneficiary choice and involvement in the treatment and recovery process;

d. assist the beneficiary in achieving recovery goals identified in the Person-Centered Plan (PCP);

e. promote symptom stability and wellness management;

f. restore personal, social, and community living skills;

g. provide case management services to assure linkage to community services and resources by assisting individuals in gaining or increasing access to necessary services;

h. restore employment related skills that focus on the development of positive work habits, abilities, talents, and skills. These activities are not to be job specific training;

i. provide or make provision for Individual Placement and Support (IPS) services in accordance with 10A NCAC 27G.1200 to facilitate the beneficiary's entry into competitive employment.

Each PR provider shall follow a clearly identified rehabilitation or evidence based treatment model consistent with best practice. The selected model(s) must be contained in the provider’s program description and be approved by their contracted Prepaid Inpatient Health Plan (PIHP).

Note: Psychiatric Rehabilitation is the same service as Psychosocial Rehabilitation and the terms are used interchangeably in this policy and in the North Carolina Medicaid State Plan.

1.1 Definitions

Rehabilitative means to restore that which one has lost, to as normal a state of health as possible.
Recovery from mental illness, or a substance use disorder as defined by the Substance Abuse and Mental Health Services Administration (SAMHSA) means the process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential. Guiding principles to recovery are: hope, person driven, many pathways, holistic, peer support, relational, culture, addresses, trauma, strengths, responsibility, and respect.

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

Preventive means to anticipate the development of a disease or condition and preclude its occurrence.

Wellness Management, according to the World Health Organization is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity.

Psychoeducation is an evidence based therapeutic intervention for the beneficiary, their family, and other individuals involved with the beneficiary’s care that provides information and support to assist in better understanding and coping with the beneficiary’s illness.

Emotional Self-Regulation is the ability to monitor and manage our own behavior such that we can calm ourselves when we are distressed and pick ourselves up when we are low. Individuals are able to respond with a range of emotions in a manner that is socially tolerable and sufficiently flexible to permit spontaneous reactions when appropriate and delay inappropriate reactions when needed.

Life Domains refer to the various parts of our lives, and are the following:

a. Emotional is a positive sense of well-being, the ability to meet the demands of everyday life, resilience, and the ability to express one's emotions appropriately.

b. Social is developing a sense of connection, belonging, and a well-developed support system.

c. Safety refers to the protection from violence, theft, or exposure to threat.

d. Housing refers to the places where we live and the need to have safe and affordable housing.

e. Medical and Health refers to the ability to maintain a healthy quality of life that allows us to get through our daily activities without undue fatigue or physical stress and the ability to recognize that our behaviors have a significant impact on our wellness.

f. Educational refers to the beneficiary's ability to obtain desired training, skills, and information necessary to meet goals.

g. Vocational is the ability to get personal fulfillment from our paid or unpaid work while still maintaining balance in our lives.

h. Legal refers to the beneficiary's contact with the legal system.
2.0 Eligibility Requirements

2.1 Provisions

2.1.1 General

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

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

b. Provider(s) shall verify each Medicaid or NCHC beneficiary’s eligibility each time a service is rendered.

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

d. Following is only one of the eligibility and other requirements for participation in the NCHC Program under GS 108A-70.21(a): Children must be between the ages of 6 through 18.

2.1.2 Specific

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

a. Medicaid

   None Apply.

b. NCHC

   NCHC beneficiaries are not eligible for Psychiatric Rehabilitation.

2.2 Special Provisions

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

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

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

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

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

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

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

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

b. EPSDT and Prior Approval Requirements

1. If the service, product, or procedure requires prior approval, the fact that the beneficiary is under 21 years of age does NOT eliminate the requirement for prior approval.

2. IMPORTANT ADDITIONAL INFORMATION about EPSDT and prior approval is found in the NCTracks Provider Claims and Billing Assistance Guide, and on the EPSDT provider page. The Web addresses are specified below.

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

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

2.2.2 EPSDT does not apply to NCHC beneficiaries

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

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

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

3.1 General Criteria Covered

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

a. the procedure, product, or service is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the beneficiary’s needs;

b. the procedure, product, or service can be safely furnished, and no equally effective and more conservative or less costly treatment is available statewide; and

c. the procedure, product, or service is furnished in a manner not primarily intended for the convenience of the beneficiary, the beneficiary’s caretaker, or the provider.

3.2 Specific Criteria Covered

3.2.1 Specific criteria covered by both Medicaid and NCHC

None Apply.

3.2.2 Medicaid Additional Criteria Covered

In addition to the specific criteria covered in Subsection 3.2.1 of this policy, Medicaid shall cover Psychiatric Rehabilitation when the beneficiary has:

a. a diagnosis as defined by the Diagnostic and Statistical Manual of Mental Disorders – Fifth Edition (DSM 5) (or any subsequent editions of this reference material) of a SMI (Serious Mental Illness) or SPMI (Severe and Persistent Mental Illness), other than a sole diagnosis of an intellectual or developmental disability or a sole diagnosis of a substance use disorder. Diagnoses such as schizophrenia spectrum and other psychotic disorders; bipolar and related disorders; and major depressive disorders are consistent with this criterion. A beneficiary with cooccurring SMI or SPMI and an intellectual or developmental disability such as autism spectrum disorders or traumatic brain injuries should be expected to be able to benefit from Psychiatric Rehabilitation. A beneficiary with cooccurring SMI or SPMI and a substance use disorder should be expected to benefit from Psychosocial Rehabilitation.

AND

b. documented significant impairment in at least two of the life domains. This impairment is related to the beneficiary’s SMI/SPMI diagnosis and impedes his or her use of the skills necessary for independent functioning in the community.

AND

c. significant functional impairment related to his or her SMI or SPMI diagnosis as demonstrated by at least ONE of the following conditions:

1. Impairment in consistently performing the skills required for basic independent functioning in the community;

2. Recurrent difficulty performing activities of daily living tasks even with support or assistance from others such as friends, family, or relatives;

3. Inability to maintain employment at a self-sustaining level; or
4. Significant difficulty in consistently carrying out the head of household responsibilities or maintaining a safe living situation.

AND

d. The beneficiary would benefit from a community rehabilitation milieu with peer support and skill building to decrease functional impairments as well as decrease social isolation.

3.2.3 Entrance Process

The following are required for a beneficiary to receive Psychiatric Rehabilitation:

a. A comprehensive clinical assessment that demonstrates medical necessity must be completed prior to provision of this service. If a substantially equivalent assessment is available, reflects the current level of functioning, and contains all the required elements outlined in clinical coverage policy 8C: *Outpatient Behavioral Health Services Provided by Direct Enrolled Providers, Subsection 7.3.3 (Comprehensive Clinical Assessment)*.

b. A signed service order is completed.

c. Prior authorization is required on the first date of this service.

3.2.4 Continued Service Criteria

The beneficiary is eligible to continue this service if the following criteria are met:

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, the history, or the tenuous nature of the functional gains;

AND

b. When the beneficiary meets one of the following requirements:

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

2. 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;

3. 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.

4. fails to make progress, or demonstrates regression, in meeting goals through the interventions outlined in the PCP. The beneficiary’s diagnosis must be reassessed to identify any unrecognized cooccurring disorders, and treatment recommendations should be revised based on the findings. This includes the consideration of alternative or additional services.
3.2.5 Service Type and Setting
PR is a day or night service provided in a licensed facility meeting the requirements of 10A NCAC 27G.1200. PR shall be available at least five hours a day, five (5) days per week (exclusive of transportation time). The PR program must include off site service activities related to transferring rehabilitative skills to the community to achieve the goals outlined in the PCP.

3.2.6 NCHC Additional Criteria Covered
None Apply.

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

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

4.1 General Criteria Not Covered
Medicaid and NCHC shall not cover the procedure, product, or service related to this policy when:
- a. the beneficiary does not meet the eligibility requirements listed in Section 2.0;
- b. the beneficiary does not meet the criteria listed in Section 3.0;
- c. the procedure, product, or service duplicates another provider’s procedure, product, or service; or
- d. the procedure, product, or service is experimental, investigational, or part of a clinical trial.

4.2 Specific Criteria Not Covered

4.2.1 Specific Criteria Not Covered by both Medicaid and NCHC
None apply.

4.2.2 Medicaid Additional Criteria Not Covered

Service Exclusions
Medicaid shall not cover the following activities under this service:
- a. Travel time (this is factored in the rate)
- b. Any habilitation activities
- c. Any social or recreational activities (or the supervision thereof)
- d. Housekeeping, homemaking, child care, laundry
- e. Clinical and administrative supervision of staff (this is factored in the rate)

Discharge Criteria
The beneficiary shall be considered for discharge from PR if all of the following criteria are met:
- 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 PR services.
c. The beneficiary or legally responsible person no longer wishes to receive PR services.

d. The beneficiary, based on presentation and failure to show improvement, or is regressing, despite modifications in the PCP. All reasonable strategies and interventions have been exhausted, indicating the need for a more appropriate best practice treatment modality based on North Carolina community practice standards (for example, National Institute of Drug Abuse, American Psychiatric Association).

4.2.3 NCHC Additional Criteria Not Covered

None apply.

5.0 Requirements for and Limitations on Coverage

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

5.1 Prior Approval

Medicaid requires prior authorization prior to rendering Psychiatric Rehabilitation.

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.

5.2.2 Specific

Utilization Management

Services are based upon a finding of medical necessity and 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 consultants.

Medically necessary services are authorized in the most cost-efficient mode and the treatment that is made available is similarly efficacious to services requested. Medically necessary services must be generally recognized as an accepted method of medical practice or treatment.

5.3 Additional Limitations or Requirements

None Apply.
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.
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 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.
d. The service order must be supported by the clinical information & recommendations from a comprehensive clinical assessment.
e. Service orders for Psychiatric Rehabilitation are valid for one calendar year from the date of plan entered on a PCP. Medical necessity must be reviewed, and services must be ordered at least annually, based on the date of plan.

5.5 Program Requirements

PR services must be available five or more hours per day, at least five days per week, and may be provided on weekends or in the evening. The number of hours that a beneficiary receives PR services are to be specified in the beneficiary's PCP.

Each PR facility must provide evidence based transitional or supported employment services to facilitate the beneficiary's entry into competitive employment. When supported employment services are provided by the facility, the services must be according to 10A NCAC 27G.1203(b). When supported employment services are provided through a vendor ship arrangement between the facility and the Division of Vocational Rehabilitation, the Rules in 10A NCAC 27G.5800 must be followed.

Only the time during which the beneficiary is actively engaged in receiving PR services is reimbursable by Medicaid.

As part of the PCP crisis plan, the PR provider shall coordinate with the PIHP 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.

The PR provider shall communicate and coordinate care with other professionals providing care to the beneficiary. This includes written progress or summary reports, telephone communication, and coordination of treatment planning.
5.6 Evidence based Practices (EBP's)

PR providers must adhere to an evidence based treatment model(s) or practice guideline(s) that support best practices treatment within PR setting. The chosen model(s) and practice(s) must address the clinical needs of the population being served.

All the requirements of this policy as well as all criteria for the chosen psychiatric rehabilitation model(s) and EBP(s) must be followed.

PR providers are expected to choose the comprehensive psychiatric rehabilitation model Clubhouse or Personalized Recovery Oriented Services. If one of these models are not chosen, the provider must develop a program based on at minimum two or more of these approved EPB’s. Whole Health Action Management, and Wellness Recovery Action Plan (WRAP), Wellness Management and Recovery (WMR), Individual Placement and Support (IPS), Family Psychoeducation (FPE), The Social Skills Training (SST), or Choose Get Keep. If the provider wishes to provide an EBP not listed above, this EBP would have to be reviewed and approved by the PIHP.

It is the intent of the DMA Psychiatric Rehabilitation policy to provide a framework for provider organizations to operate a variety of psychosocial rehabilitation models. The North Carolina DMA Psychiatric Rehabilitation policy does not endorse any single model but does provide a framework for providers to offer a variety of models if the model meets the requirements outlined in the PR policy, has been approved by the PIHP, is rehabilitative in nature, and beneficiaries receiving the service meet medical necessity. The PIHP will review and approve the model selected by the contracted provider and will assign a rate. For PR services not reimbursed by the PIHPs, DMA shall review and approve the model selected by the provider and assign one of the three rate tiers outlined above.

5.7 Other Service Limitations

The following limitations apply:

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

b. A beneficiary shall receive PR services from only one PR provider organization during any active authorization period for this service.

c. A beneficiary shall not receive PR services. If they are a resident of a nursing facility or in an inpatient setting.

PR cannot be provided during the same authorization period with the following services:

a. Partial Hospitalization

b. Substance Use Intensive Outpatient Program

c. Substance Abuse Comprehensive Outpatient Treatment

d. Assertive Community Treatment Team

Note: A PR provider who operates a group home must not self-refer a beneficiary from their group home to their PR.
5.8 Documentation Requirements

Services billed to Medicaid must comply with Medicaid reimbursement guidelines, and all documentation must relate to goals in the beneficiary’s PCP.

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:

a. The staff person who provides the service must sign and date the written entry. The signature must report credentials for licensed professionals or a job title for qualified professionals and certified peer support specialists.

b. A Qualified Professional (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

PR requires a weekly note written and signed by the person(s) who provided the service. More than one intervention, activity, or goal may be reported in one service note. Each service note page must be identified with the beneficiary’s name, Medicaid identification number and record number. Service notes, unless otherwise noted in the service definition, must contain ALL of the following:

a. Date of service provision;

b. Name of service provided (such as PR);

c. Type of contact (face to face, telephone call, collateral);

d. Place of service;

e. Purpose of the contact as it relates to the treatment plan goal(s);

f. Description of the intervention provided. Documentation of the intervention must accurately reflect treatment for the duration of time indicated;

h. Duration of service: Amount of time spent performing the intervention;

i. Assessment of the effectiveness of the intervention and the beneficiary’s progress toward the beneficiary’s goal; and

j. Signature and credentials or job title of the staff member who provided the service.

5.8.3 PR Specific Documentation Requirements

In addition to the above documentation requirements, PR provider shall:

a. document coordination of care activities; and

b. discuss the discharge plan with the beneficiary and document this discussion and the discharge plan in the service record.

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

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

a. meet Medicaid or NCHC qualifications for participation;

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

6.1 Provider Qualifications and Occupational Licensing Entity Regulations
In addition to the qualifications in Section 6.0 above, the provider(s) shall:

a. meet the provider qualification policies, procedures, and standards established by the North Carolina Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS);

b. meet the provider qualification policies, procedures, and standards established by DMA;

c. fulfill the requirements of 10A NCAC 27G;

d. demonstrate that they meet these standards by being credentialed by the PIHP;

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

f. comply with all applicable federal and state requirements. This includes the North Carolina Department of Health and Human Services statutes, rules, policies, Communication Bulletins, Medicaid bulletins, and other published instructions.

6.2 Provider Certifications

a. Provider shall be endorsed by PIHP. Additionally, the provider shall achieve national accreditation within one (1) calendar year of enrollment with DMA.

b. A facility providing PR services shall be licensed under 10A NCAC 27G .1200.

6.3 Staffing Requirements

a. 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.

b. The program must be under the direction of a person who meets the requirements specified for Qualified Professional status according to 10A NCAC 27G.0104. The Qualified Professional is responsible for the overall PR program and the supervision of program staff.

c. One of the PR staff must be credentialed by the Psychiatric Rehabilitation Association as a Certified Psychiatric Rehabilitation Practitioner (CPRP). It is recommended that this be the Program Director. If the Program Director is not a CPRP, he or she must have a minimum of two years of experience in adult mental health treatment services and must have been actively involved in program development, implementation, and service delivery to the population and age to be served.

d. All staff working in a PR program must have the knowledge, skills and abilities required by the population and age to be served.

e. All PR programs must maintain staffing ratios that ensure the treatment, health and safety of clients served in the facility. A minimum of two staff must be present with beneficiaries at all times. The exception is when only one beneficiary is present, in which case only one staff member is required.
f. Each PR site must have the following three (3) positions present to provide services:

1. One full time Program Director per site who meets the requirements specified for a Qualified Professional;

2. One FTE Qualified Professional whose duties consist of:
   A. developing, implementing, and monitoring the PCP
   B. works with other providers, including behavioral and medical, to include their input in the PCP planning process
   C. activities listed under Associate Professional;

AND

3. One additional FTE (Qualified Professional, Associate Professional, Certified Peer Support Specialist, or Paraprofessional).
   A. Associate Professional (AP) duties consist of:
      i. behavioral interventions/management
      ii. restoration of communication and problem-solving skills
      iii. anger management
      iv. medication monitoring
      v. monitoring of changes in psychiatric symptoms or functioning
      vi. activities listed under Paraprofessional

   B. Certified Peer Support Specialist duties consist of:
      i. restoration of prevocational activities
      ii. family support
      iii. social, personal care, community living, and other skill restoration
      iv. adaptive skill training
      v. assist the beneficiary in developing leisure time activities
      vi. assist the beneficiary in pursuing needed educational services
      vii. documenting the status of the beneficiary’s progress and the effectiveness of the strategies and interventions outlined in the PCP

In addition to the above staffing requirements, for programs serving more than eight (8) beneficiaries, the following staff to beneficiary ratios apply:

a. One Qualified Professional must be on staff for every 24 beneficiaries, based on average daily attendance. The PR Program Director may serve as this Qualified Professional.

b. At least one staff member on site for each eight or fewer beneficiaries in average daily attendance must be maintained, however, the staffing configuration must be adequate to anticipate and meet the needs of the beneficiaries receiving this service.

c. One of the staff (other than the Program Director) shall be designated to address the vocational needs of the beneficiaries and has the knowledge, skills, and abilities required by the population and age to be served to provide transitional or supported employment services.

If, for additional staffing purposes, the program has staff who meet the requirements specified for Associate Professional 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. Supervision of a Certified Peer...
Support Specialist shall follow the same supervision requirements specified in 10A NCAC 27G.0204 for paraprofessionals.

The above staff requirements represent the minimum level of staffing to operate a PR program. The PR provider shall staff to meet the requirements of the chosen model. If the chosen model requires additional staff, the PR provider shall staff to meet the model and the rate would reflect the costs of the chosen model.

6.4 Staff Training and Supervision Requirements

6.4.1 Staff Training

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

a. Within 30 calendar days of hire to provide PR services or within 30 calendar days of the effective date of this policy for staff who were currently working in PR, all staff shall complete the following training requirements:
   1. Three hours of training in PR service definition required components;
   2. An overview of vocational, wellness management and recovery concepts (3 hours).

b. Within 90 calendar days of hire to provide this service or within 90 calendar days of the effective date of this policy for staff who were currently working in PR, all PR staff shall complete the following training requirements:
   1. Motivational Interviewing (13-hour Introductory Training);
   2. The DHHS approved training in Crisis Response (three hours);
   3. Person Centered Thinking (six hours);
   4. QP staff responsible for PCP development shall complete “PCP Instructional Elements” training (three hours);
   5. All staff participating in the delivery of the PR model or EBP shall complete the training requirements of that model. All follow up training or ongoing continuing education requirements for fidelity of the psychiatric rehabilitation model or EBP must be followed.

c. A minimum of 10 hours of continuing education relevant to PR must be completed annually.

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

6.4.2 Supervision

If the PR 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. Clinical or professional supervision must be provided according to the supervision and staffing requirements outlined in the policy. Supervision must 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. 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).

The PR provider shall follow the standard of care and any fidelity reviews of the selected Psychiatric Rehabilitation model or Evidence Based Practice. Providers shall complete the required certification or licensure of the selected PR model(s) or EBP (as required by the developer of the model) and shall document ongoing supervision and compliance within the terms of the model to assure its fidelity.

7.0 Additional Requirements

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

7.1 Compliance

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

a. All applicable agreements, federal, state and local laws and regulations including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements; and

b. All DMA’s clinical (medical) coverage policies, guidelines, policies, provider manuals, Communication Bulletins, Medicaid Bulletins, and bulletins published by the Centers for Medicare and Medicaid Services (CMS), DHHS, DHHS division(s) or fiscal contractor(s).

7.2 Expected Clinical Outcomes

Provider(s) shall select outcome measures that will be tracked and utilized as a part of their quality improvement efforts. Expected outcomes for PR consist of the following:

a. reduced psychiatric symptoms as identified in the PCP;

b. reduced psychiatric hospitalizations (collect data on days, episodes, voluntary);

c. beneficiary satisfaction with housing status;

d. improved daily living skills (personal, social, community);

e. increased access to necessary services in all life domains;

f. improved use of appropriate coping skills as identified in the PCP;

g. improved prevocational skills;

h. beneficiary satisfaction with employment;

i. reduced criminal justice involvement;

j. decreased use of substances;

k. beneficiary satisfaction with the quality of their life; and

l. increased active participation in treatment and planning.
8.0 Policy Implementation and History

Original Effective Date: 01/01/2004

History:

<table>
<thead>
<tr>
<th>Date</th>
<th>Section or Subsection Amended</th>
<th>Change</th>
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<tbody>
<tr>
<td></td>
<td>All Sections and Attachment(s)</td>
<td>Service definition for Psychosocial Rehabilitation was removed from clinical coverage policy 8A to become a standalone new clinical coverage policy 8A-4, documenting the current coverage of Psychiatric Rehabilitation (Psychosocial Rehabilitation).</td>
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</table>
Attachment A: Claims Related Information

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

A. Claim Type

Professional (CMS-1500/837P transaction)

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. The diagnosis is made using DSM and converted to ICD for billing.

C. Code(s)

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

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

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<tr>
<th>HCPCS Code(s)</th>
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<tr>
<td>H2017</td>
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<td>1 unit =15 minutes</td>
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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.

Each of the tiers below will be represented by a modifier. DMA will reimburse PR services at one of the rate tiers and each of the rate tiers will be identified with the following modifier:

Tier 1 – Clubhouse model – Modifier:
Tier 2 – Personalized Recovery Oriented Services model – Modifier:
Tier 3 – PR Individualized program utilizing two or more of the EBPs outlined in this policy – Modifier.

The PIHP, as a part of their contracting process with the provider, will assign a rate for the provider’s chosen model(s).

E. Billing Units

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

F. Place of Service

PR is a rehabilitative service in a licensed facility. PR provides opportunities for a beneficiary to practice rehabilitative skills in the community.

G. Co payments


For NCHC refer to G.S. 108A-70.21(d)

H. Reimbursement

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

For a schedule of rates, refer to: http://dma.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.