

**LIMITATIONS ON AMOUNT  
DURATION AND SCOPE OF SERVICES**

General Provisions Applicable to All Services:

Payment for Services Furnished Out-of-State

Out-of-state services, furnished in accordance with 42 CFR 431.52, are subject to the same prior approval and continued stay reviews that would be required if the services were rendered by an in-state provider, and must be subject to the utilization review and oversight requirements of the provider's home state Medicaid program.

In addition, out-of-state services provided in accordance with 42 CFR 431.52(2)(b)(iii) are subject to prior approval to go out of state.

In accordance with 42 CFR 431.52(2)(b)(iv), the state Medicaid agency will determine whether it is the general practice for recipients in a particular locality to use medical providers in another state.

Prior Approval

Prior approval is required for certain procedures, products, and services. The decision to require prior approval for a specific procedure, product or service and the requirements that must be met for prior approval are based on evaluation of the factors such as: utilization; efficacy; safety; potential risk to patients; potential for misuse or abuse; high cost; the availability of more cost effective or equivalent procedures, products and services; and legislative mandate. Specific prior approval requirements are published in Medicaid Clinical Coverage Policies on the NC Division of Medial Assistance website ([www.dhhs.state.nc.us/dma/mp/mpindex.htm](http://www.dhhs.state.nc.us/dma/mp/mpindex.htm)).

Retroactive prior approval for procedures, products, and services that require prior approval will not be permitted, except in cases where retroactive eligibility is established.

1. Inpatient General Hospital Services:

All medical services performed must be medically necessary and may not be experimental in nature. Medical necessity is determined by generally accepted North Carolina community practice standards as verified by independent Medicaid consultants.

- A. Prior approval is required for cosmetic surgery, bone marrow, and surgical transplants excluding bone, skin, corneal, kidney and autologous tendon transplants. Prior approval is based on medical necessity and state medical policy.
- B. Medical necessity for on-going inpatient general hospital services will be determined initially by a hospital's Utilization Review Committee and may be subject to post-payment review by the State Agency. All claims will be subject to prepayment review for Medicaid coverage.
- C. The State Agency may grant a maximum of three Administrative days to arrange for discharge of a patient to a lower level-of-care. With prior approval by the State Medicaid agency, the hospital may be reimbursed for days in excess of the three administrative days at the statewide average rate for the particular level of care needed in the event a lower level-of-care bed in a Medicaid approved health care institution is not available. The hospital must, however, make every effort to place the recipient in an appropriate institution within the three-day administrative time allowance.
- D. The following are non-covered services: telephone, television, or other convenience items not routinely provided to other patients.

PLACE HOLDER FOR  
ATTACHMENT 3.1-A.1  
PAGES 2, 3 AND 4  
ARE OBSOLETE OR HAVE  
BEEN MOVED IN OTHER  
AREAS OF THE STATE  
PLAN, THERE ARE NO  
MISSING PAGES

Mandatory Services 42 CFR 440.230

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Mandatory services visits are provided in accordance with 42 CFR 440.230 per recipient per State fiscal year. Exceptions to a visit limitation may be authorized by the State when additional visits are medically necessary. The mandatory services visit limit is 22. This limitation does not apply to EPSDT eligible children.

2. a. Outpatient Hospital Services

All medical services performed must be medically necessary and may not be experimental in nature.

- (1) Prior approval shall be required for each psychiatric outpatient visit after the eighth visit for recipients 21 years and over. The visit limitation per year does not apply to recipients 21 years and over receiving mental health services subject to utilization review. Approval will be based on medical necessity.
- (2) Prior approval shall be required for each psychiatric hospital outpatient visit after the 16<sup>th</sup> visit for recipients under age 21.
- (3) Routine physical examinations and immunizations are covered under Adult Health Screening and under Early Periodic Screening Diagnosis and Treatment (EPSDT).
- (4) “Take home drugs”, medical supplies, equipment and appliances are not covered, except for small quantities of medical supplies, legend drugs or insulin needed by the patient until such time as the patient can obtain a continuing supply.
- (5) Injections are not covered if oral drugs are suitable.
- (6) Office visits in a hospital outpatient setting are included in the visit limit per recipient per State fiscal year. This limitation does not apply to adults 21 and over receiving mental health services subject to independent utilization review.

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Mandatory Services 42 CFR 440.230

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Mandatory services visits are provided in accordance with 42 CFR 440.230 per recipient per State fiscal year. Exceptions to a visit limitation may be authorized by the State when additional visits are medically necessary. The mandatory services visit limit is 22. This limitation does not apply to EPSDT eligible children.

2. b. Rural Health Clinic Services and other Ambulatory Services Furnished by a Rural Health Clinic

All medical services performed must be medically necessary and may not be experimental in nature.

- (1) Other ambulatory services provided by Rural Health Clinics are:
  - (a) Chiropractic services
  - (b) Dental Services
  - (c) Drugs, legend and insulin
  - (d) EPSDT
  - (e) Eyeglasses and visual aids
  - (f) Family Planning Services
  - (g) Hearing Aids
  - (h) Optometric Services
  - (i) Podiatry Services
- (2) Rural Health Clinic Services are subject to the limitations of the physicians' services program.
- (3) Office visits in a RHC are included in the visit limit per recipient per State fiscal year.

2. c. Federally Qualified Health Center (FQHC) services and other ambulatory services

Limitations are the same as in 2.b

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

3. Other laboratory and X-ray services

Laboratory and X-ray services shall be covered to the extent permitted in federal Medicaid regulations and subject to the following conditions:

- (1) The service is not performed in connection with a routine physical examination.
- (2) It is provided in an office or similar facility other than a hospital outpatient department or a clinic.
- (3) Clinical laboratory services are rendered by medical care entities who are issued a certificate of waiver, registration certificate, or certificate of accreditation under the Clinical Laboratories Improvement Amendments of 1988.
- (4) Portable X-ray services are medically necessary and ordered in writing by the attending physician. Services may be provided only by providers who are Medicare certified and inspected by the N.C. Division of Facility Services and are limited to provision in the patient's place of residence. The ordering physician must:
  - (a) State the patient's diagnosis, and
  - (b) Indicate the condition suspected, and
  - (c) Reason why "portable" service is needed.
- (5) Portable ultrasound services are medically necessary and ordered in writing by the attending physician. Providers must be Medicare certified as physiological labs, assure its personnel are licensed or registered in accordance with applicable State laws, and comply with manufacturer's guidelines for use of and routine inspection of equipment. The ordering physician must:
  - (a) State the patient's diagnosis, and
  - (b) Indicate the condition suspected, and
  - (c) Reason why "portable" service is needed

4.a. Nursing Facility Services

- (1) Prior approval is required. This approval is based on reporting form for each patient to be admitted to a nursing facility signed by the attending physician which indicates anticipated restoration potential, treatments orders, and type of care recommended.

- (2) Where cases warrant expeditious action, telephone approvals can be obtained; these must be followed up with the completed reporting form indicated in (1) above.
- (3) Private accommodations are authorized only when directed by a physician as medically necessary or when all semi-private accommodations are occupied.
- (4) The items and services furnished in NFs and ICF-MRs that are payable by the Medicaid Program when medically necessary and for which recipients may not be charged are listed below. Unless stated otherwise these services are payable only to long term care facilities.
  - (a) Semi-private room, ward accommodations or private room if medically necessary, including room supplies such as water pitchers, basins, and bedpans.
  - (b) Nursing staff services.
  - (c) Food and intravenous fluids or solutions.
  - (d) Linens and patient gowns and laundering of these items.
  - (e) Housekeeping services.
  - (f) Social services and activity programs.
  - (g) Physical therapy, speech therapy, audiology, occupational therapy, respiratory therapy, and all other forms of therapy.
  - (h) Medical supplies, oxygen, orthotics, prostheses and durable medical equipment.
  - (i) Non legend drugs, serums, vaccines, antigens, and antitoxins.
  - (j) Transportation to other medical providers for routine, non-emergency care.
  - (k) Laboratory and radiology services, payable to either the long term care facility or directly to the provider furnishing the service.
  - (l) Physician and dental services, payable only to the practitioners if provided in private facilities.
  - (m) Legend drugs and insulin payable only to pharmacies if provided in private facilities.
  - (n) Transportation to other medical providers for emergency care, payable only to ambulance providers.

The following items can be charged to recipients:

- (a) Customary room charge to reserve a room during a recipient's hospital stay, therapeutic leave in excess of the maximum allowed, and other absences.
- (b) Customary private room differential charge if a private room is not medically necessary.
- (c) Private duty nurse or attendants.
- (d) Telephone, television, newspaper, and magazines.
- (e) Guest meals.
- (f) Barber and beauty shop, services other than routine grooming required as part of the patient's care plan.
- (g) Personal clothing and laundry
- (h) Personal dental and grooming items.
- (i) Tobacco products
- (j) Burial services and items.

Level of Care criteria is described in Appendix 1 of Attachment 3.1-A. Level of Care criteria for non acute intensive rehabilitation head-injury care described in Appendix 3 of Attachment 3.1-A. Level of Care criteria for ventilator-dependent care described in Appendix 4 of Attachment 3.1-A.

4.b. Early and Periodic Screening, Diagnosis and Treatment

(1) Hearing Aid Services

Prior approval is required for hearing aids. The prior approval request must be supported by a certification of need for beginning the hearing aid selection process (medical clearance) from a physician or otologist (including otolaryngologist or otorhinolaryngologist). A copy of the hearing evaluation (including the audiogram) and the results of the hearing aid selection and evaluation must be included. Hearing aid services are provided in accordance with 42 CFR 440.110.

(2) Dental Services

Covers fillings, extractions, restorative services, stainless steel space maintainers, prophylaxes, scaling and curettage, fluoride, x-rays, relief of pain, periodontal services, complete and partial dentures with rebasing and relining, endodontic therapy, surgery, and orthodontics in accordance with evidence-based best practices and/or where medical necessity dictates.

(4) Prosthetic and Orthotic Devices

Medically necessary orthotic and prosthetic devices are covered by the Medicaid program when prescribed by a qualified licensed healthcare practitioner and supplied by a qualified provider.

Only items determined to be medically necessary, effective and efficient are covered. Items which require prior approval are indicated by an asterisk beside the HCPCS code on the Orthotic and Prosthetic Fee Schedule. This fee schedule is located at [www.dhhs.state.nc.us/dma/fee/fee.htm](http://www.dhhs.state.nc.us/dma/fee/fee.htm).

A qualified orthotic and prosthetic device provider must be approved by the Division of Medical Assistance. The provider requirements are published in Medicaid Clinical Coverage Policies on the NC Division of Medical Assistance website ([www.dhhs.state.nc.us/dma/dme/5B.pdf](http://www.dhhs.state.nc.us/dma/dme/5B.pdf)).

Prior approval is required for certain orthotic and prosthetic devices. The decision to require prior approval for a specific procedure, product or service and the requirements that must be met for prior approval are based on evaluation of the factors such as: utilization; efficacy; safety; potential risk to patients; potential for misuse or abuse; high cost; the availability of more cost effective or equivalent procedures, products and services; and legislative mandate. High cost is cost in comparison to other covered items and related maintenance. Such a designation would usually be arrived at by a team of DMA staff from fiscal, programmatic and Program Integrity areas. Whether the recipient gets the item or not is dependent on the rationale for medical need and the unavailability of another less costly item that would adequately address the need. Session Law 2004-124 states "medically necessary prosthetics and orthotics are subject to prior approval and utilization review." Specific prior approval requirements are published in Medicaid Clinical Coverage Policies on the NC Division of Medical Assistance website ([www.dhhs.state.nc.us/dma/dme/5B.pdf](http://www.dhhs.state.nc.us/dma/dme/5B.pdf)).

*\*Adult Orthotic and Prosthetic Information is located at: Attachment 3.1-A.1, Page 15.*

(5) Selected Services Are Covered

Selected services include physical, occupational, speech, language pathology/audiology, and respiratory therapy. Services include but are not limited to: inpatient hospital; nursing facilities; and outpatient services in physician offices and hospitals; and local management entities, as well as locations defined by clinical policies.

Prior to treatment a screening service provided by a practitioner licensed according to North Carolina General Statute Chapter 90 must document that the treatment is medically necessary to correct or ameliorate any defects or chronic conditions.

The amount, duration and scope of the services must be expected to correct or ameliorate any defects or chronic conditions according to the referring treatment plan of care. These services must be provided in the most economical setting available according to clinical policies and limitations promulgated in accordance with Session Law 2001-424.

(6) The above listed services are covered as follows:

Other Diagnostic Screening, Preventive and Rehabilitative Services are reimbursed in accordance with Attachment 4.19-B. Clinic services, Hospital Outpatient services, Home Health Agencies and Physician Services are also reimbursed in accordance with Attachment 4.19-B.

The agency assures that if there are providers involved whose payment is based on reasonable cost, the State will provide appropriate cost reimbursement methodologies. The agency has waived the 6 prescription limit and the 24 visit limit for ambulatory visits for EPSDT eligible clients. The agency will cover all diagnostic and treatment services listed in 1905(a) which are medically necessary to correct or lessen health problems detected during screening. These services will be made available based on individual client needs.

(7) Assurance 1905(a) Services

The state assures that EPSDT eligible clients have access to 1905(A) services not specifically listed in the state plan when they are medically necessary. Services provided as described in Section 1905(a) to correct or ameliorate defects and physical and mental illnesses and conditions discovered by screening services and not covered in the state plan will be provided if determined to be medically necessary by the appropriate agency staff or consultants.

**4.b Early and periodic screening, diagnostic and treatment services for individuals under 21 years of age, and treatment of conditions found.**

- (8) Services provided under this section are provided by licensed practitioners (within their scope of practice as determined by the North Carolina Practice Acts per discipline) or programs/agencies for the mentally ill and substance abusers certified as meeting the program standards of the Commission on Mental Health, Developmental Disabilities and Substance Abuse Services or as Critical Access Behavioral Health Care Agencies, and directly enrolled in Medicaid. Staff of the agency providing services will also meet requirements set forth in Federal regulations or the requirements for one of the three categories described on pages 7c.10 and 7c.11. These services are available to categorically needy and medically needy recipients. Services include the following:

Medically necessary diagnostic evaluations or assessments (Diagnostic Assessment) identify the existence, nature and extent of illness. The services may include a systematic appraisal of mental, psychological, physical, behavioral, functional, social, economic and/or intellectual limitations and resources of the individual in order to determine the nature and extent of illness. This information will be used in the formulation of an individualized person centered plan for the recipient.

Other medically necessary diagnostic, screening, treatment, preventive and rehabilitative (ODSPR) services for the mentally ill and substance abusers are covered benefits when medically necessary. Screening services means the use of standardized tests given under medical direction. Diagnostic, preventive, or rehabilitative services must be ordered by a physician, licensed psychologist, physician's assistant or nurse practitioner practicing within the scope of his/her practice according to Chapter 90 of the North Carolina General Statutes. Specific-Services for children from age 0 to age 3 can be found at Attachment 3.1-A.1 page 7g.1 "*Early Intervention Rehabilitative Services.*"

Covered services are provided to recipients in their residence or in a community setting, which may be any location other than in a public institution (IMD), other inpatient setting, jail or detention facility.

Inpatient psychiatric facilities serving individuals under age 21 will meet the requirement of 42 Code of Federal Regulations Part 441, Subpart D, and Part 483, Subpart G.

Critical Access Behavioral Health Agencies (CABHA), for profit, not for profit, public, or private behavioral health care, behavioral health services provider agencies, will be certified by the North Carolina Department of Health and Human Services (the Department) as meeting the following staffing, and operational certification requirements.

4.b **Early and periodic screening, diagnostic and treatment services for individuals under 21 years of age, and treatment of conditions found. (continued)**

Critical Access Behavioral Health Agency (CABHA)

A Critical Access Behavioral Health Agency must meet all statutory, rule and policy requirements for Medicaid mental health and substance abuse service provision and monitoring; be determined to be in good standing with the Department; and have a three year (or longer) accreditation from an accrediting body recognized by the Secretary of the Department of Health and Human Services. State statutory requirements regulating the provision of mental health and substance abuse services are in North Carolina General Statute, Chapter 122C; administrative rules relating to these services are in 10A NCAC 27 and clinical policy requirements are specified in Medicaid Clinical Policy Section 8. Medicaid and enrollment policy require compliance with Federal Medicaid Policy relating to confidentiality, record retention, fraud and abuse reporting and education, documentation, staff qualifications and compliance with clinical standards for each service. Required staff for a CABHA includes a Medical Director; a Clinical Director and a Quality Management/Training Director.

4.b **Early and periodic screening, diagnostic and treatment services for individuals under 21 years of age, and treatment of conditions found. (continued)**

**Critical Access Behavioral Health Agency (CABHA) (continued)**

Each CABHA is required to offer at a minimum the following five services;

1. Comprehensive clinical assessment, which is defined as a face to face evaluative review by a qualified licensed practitioner, of a recipient’s medical, psychological, familial, social and psychiatric treatment history; current mental status and functioning, strengths, natural supports, current treatment and medication regime, for the purpose of developing a diagnostic formulation of the recipient’s treatment needs and treatment plan.; may be provided under Diagnostic Assessment, Attachment 3.1-A1, Page 7c.2 or under Rehabilitative Services for Behavioral Health, Page 7c.12 – 13.
2. Medication management defined as pharmacologic management including review of medication use, both current and historical, if indicated; evaluation of symptoms being treated, side effects and effectiveness of current medication(s), adjustment of medications if indicated, and prescription, provided by a medical professional practicing within the scope of his or her licensure; may be provided under Physician Services, Attachment 3.1-A.1, Page 7h or under Rehabilitative Services for Behavioral Health, Page 7c.12 – 13.
3. Outpatient therapy defined as outpatient psychotherapy including individual insight oriented, behavior modifying, and/or supportive psychotherapy; interactive psychotherapy; family psychotherapy; and group psychotherapy. Service can be billed by all licensed clinicians according to their scope of practice, as indicated on Attachment 3.1-A.1., page 7c.12 – 13.
- 4- At least two additional mental health and/or substance abuse services from the list below for which the agency has been credentialed from the Local Management Entity in the same region where it provides the services and which provide a continuum of service which is age and disability specific. There is a description of each of the services, including who provides the services and their qualifications in the State Plan in Attachment 3.1-A.1.,-on the page as indicated below.

These services must include two or more of the following:

Services	Page Reference
Intensive In-Home (IIH)	Page 7c.6
Community Support Team (CST)	Page 15a.6
Substance Abuse Intensive Outpatient Program (SAIOP)	Pages 7c.8 & 15a.9-A
Substance Abuse Comprehensive Outpatient Treatment (SACOT)	Page 15a.10
Child and Adolescent Day Treatment	Page 7c.4
Psychosocial Rehabilitation (PSR)	Page 15a.3
Assertive Community Treatment Team (ACTT)	15a.7
Multi-Systemic Therapy (MST)	Page 7c.7
Partial Hospitalization (PH)	Pages 7c.5 & 15a.4
Substance Abuse Medically Monitored Community Residential Treatment	Page 15a.11-A
Substance Abuse Non-Medical Community Residential Treatment	Page 15a.11
Outpatient Opioid Treatment	Page 15a.9
(Therapeutic Foster Care) Child Residential Level II – Family Type	Page 15a.19
Child Residential Level II – Program Type	Page 15a.19
Child Residential Level III and IV	Page 15a.20

CABHAs and non-CABHA agencies may provide Comprehensive Clinical Assessments, Medication Management, and Outpatient Therapy.

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**4.b Early and periodic screening, diagnostic and treatment services for individuals under 21 years of age, and treatment of conditions found. (continued)**

Only CABHAs will be able to provide Community Support Team, Intensive In-Home, Child and Adolescent Day Treatment after December 31, 2010.

CABHAs must coordinate with other provider participants, Carolina Access and other primary care providers to improve the coordination of services within the Local Management Entity's community of providers.

The following services under this section will be covered when a determination is made that the services are medically necessary and will meet specific behavioral health needs of the recipient. Specific services must correct or ameliorate diagnosable conditions or prevent the anticipated deterioration of the patient's condition. Services provided to family members of the recipient must be related to the recipient's mental health/substance abuse disability.

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4.b.(8) Diagnostic, Screening, Treatment, Preventive and Rehabilitative Services (continued)  
Description of Services

- (a) Psychotherapy Services:  
For the complete description of the service providers, their qualifications, service limitations and service descriptions, see Attachment 3.1-A pages 15a.16 and 15a.7
- (b) Diagnostic Assessment (42 CFR 440.130(a))

This is a clinical face to face evaluation of a beneficiary's MH/DD/SAS condition that will establish a need for the enhanced benefit package of services. It is a team service and must include evaluations by either, a physician, physician assistant, nurse practitioner or licensed psychologist who can sign an order for services and a licensed or certified practitioner with expertise in MH/DD/SAS as appropriate and consist of the following:

- a chronological general health and behavioral health history (includes both mental health and substance abuse) 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; biological, psychological, familial, social, developmental and environmental dimensions and identified strengths and weaknesses in each area;
- a description of the presenting problems, including source of distress, precipitating events, associated problems or symptoms, recent progressions, and current medications;
- a strengths/problem summary which addresses risk of harm, functional status, co-morbidity, recovery environment, and treatment and recovery history;
- diagnoses on all five (5) axes of DSM-IV;
- evidence of an interdisciplinary team progress note that documents the team's review and discussion of the assessment;
- a recommendation regarding target population eligibility; and
- evidence of beneficiary participation including families, or when applicable, guardians or other caregivers.

Documentation must include the following elements:

- a chronological general health and behavioral health history (includes both mental health and substance abuse) 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; biological, psychological, familial, social, developmental and environmental dimensions and identified strengths and weaknesses in each area;
- a description of the presenting problems, including source of distress, precipitating events, associated problems or symptoms, recent progressions, and current medications;
- strengths/problem summary which addresses risk of harm, functional status, co-morbidity, recovery environment, and treatment and recovery history;
- diagnoses on all five (5) axes of DSM-IV;
- evidence of an interdisciplinary team progress note that documents the team's review and discussion of the assessment;
- a recommendation regarding target population eligibility; and
- evidence of beneficiary participation including families, or when applicable, guardians or other caregivers.

A beneficiary may receive one diagnostic assessment per year without any additional authorization.

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**4.b Early and periodic screening, diagnostic and treatment services for individuals under 21 years of age, and treatment of conditions found. (continued)**

(d) Mental Health Day Treatment

This service is available for children from age 3 up through age 20 and includes therapeutic or rehabilitation goals of the consumer in a structured setting. The interventions are outlined in the child/adolescent person centered treatment plan and may include:

- behavioral interventions,
- social and other skill development,
- communication enhancement,
- problem- solving skills,
- anger management,
- monitoring of psychiatric symptoms; and
- psycho-educational activities as appropriate.

These interventions are designed to support symptom stability, increase the recipient's ability to cope and relate to others and enhancing the highest level of functioning possible. The service will also contain a care coordination component with assessment, monitoring, linking to services related to mental health needs and coordination of mental health services. Documentation must include: a daily full service note that includes the recipient's name, Medicaid identification number, date of service, purpose of contact, describes the provider's interventions, includes the time spent performing the interventions, effectiveness of the intervention, and the signature of the staff providing the service. This service must be available three hours a day minimally in a licensed program. After December 31, 2010, this service can only be provided by and billed by a Critical Access Behavioral Health Care Agency (CABHA). All services in the milieu are provided by a team which may have the following configuration; providers meet the qualified professional requirements, associate professionals and paraprofessionals. The service must be ordered by a physician, licensed psychologists, physician's assistant or nurse practitioner and prior approval will be required via the statewide UR vendor or by an approved LME, contracted with the Medicaid Agency and meeting the same standards and requirements as the statewide vendor. This initial prior approval process will ensure that the level of the service is appropriate and concurrent reviews will determine the ongoing medical necessity for the service or the need to move up or down the continuum of services to another level of care. This service can only be provided by one day treatment provider at a time and cannot be billed on the same day as any inpatient, residential, or any other intensive in home service.

4.b.(8) Diagnostic, Screening, Treatment, Preventive and Rehabilitative Services (continued)  
Description of Services

(e) Partial Hospital (PH)

This is a short term service for acutely mentally ill children which provides a broad range of intensive therapeutic approaches which may include:

- Individual/group therapies,
- Increase the individual's ability to relate to others,
- Community living skills/training,
- Coping skills,
- Medical services; and
- This is used as a step up to inpatient or a step down from inpatient.

Physician involvement is required. This service must be offered at a minimum of 4 hours per day, 5 days/week. Clinical criteria (medical necessity criteria for admission and continued stay) are embedded in the service definition. Documentation must include: a daily full service note that includes the recipient's name, Medicaid identification number, date of service, purpose of contact, describes the provider's interventions, includes the time spent performing the interventions, effectiveness of the intervention, and the signature of the staff providing the service. The service must be ordered by a physician, licensed psychologists, physician's assistant or nurse practitioner and prior approval will be required via the statewide UR vendor or by an approved LME contracted with the Medicaid Agency and meeting the same standards and requirements as the statewide vendor. This initial prior approval process will ensure that the level of the service is appropriate and concurrent reviews will determine the ongoing medical necessity for the service or the need to move up or down the continuum of services to another level of care.

Provider agencies for Partial Hospitalization are licensed by the Division of Health Service Regulation, credentialed by the LMEs as meeting the program specific requirements for provision of Partial Hospitalization and enrolled in Medicaid. The staff providing this service are employees of the enrolled agency. Their qualifications and the discrete service components they perform are listed below.

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. Staff shall include at least one qualified mental health professional.

The following sets forth the activities included in this service definition. These activities reflect the appropriate scope of practice for the Partial Hospital staff identified below.

Physician: Participate in diagnosis, treatment planning, and admission/discharge decisions.

Social Workers, Psychologists, therapists: Group activities and therapy such as individual therapy and recreational therapy.

Case Managers: Case Management functions

Paraprofessional staff: Community living skills/training under the supervision of a Qualified Professional.

4.b.(8) Diagnostic, Screening, Treatment, Preventive and Rehabilitative Services (continued)  
Description of Services

(f) Mobile Crisis Management

This involves all supports, services and treatments necessary to provide integrated crisis response, crisis stabilization interventions and crisis prevention activities. It is available 24/7/365 and provides immediate evaluation, triage and access to acute MH/DD/SAS services, treatment, supports to effect symptom reduction, harm reduction and/or to safely transition persons in acute crisis to the appropriate environment for stabilization. It is provided by a team that includes a Qualified Professional who must be either, a nurse, a clinical social worker or psychologist. Teams include substance abuse professionals, and a psychiatrist must be available for face to face or telephone consults. Paraprofessionals with crisis management experience may also be included on the team but must work under the supervision of a professional. Experience with the appropriate disability group is required and 20 hours of crisis intervention training within the first 90 days of employment is necessary. The maximum length of the service is 24 hours per episode and prior authorization will be required after the first 8 hours for the remaining 16 hours. Documentation must include: a service note that includes the recipient's name, Medicaid identification number, date of service, purpose of contact, describes the provider's interventions, includes the time spent performing the interventions, effectiveness of the intervention, and the signature of the staff providing the service.

NOTE: This has a limitation; however the service requires stabilization or movement into an environment that can stabilize so it is not really a termination of service.

**4.b Early and periodic screening, diagnostic and treatment services for individuals under 21 years of age, and treatment of conditions found. (continued)**

(g) Intensive In-Home

A time limited mental health/substance abuse service that can be provided through age 20 in order to:

- diffuse current crisis as a first responder,
- intervene to reduce likelihood of re-occurrence,
- ensure linkage to community services and resources,
- monitor and manage presenting psychiatric and/or addictions,
- provide self-help and living skills for youth; and
- work with caregivers in implementation of home-based supports and other rehabilitative supports to prevent out of home placement for the child.

This is a team service provided by qualified professionals, associate professionals and paraprofessionals. There is a team to family ratio to keep case load manageable and staff must complete intensive in home training with in the first 90 days of employment. Services are provided in the home or community and not billable for children in detention or inpatient settings. The service requires a minimum of 12 face to face contacts the first month with a contact being defined as all visits within a 24 hour period. A minimum of 2 hours of service must be provided each day for the service to be billable. Number of visits per month for the second and third month of the service will be titrated with the expectation of six visits per month. Documentation must include: a daily full service note that includes the recipient's name, Medicaid identification number, date of service, purpose of contact, describes the provider's interventions, includes the time spent performing the interventions, effectiveness of the intervention, and the signature of the staff providing the service. After December 31, 2010, this service can only be provided by and billed by a Critical Access Behavioral Health Care Agency (CABHA). The service must be ordered by a physician, licensed psychologists, physician's assistant or nurse practitioner and prior approval will be required via the statewide UR vendor or by an approved LME contracted with the Medicaid Agency and meeting the same standards and requirements as the statewide vendor. This initial prior approval process will ensure that the level of the service is appropriate and concurrent reviews will determine the ongoing medical necessity for the service or the need to move up or down the continuum of services to another level of care.

This service can only be provided by one Intensive In-Home provider at the time and cannot be billed on the same day as Multisystemic Therapy, Day Treatment, Hourly Respite, Individual, group or family therapy, SAIOP, or living in a Level II-IV child residential (Attachment 3.1-A.1, Pages 15a.19-20) or substance abuse residential facility.

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4.b.(8) Diagnostic, Screening, Treatment, Preventive and Rehabilitative Services (continued)  
Description of Services

(h) Multisystemic Therapy (MST)

This mental health/substance abuse program is an evidenced-based practice designed for youth generally between the ages of 7 and 17 who have antisocial, aggressive/violent behaviors and are at risk for out of home placement due to delinquency; adjudicated youth returning from out of home placement and/or chronic or violent juvenile offenders; and youths with serious emotional disturbances or abusing substances. As required by EPSDT, youth outside of these age ranges would be able to receive the service if medically necessary and if no other more appropriate service is available. This is a team service that has the ability to provide service 24/7/365. The service components include assessment, individual therapeutic interventions with the youth and family, care coordination, and crisis stabilization. Specialized therapeutic interventions are available to address special areas such as substance abuse, sexual abuse, sex offending, and 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. The service must be ordered by a physician, licensed psychologists, physician's assistant or nurse practitioner and prior approval will be required via the statewide UR vendor or by an approved LME contracted with the Medicaid Agency and meeting the same standards and requirements as the statewide vendor. This initial prior approval process will ensure that the level of the service is appropriate and concurrent reviews will determine the ongoing medical necessity for the service or the need to move up or down the continuum of services to another level of care.

Recipients residing in detention facilities, halfway houses or wilderness camps under governmental control, an inmate receiving outpatient treatment, or receiving care on premises of prison, jail, detention center, or other penal setting are not eligible for receiving any Medicaid Federal Financial Participation (FFP) through MST or any other Medicaid funded service.

A minimum of 12 contacts are required within the first month of the service and for the next two months an average of 6 contacts per month will occur. It is the expectation that service frequency will be titrated over the last two months. Documentation must include: a daily full service note that includes the recipient's name, Medicaid identification number, date of service, purpose of contact, describes the provider's interventions, includes the time spent performing the interventions, effectiveness of the intervention, and the signature of the staff providing the service.

Clinical criteria (medical necessity criteria for admission and continued stay) are embedded in the service definition. The provider qualifications are at a minimum a master's level Qualified Professional (QP) who is the team supervisor and three QP staff as defined in State rule 10A NCAC 27G .0104 as follows:

- (a) an individual who holds a license, provisional license, certificate, registration or permit issued by the governing board regulating a human service profession, except a registered nurse who is licensed to practice in the State of North Carolina by the North Carolina Board of Nursing who also has four years of full-time accumulated experience in MH/DD/SA with the population served; or

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(b) a graduate of a college or university with a Masters degree in a human service field and has one year of full-time, post-graduate degree accumulated MH/DD/SA experience with the population served, or a substance abuse professional who has one year of full-time, post-graduate degree accumulated supervised experience in alcoholism and drug abuse counseling; or

(c) a graduate of a college or university with a bachelor's degree in a human service field and has two years of full-time, post-bachelor's degree accumulated MH/DD/SA experience with the population served, or a substance abuse professional who has two years of full-time, post-bachelor's degree accumulated supervised experience in alcoholism and drug abuse counseling; or

(d) a graduate of a college or university with a bachelor's degree in a field other than human services and has four years of full-time, post-bachelor's degree accumulated MH/DD/SA experience with the population served, or a substance abuse professional who has four years of full-time, post-bachelor's degree accumulated supervised experience in alcoholism and drug abuse counseling.

Providers wish to offer MST as a service must be credentialed by their Local Management Entity, be licensed by MST Inc, and be enrolled as a North Carolina Medicaid provider. These providers agree to adhere to the principles of MST.

Staff is required to participate in MST introductory training and quarterly training on topics related to the needs of MST youth and their family on an ongoing basis. All MST staff shall receive a minimum of one hour of group supervision and one hour of telephone consultation per week from specially trained MST supervisors. Limitations are in place to prevent reimbursement for duplication of services.

4.b.(8) Diagnostic, Screening, Treatment, Preventive and Rehabilitative Services (continued)  
Description of Services

(i) Substance Abuse Intensive Outpatient (SAIOP)

This service provides motivational enhancement and engagement therapies for recovery, random alcohol/drug testing and strategies for relapse prevention to include community and/or other strategies for relapse preventions. These therapies include:

- Individual counseling and support,
- Group counseling and support,
- Family counseling and support,
- Biochemical assays to identify recent drug use (e.g. urine drug screens),
- Strategies for relapse prevention: community and social support systems in treatment,
- Crisis contingency planning,
- Disease management; and
- Treatment support activities that have been adapted or specifically designed for persons with physical disabilities or persons with co-occurring disorders of mental illness and/or developmental disabilities and/or substance abuse/dependence.

Family counseling and support as well as group counseling and support are provided only for the direct benefit of the recipient of the SAIOP program.

SAIOP must be available for a minimum of 3 hours per day, be operated out of a licensed substance abuse facility and can be provided in a variety of settings. The maximum face to face ratio is an average of not more than 12 recipients to 1 direct services staff based on average daily attendance. Documentation must include: a service note that includes the recipient's name, Medicaid identification number, date of service, purpose of contact, describes the provider's interventions, includes the time spent performing the interventions, effectiveness of the intervention, and the signature of the staff providing the service. This service can only be provided by qualified substance abuse professional staff with the following licenses or certifications: Licensed Psychological Associates, Licensed Professional Counselors, Licensed Clinical Social Workers, Certified Substance Abuse Counselors, and Licensed Clinical Addiction Specialists. This service must be ordered by an MD, NP, PA or PhD psychologist. Prior approval will be required via the statewide UR vendor or by an approved LME contracted with the Medicaid Agency and meeting the same standards and requirements as the statewide vendor. This initial prior approval process will ensure that the level of the service is appropriate and concurrent reviews will determine the ongoing medical necessity for the service or the need to move up or down the continuum of services to another level of care.

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4.b.(8) Diagnostic, Screening, Treatment, Preventive and Rehabilitative Services (continued)  
Description of Services

(j) Ambulatory Detoxification

Ambulatory Detoxification is an organized service available to children and adults, delivered by trained practitioners who provide medically supervised evaluations, detoxification and referral services according to a predetermined schedule. Medical supervision consists of a physician available 24 hours a day by telephone, a registered nurse who monitors the recipient's progress and medication, and appropriately licensed and credentialed staff to administer medications in accordance with physician orders. Ambulatory Detoxification service components include outpatient services 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 patient's level of clinical severity and to achieve safe and comfortable withdrawal from mood-altering drugs (including alcohol) and to effectively facilitate the patient's transition into ongoing treatment and recovery. These services are provided in a licensed facility with regularly scheduled sessions by a Certified Clinical Supervisor (CCS), Licensed Clinical Addictions Specialist (LCAS), Qualified Professional (QP) or Associate Professional (AP). A CCS is an individual who is certified as such by the North Carolina Substance Abuse Professional Certification Board. A LCAS is certified as such by the North Carolina Substance Abuse Professional Certification Board. The Qualified Professional is:

- (a) an individual who holds a license, provisional license, certificate, registration or permit issued by the governing board regulating a human service profession, except a registered nurse who is licensed to practice in the State of North Carolina by the North Carolina Board of Nursing who also has four years of full-time accumulated experience in MH/DD/SA with the population served; or
- (b) a graduate of a college or university with a Masters degree in a human service field and has one year of full-time, post-graduate degree accumulated MH/DD/SA experience with the population served, or a substance abuse professional who has one year of full-time, post-graduate degree accumulated supervised experience in alcoholism and drug abuse counseling; or
- (c) a graduate of a college or university with a bachelor's degree in a human service field and has two years of full-time, post-bachelor's degree accumulated MH/DD/SA experience with the population served, or a substance abuse professional who has two years of full-time, post-bachelor's degree accumulated supervised experience in alcoholism and drug abuse counseling; or
- (d) a graduate of a college or university with a bachelor's degree in a field other than human services and has four years of full-time, post-bachelor's degree accumulated MH/DD/SA experience with the population served, or a substance abuse professional who has four years of full-time, post-bachelor's degree accumulated supervised experience in alcoholism and drug abuse counseling.

An AP within the mental health, developmental disabilities and substance abuse services (MH/DD/SAs) system of care is a:

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4.b.(8) Diagnostic, Screening, Treatment, Preventive and Rehabilitative Services (continued)

Description of Services

(a) graduate of a college or university with a Masters degree in a human service field with less than one year of full-time, post-graduate degree accumulated MH/DD/SA experience with the population served, or a substance abuse professional with less than one year of full-time, post-graduate degree accumulated supervised experience in alcoholism and drug abuse counseling. Supervision shall be provided by a qualified professional with the population served until the individual meets one year of experience. The supervisor and the employee shall develop an individualized supervision plan upon hiring. The parties shall review the plan annually; or

(b) graduate of a college or university with a bachelor's degree in a human service field with less than two years of full-time, post-bachelor's degree accumulated MH/DD/SA experience with the population served, or a substance abuse professional with less than two years of full-time, post-bachelor's degree accumulated supervised experience in alcoholism and drug abuse counseling. Supervision shall be provided by a qualified professional with the population served until the individual meets two years of experience. The supervisor and the employee shall develop an individualized supervision plan upon hiring. The parties shall review the plan annually; or

(c) graduate of a college or university with a bachelor's degree in a field other than human services with less than four years of full-time, post-bachelor's degree accumulated MH/DD/SA experience with the population served, or a substance abuse professional with less than four years of full-time, post-bachelor's degree accumulated supervised experience in alcoholism and drug abuse counseling. Supervision shall be provided by a qualified professional with the population served until the individual meets four years of experience. The supervisor and the employee shall develop an individualized supervision plan upon hiring. The parties shall review the plan annually; or

(d) registered nurse who is licensed to practice in the State of North Carolina by the North Carolina Board of Nursing with less than four years of full-time accumulated experience in MH/DD/SA with the population served. Supervision shall be provided by a qualified professional with the population served until the individual meets four years of experience. The supervisor and the employee shall develop an individualized supervision plan upon hiring. The parties shall review the plan annually.

Ambulatory Detoxification is an outpatient service that provides periodic services involving the provision of supportive services, particularly active support systems under the supervision of a physician for clients who are experiencing physical withdrawal from alcohol and other drugs, including but not limited to appropriate medical, nursing and specialized substance abuse services. This service must be provided in an Ambulatory Detoxification Facility licensed under 10A NCAC 27G .3301. Each outpatient detoxification facility shall operate at least eight hours per day, for a minimum of five days per week.

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4.b.(8) Diagnostic, Screening, Treatment, Preventive and Rehabilitative Services (continued)  
Description of Services

Documentation must include: a service note that includes the recipient's name, Medicaid identification number, date of service, purpose of contact, describes the provider's interventions, includes the time spent performing the interventions, effectiveness of the intervention, and the signature of the staff providing the service. A physician is available 24/7 to conduct an assessment within 24 hours of admission. A registered nurse is available to conduct a nursing assessment on admission and oversee the monitoring of patient's progress and medications. This service must be ordered by an MD, NP, PA or PhD psychologist. Prior approval will be required via the statewide UR vendor or by an approved LME contracted with the Medicaid Agency and meeting the same standards and requirements as the statewide vendor. This initial prior approval process will ensure that the level of the service is appropriate and concurrent reviews will determine the ongoing medical necessity for the service or the need to move up or down the continuum of services to another level of care.

4.b.(8) Diagnostic, Screening, Treatment, Preventive and Rehabilitative Services (continued)  
Description of Services

(k) Professional Treatment Services in Facility-Based Crisis Program – Children and Adolescents

Professional Treatment Services in a Facility-Based Crisis Program – Children and Adolescents is a service for children and adolescents up to age 21 who meet the medical necessity criteria for crisis stabilization services furnished in a 24-hour residential facility, licensed under 10A NCAC 27G .5000, with 16 beds or less (the 16 bed limit is inclusive of Facility-Based Crisis -- Adult and Facility-Based Crisis -- Child). A Facility-Based Crisis provider shall be designated as an involuntary treatment facility. The Facility-Based Crisis Program is under the clinical oversight of a psychiatrist. This is a short term service that provides disability-specific care and treatment in a non-hospital setting for individuals requiring acute crisis stabilization. The goals of this service include:

- reduction of acute psychiatric symptoms that precipitated the need for this service,
- reduction of acute negative effects of substance related disorders with enhanced motivation for treatment and/or relapse prevention,
- stabilizing or managing the crisis situation,
- preventing hospitalization or other institutionalization,
- accessing services as indicated in the comprehensive clinical assessment, and
- reduction of behaviors that led to the crisis.

A comprehensive clinical assessment is an intensive clinical and functional face-to-face evaluation of an individual's presenting mental health, developmental disability, and/or substance abuse condition that result in the issuance of a written report, providing the clinical basis for the development of the Person Centered Plan. The comprehensive clinical assessment is provided by a directly enrolled licensed professional as outlined in the Division of Medical Assistance Clinical Coverage Policy 8C.

This crisis stabilization service includes a comprehensive clinical assessment, treatment intervention (which may include the development and implementation of a behavior management or support plan), and aftercare planning.

Treatment interventions include:

- intensive treatment, behavior management support and interventions, detoxification protocols as addressed in the recipient's service plan;
- active engagement of the family, caregiver and/or legally responsible person in crisis stabilization and treatment interventions as appropriate;
- stabilization of the immediate presenting issues, behaviors or symptoms that have resulted in the need for crisis intervention or detoxification; and
- monitoring of his/her medical condition and response to the treatment protocol to ensure the safety of the individual.

4.b.(8) Diagnostic, Screening, Treatment, Preventive and Rehabilitative Services (continued)  
Description of Services

(k) Professional Treatment Services in Facility-Based Crisis Program – Children and Adolescents  
(continued)

The staff member responsible for furnishing the above treatment interventions shall be selected from the list of qualified providers on pages 7c.9b, 7c.9c and 7c.9d, based on their qualifications and scope of practice, and will be specified in the Person Centered Plan. Each facility shall have staff ratios, trained staff, and protocols and procedures in conformance with State policies and rules.

Aftercare planning includes: (aftercare planning is the responsibility of the Qualified Professional)

Discharge planning which begins at admission, including:

- arranging for linkage to new or existing services that will provide further treatment, habilitation and/or rehabilitation upon discharge from the Facility-Based Crisis service;
- arranging for linkage to a higher level of care as medically necessary;
- identifying, linking to, and collaborating with informal and natural supports in the community; and
- developing or revising the crisis plan to assist the recipient and his or her supports in preventing and managing future crisis events.

This is a short-term service that is not reimbursable for more than 30 days in a calendar year. This service is designed as a time-limited alternative to hospitalization for an individual in crisis.

Providers are required to staff programs according to population designation above. Staff eligible to provide this service include: Board-eligible or board certified child psychiatrist or a general psychiatrist with a minimum of two years experience in the treatment of children and adolescents, Licensed Practicing Psychologists, Licensed Professionals (Licensed Clinical Social Workers, Licensed Professional Counselors, Licensed Clinical Addiction Specialists, Licensed Marriage and Family Therapists, Registered Nurses, Licensed Practical Nurse, Qualified Professionals, Associate Professional and/or Paraprofessionals with disability-specific knowledge, skills, and abilities required by the population and age to be served. Associate Professionals and Paraprofessionals will be supervised according to 10A NCAC 27G .0203 - .0204. The program shall be under the supervision of a psychiatrist, the licensed professional provides clinical supervision to the program, and the program shall have the capacity to provide more intensive supervision in response to the needs of individual clients.

Associate Professional (AP) within the mental health, developmental disabilities and substance abuse services (MH/DD/SAS) system of care means an individual who is a:

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4.b.(8) Diagnostic, Screening, Treatment, Preventive and Rehabilitative Services (continued)  
Description of Services

(k) Professional Treatment Services in Facility-Based Crisis Program – Children and Adolescents  
(continued)

(a) graduate of a college or university with a Masters degree in a human service field with less than one year of full-time, post-graduate degree accumulated MH/DD/SAS experience with the population served, or a substance abuse professional with less than one year of full-time, post-graduate degree accumulated supervised experience in alcoholism and drug abuse counseling. Supervision shall be provided by a qualified professional with the population served until the individual meets one year of experience. The supervisor and the employee shall develop an individualized supervision plan upon hiring. The parties shall review the plan annually; or

(b) graduate of a college or university with a bachelor's degree in a human service field with less than two years of full-time, post-bachelor's degree accumulated MH/DD/SAS experience with the population served, or a substance abuse professional with less than two years of full-time, post-bachelor's degree accumulated supervised experience in alcoholism and drug abuse counseling. Supervision shall be provided by a qualified professional with the population served until the individual meets two years of experience. The supervisor and the employee shall develop an individualized supervision plan upon hiring. The parties shall review the plan annually; or

(c) graduate of a college or university with a bachelor's degree in a field other than human services with less than four years of full-time, post-bachelor's degree accumulated MH/DD/SAS experience with the population served, or a substance abuse professional with less than four years of full-time, post-bachelor's degree accumulated supervised experience in alcoholism and drug abuse counseling. Supervision shall be provided by a qualified professional with the population served until the individual meets four years of experience. The supervisor and the employee shall develop an individualized supervision plan upon hiring. The parties shall review the plan annually; or

(d) Registered Nurse who is licensed to practice in the State of North Carolina by the North Carolina Board of Nursing with less than four years of full-time accumulated experience in MH/DD/SAS with the population served. Supervision shall be provided by a qualified professional with the population served until the individual meets four years of experience. The supervisor and the employee shall develop an individualized supervision plan upon hiring. The parties shall review the plan annually.

Paraprofessional (PP) within the MH/DD/SAS system of care means an individual who, with the exception of staff providing respite services or personal care services, has a GED or high school diploma; or no GED or high school diploma, employed prior to November 1, 2001 to provide a MH/DD/SAS service. Supervision shall be provided by a qualified professional or associate professional with the population served. The supervisor and the employee shall develop an individualized supervision plan upon hiring. The parties shall review the plan annually.

4.b.(8) Diagnostic, Screening, Treatment, Preventive and Rehabilitative Services (continued)  
Description of Services

(k) Professional Treatment Services in Facility-Based Crisis Program – Children and Adolescents  
(continued)

Qualified Professional (QP) means, within the MH/DD/SAS system of care:

- (a) an individual who holds a license, provisional license, certificate, registration or permit issued by the governing board regulating a human service profession, except a registered nurse who is licensed to practice in the State of North Carolina by the North Carolina Board of Nursing who also has four years of full-time accumulated experience in MH/DD/SAS with the population served.

The Licensed Qualified Professional will be a Licensed Professional (LP) holding a valid license issued by the governing board regulating a human service profession in the State of North Carolina. Individuals licensed as a Clinical Addiction Specialist, Clinical Social Worker, Marriage and Family Therapist, Professional Counselor, Psychiatrist, or Psychologist. The specific requirements for each of the above licensed professionals are listed below.

- Licensed Clinical Addiction Specialist means an individual who is licensed as such by the North Carolina Substance Abuse Professional Practice Board.
- Licensed Clinical Social Worker means a social worker who is licensed as such by the N.C. Social Work Certification and Licensure Board.
- Licensed marriage and family therapist means an individual who is licensed as such by the North Carolina Marriage and Family Licensing Board.
- Licensed Professional Counselor (LPC) means a counselor who is licensed as such by the North Carolina Board of Licensed Professional Counselors.
- Psychiatrist means an individual who is licensed to practice medicine in the State of North Carolina and who has completed a training program in psychiatry accredited by the Accreditation Council for Graduate Medical Education.
- Psychologist means an individual who is licensed to practice psychology in the State of North Carolina as either a licensed psychologist or a licensed psychological associate, or

If not licensed, the QP will be:

- (b) a graduate of a college or university with a Masters degree in a human service field and has one year of full-time, post-graduate degree accumulated MH/DD/SAS experience with the population served, or a substance abuse professional who has one year of full-time, post-graduate degree accumulated supervised experience in alcoholism and drug abuse counseling; or

- (c) a graduate of a college or university with a bachelor's degree in a human service field and has two years of full-time, post-bachelor's degree accumulated MH/DD/SAS experience with the population served, or a substance abuse professional who has two years of full-time, post-bachelor's degree accumulated supervised experience in alcoholism and drug abuse counseling; or

4.b.(8) Diagnostic, Screening, Treatment, Preventive and Rehabilitative Services (continued)  
Description of Services

(k) Professional Treatment Services in Facility-Based Crisis Program – Children and Adolescents  
(continued)

(d) a graduate of a college or university with a bachelor's degree in a field other than human services and has four years of full-time, post-bachelor's degree accumulated MH/DD/SAS experience with the population served, or a substance abuse professional who has four years of full-time, post-bachelor's degree accumulated supervised experience in alcoholism and drug abuse counseling.

Degrees in a human service field, include but are not limited to, the following degrees: psychology, social work, mental health counseling, rehabilitation counseling, addictions, psychiatric nursing, special education and therapeutic recreation.

The Facility Based Crisis program must address the age, behavior, and developmental functioning of each recipient to ensure safety, health and appropriate treatment interventions within the program milieu. The facility must ensure the physical separation of children from adolescents by living quarters, common areas, and in treatment, etc. If adults and children are receiving services in the same building, the facility must ensure complete physical separation between adults and children. All facilities serving both children and adults shall have 16 beds or less. Each facility must be staffed at a minimum of a psychiatrist, a registered nurse (24 hours/day), and an additional licensed professional. A physician is available 24/7 and must conduct a psychiatric assessment within 24 hours of admission. A registered nurse must conduct a nursing assessment on admission and oversee the monitoring of patient's progress and medications. A licensed professional must conduct a comprehensive clinical assessment upon admission. Treatment interventions may be performed by all staff based on their qualifications and/or scope of practice. Aftercare planning may be performed by any Qualified Professional.

This service must be ordered by an MD, NP, PA or PhD psychologist. Prior approval will be required via the statewide UR vendor or by an approved LME contracted with the Medicaid Agency and meeting the same standards and requirements as the statewide vendor. This initial prior approval process will ensure that the level of the service is appropriate and concurrent reviews will determine the ongoing medical necessity for the service or the need to move up or down the continuum of services to another level of care. Documentation must include: a service note that includes the recipient's name, Medicaid identification number, date of service, purpose of contact, describes the provider's interventions, includes the time spent performing the interventions, effectiveness of the intervention, and the signature of the staff providing the service. Facility Based Crisis is not available for:

- a. room and board services;
- b. educational, vocational and job training services;
- c. habilitation services;
- d. services to inmates in public institutions as defined in 42 CFR §435.1010;
- e. services to individuals residing in institutions for mental diseases as described in 42 CFR§435.1010;
- f. recreational and social activities; and
- g. services that must be covered elsewhere in the state Medicaid plan.

4.b.(9) Behavioral Health Rehabilitative Services (continued)

(d) Provider Qualifications for Staff Employed by Agencies Enrolled with Medicaid

Providers will meet either the appropriate Federal regulations or the requirements for one of the three categories described on pages 7c.10 and 7c.11.

i) Paraprofessional

“Paraprofessional” within the mental health and substance system means an individual who has a GED or high school diploma (or no GED or high school diploma if employed prior to November 1, 2001). Supervision shall be provided by a qualified professional or associate professional with the population served.

ii) Associate Professional (AP)

“Associate Professional” within the mental health and substance abuse services system means an individual who is a:

- graduate of college or university with a Masters degree in a human service field and less than one year of full time post-graduate mental health or substance abuse experience with the population served or a substance abuse professional with less than one year of full-time, post-graduate degree supervised experience in alcoholism and drug abuse counseling. Supervision shall be provided by a qualified professional with the population served until the individual meets one year of experience; or
- graduate of college or university with a bachelor’s degree in a human service field with less than two years of full-time post-bachelor’s degree mental health or substance abuse experience with the population served, or a substance abuse professional with less than two years post bachelor’s degree accumulated supervised experience in alcoholism and drug abuse counseling. Supervision shall be provided by a qualified professional with the population served until the individual meets two years of experience; or
- graduate of a college or university with a bachelor’s degree in a field other than human services with less than four years of full-time, post bachelor’s degree accumulated supervised experience in mental health or substance abuse with the population served. Supervision shall be provided by a qualified professional with the population served until the individual meets four years of experience; or
- registered nurse who is licensed to practice in the State of North Carolina by the North Carolina Board of Nursing with less than four years of full-time accumulated experience in mental health or substance abuse with the population served. Supervision shall be provided by a qualified professional with the population served until the individual meets four years of experience.

4.b.(9) Behavioral Health Rehabilitative Services (continued)

(d) Provider Qualifications for Staff Employed by Agencies Enrolled with Medicaid

(iii) Qualified Professional (QP)

“Qualified Professional” within the mental health and substance abuse system means:

- an individual who holds a license, provisional license, certificate, registration or permit issued by the governing board regulating a human service profession, except a registered nurse who is licensed to practice in the State of North Carolina by the North Carolina Board of Nursing, who also has four years of full-time accumulated experience in mh/sa with the population served; or
- a graduate of a college or university with a Masters degree in a human service field and one year of full-time, post-graduate degree experience with the population served or a substance abuse professional with one year of full-time, post-graduate degree accumulated supervised experience in alcoholism and drug abuse counseling; or
- a graduate of college or university with a bachelor’s degree in a human service field and two years of full-time, post-bachelor’s degree experience with the population served or a substance abuse professional who has two years full-time, post-bachelor’s degree accumulated supervised alcoholism and drug abuse counseling; or
- a graduate of a college or university with a bachelor’s degree in a field other than human services with four years of full-time, post-bachelors degree accumulated mh/sa experience with the population served.

This category includes Substance Abuse Professional, Certified Substance Abuse Counselors (CSAC), Certified Clinical Supervisor (CCS), Licensed Clinical Addictions Specialist (LCAS) \*

The full descriptions of categories of providers are found in the North Carolina Administrative Code

Supervision is provided as described below:

Covered services are provided to recipients by agencies directly enrolled in the Medicaid program which employ qualified professionals, associate professional and paraprofessionals. Medically necessary services delivered by associate and paraprofessionals are delivered under the supervision and direction of the qualified professional. The qualified professional personally works with consumers to develop the person centered individualized treatment plan and meets with consumers periodically during the course of treatment to monitor the services being delivered and to review the need for continued services. The supervising qualified professional assumes professional responsibility for the services provided by associate and paraprofessionals and spends as much time as necessary directly supervising services to ensure that recipients are receiving services in a safe and efficient manner in accordance with accepted standards of practice. The terms of the qualified professional’s employment with the directly enrolled agency providing service ensures that the qualified professional is adequately supervising the associate and paraprofessionals. The agencies ensure that supervisory ratios are reasonable and ethical and provide adequate opportunity for the qualified professional to effectively supervise the associate and paraprofessional staff assigned. Documentation is kept to support the supervision provided to associate and paraprofessional staff in the delivery of medically necessary services.

4.b.(9) Rehabilitative Services for Behavioral Health of EPSDT Eligible

- (a) The agency assures that if there are providers involved whose payment is based on reasonable cost, the State will provide appropriate cost reimbursement methodologies. Services are reimbursed in accordance with Attachment 4.19-B.
- (b) Services may be provided by: Licensed or certified psychologists, licensed clinical social workers, certified clinical nurse specialists in psychiatric mental health advanced practice, nurse practitioners certified in psychiatric mental health advanced practice, licensed psychological associates, licensed professional counselors, licensed marriage and family therapists, certified/licensed clinical addictions specialists, and certified/licensed clinical supervisors, when Medicaid-eligible children are referred by the Community Care of North Carolina primary care physician, a Medicaid enrolled psychiatrist, or the area mental health program or local management entity. Prior approval shall be required for each psychiatric outpatient visit after the 16<sup>th</sup> visit each calendar year for recipients under age 21.

The first 16 visits are unmanaged visits. Unmanaged visits are defined as services that do not require prior approval by a utilization review vendor under the fee for service delivery system. For individuals under 21, Medicaid policy does require that the child or adolescent be referred for these services through the child's Community Care of North Carolina primary care physician, a Medicaid enrolled psychiatrist or the Local Management Entity (LME). The referral is not limited to the primary care physician but does include a choice of referral sources. The referral is requested by the practitioner offering services and is indicated on the request for reimbursement. The reason for the requirement for a referral for children and adolescents is to promote coordination of care including medical and behavioral health services when indicated for this population.

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4.b.(9) Rehabilitative Services for Behavioral Health of EPSDT Eligible (*continued*)

(c) Services under this section are provided by licensed practitioners or programs/agencies for the mentally ill, developmentally disabled and substance abusers certified/licensed as clinical addiction specialists (LCAS) and clinical supervisors (CCS) meeting the program standards of the Commission on Mental Health, Developmental Disabilities and Substance Abuse Services; and who are directly enrolled with Medicaid. These services are available to categorically needy and medically needy recipients.

Services may be provided by:

Licensed or certified psychologists, licensed clinical social workers, licensed clinical social worker associates, certified clinical nurse specialists in psychiatric mental health advanced practice, nurse practitioners certified in psychiatric mental health advanced practice, licensed psychological associates, licensed professional counselors, licensed professional counselor associates, licensed marriage and family therapists, licensed marriage and family therapist associates, certified/licensed clinical addictions specialists, licensed clinical addictions specialist associates, and certified/licensed clinical supervisors.

For individuals under 21, the first 16 visits are unmanaged visits. Unmanaged visits are defined as services that do not require prior approval by a utilization review vendor under the fee for service delivery system. For individuals under 21, Medicaid policy does require that the child or adolescent be referred for these services through the child's Community Care of North Carolina primary care physician, a Medicaid enrolled psychiatrist or the Local Management Entity (LME). The referral is not limited to the primary care physician but does include a choice of referral sources. The referral is requested by the practitioner offering services and is indicated on the request for reimbursement. The reason for the requirement for a referral for children and adolescents is to promote coordination of care including medical and behavioral health services when indicated for this population.

For individuals 21 years and older, the first 8 visits are unmanaged visits. Unmanaged visits are defined as services that do not require prior approval by a utilization review vendor under the fee for service delivery system. Medicaid eligible adults (21 years and older) may be self-referred.

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Services include the following:

1. Outpatient Psychotherapy services are individual psychotherapy, family psychotherapy; and group psychotherapy. Psychotherapy, as defined in the 2011 American Medical Association's Current Procedural Terminology (CPT) Manual, is the treatment for mental illness as well as substance use disorders in which the clinician through therapeutic communication attempts to alleviate the emotional disturbances and reverse or change maladaptive patterns of behavior. Individual psychotherapy is psychotherapy provided with the licensed clinician and the beneficiary on a one-to-one face-to-face basis. Family psychotherapy is psychotherapy provided with the licensed clinician and one or more family members face-to-face. Group psychotherapy is psychotherapy provided with the licensed clinician and more than one beneficiary face to face. Psychotherapy services may be provided in a variety of settings and psychotherapy may be practiced utilizing a variety of models many of which have significant evidence backing their efficacy. These models include Behavior Therapy, Cognitive Therapy, Psychodynamic Therapy, Cognitive Behavioral Therapy, and Person-Centered Therapy. Behavior Therapy is a treatment model that focuses on modifying. Observable behavior in order to regain and restore the beneficiary's level of social and emotional functioning and engagement in the community. Cognitive Therapy is a treatment model that focuses on challenging and changing distorted thinking in order to regain and restore the beneficiary's level of social and emotional functioning and engagement in the community. Psychodynamic Therapy is a treatment model that assumes dysfunctional behavior is caused by unconscious internal conflicts. The focus of treatment is to gain insight into unconscious motives of behavior in order to regain and restore the beneficiary's level of social and emotional functioning and engagement in the community. Cognitive Behavioral Therapy is a treatment model that assumes that maladaptive thinking patterns cause maladaptive behavior as well as negative emotions. The treatment focuses on changing the recipient's thoughts in order to change behavior as well as emotions in order to regain and restore the beneficiary's level of social and emotional functioning and engagement in the community.

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Person-Centered Therapy is a nondirective treatment model in which the clinician helps the beneficiary increase understanding and awareness of attitudes, feelings, and behavior, in order to regain and restore the beneficiary's level of social and emotional functioning and engagement in the community.

All psychotherapy services are only for the benefit of Medicaid recipients. These services can be furnished by all the North Carolina licensed and certified clinicians listed below. These North Carolina licensed and certified clinicians are: licensed psychologists, licensed clinical social workers, certified clinical nurse specialists in psychiatric mental health advanced practice, nurse practitioners certified in psychiatric mental health advanced practice, licensed physician assistants, licensed psychological associates, licensed professional counselors, licensed marriage and family therapists, licensed clinical addictions specialists, and certified clinical supervisors. Each of the above listed clinicians are licensed by their respective occupational licensing board and are credentialed to practice independently and it is within their scope of practice to provide individual psychotherapy, family psychotherapy, and group psychotherapy.

Psychological testing (e.g., Minnesota Multiphasic Personality Inventory, Rorschach, Wechsler Adult Intelligence Scale) includes written, visual, or verbal evaluations administered to assess the cognitive and emotional functioning of recipients. Developmental testing (e.g., Developmental Screening Test, Bayley Scales of Infant and Toddler Development, Mullen Scales of Early Learning) includes assessment of motor, language, social, adaptive and/or cognitive functioning by standardized developmental instruments. Neuro-behavioral testing (e.g., Halstead-Reitan, Wechsler Memory Scales, Wisconsin Card Sorting Test) includes standard tests designed to evaluate different aspects of the functioning of the central nervous system, including attention, motor performance, perceptual coding, learning, memory and affect. The SPA states on page 3.1-A.1, Page 15a.17: "These services can only be billed by PhD and Master's Level Psychologist, licensed in the State of NC."

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These individuals have, within the scope of their practice, the ability to perform psychological testing, developmental testing, and neurobehavioral testing. However, each individual psychologist must also have the training and experience required in order to ethically provide each of these assessments according to the requirements of the North Carolina Psychology Board.

Psychological testing, developmental testing, and neuro-behavioral testing should result in recommendations regarding the need for rehabilitative treatment which may include outpatient services and should result in recommendations for type, duration, frequency, or amount of rehabilitative services.

- (d) All disciplines are licensed or credentialed by the State as mental health clinicians and can practice independently with oversight by their individual boards. Nurse Practitioners must have oversight by the Medical Board, while Licensed Psychological Associates must have supervision by a PhD to bill certain services. This type of requirement does not exist for the other disciplines. Certified/Licensed Clinical Supervisors (CCS) and Certified/Licensed Clinical Addictions Specialists (CCAS) requirements have been approved by the Division of Mental Health/Developmental Disabilities/Substance Abuse Services and are able to practice independently to provide counseling services only.
- (e) Behavioral assessment and counseling codes may be billed by all clinicians. CPT codes or counseling codes should be used to define services provided not based on discipline.

4.b.(9) Rehabilitative Services for Behavioral Health of EPSDT Eligible (continued)

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(d) EPSDT Early Intervention Rehabilitative Services:

Medicaid-eligible children from birth to age three who are referred to and/or determined to be eligible for the NC Infant-Toddler Program under Part C of the Individuals with Disabilities Education Act (IDEA) are eligible for services through the Children's Developmental Service Agency (CDSA). The CDSA is the local lead agency for the NC Infant-Toddler Program.

Rehabilitative Services for Infants and Toddlers include a range of coordinated services provided to children from birth to age 3 in order to correct, reduce, or prevent further deterioration of identified deficits in the cognitive, communicative, physical, socioemotional, physical, or adaptive developmental status.

They can also be targeted at restoring the developmental capacity of children who are felt to be at risk for such deficits because of specific medical, biological, or environmental risk factors. Children under three must meet all eligibility for early intervention services delineated in the "North Carolina Infant and Toddler Manual."

Deficits are identified through comprehensive screening, assessments, and evaluations. Recommended services must be face-to-face encounters, medically necessary, within the scope of practice of the provider, and intended to maximize reduction of identified disability (ies) or deficit (s) and restoration of a recipient to his best possible functional level. Services include providing information related to the health and development of a child, skills training, modeling and offering anticipatory guidance to parents and to caregivers and assisting those in identifying, planning and maintaining a regimen related to regaining the child's functioning. Services may be provided in office settings, home, day care center, or other natural environment locations.

Provision of services to the family or caregivers must be directed to meeting the identified child's medical treatment needs. Services provided to non-Medicaid eligible family members independent of meeting the identified needs of the child are not covered by Medicaid. Services must be ordered by and under the direction of a Physician, Psychologist, Advanced Practice Nurse, or Physician's Assistant.

The following services are covered when medically necessary.

4.b.(9) Rehabilitative Services for Behavioral Health of EPSDT Eligible (continued)  
(d) EPSDT Early Intervention Rehabilitative Services

Services include:

Audiological: services to identify children with auditory impairment, using at risk criteria and appropriate audiologic evaluation procedures to determine the range, nature, and degree of hearing loss and communication functions. It includes referral for medical and other services necessary for the rehabilitation, provision of auditory training and aural rehabilitation, and determination of the child's need for amplification and its selection, use, and evaluation. These services must be provided by an Audiologist. As defined in 42 CFR 440.110, an Audiologist who has a valid license issued by the NC Board of Examiners for Speech and Language Pathologists and Audiologists.

Nutritional Assessment: services that include conducting nutritional assessments, developing and monitoring appropriate plans to address the nutritional needs of the child, based on the findings of the nutritional assessment, and making referrals to appropriate community resources to carry out nutritional goals. These services must be provided by a Nutritionist/Dietician registered with the American Dietetic Association's Commission on Dietetic Registration or licensed by the NC Board of Dietetics/Nutrition.

Occupational Therapy: services to address the functional needs of a child related to adaptive development, adaptive behavior and play, and sensory, motor, and postural development to improve the child's functional ability to perform tasks, including identification, assessment, intervention, adaptation of the environment, and selection of assistive and orthotic devices. These services must be provided by an Occupational Therapist as defined in 42 CFR 440.110 and be licensed pursuant to North Carolina State law or by a licensed Occupational Therapy Assistant under the supervision of a licensed Occupational Therapist.

Physical Therapy: services to address the promotion of sensor motor function through enhancement of musculoskeletal status, neurobehavioral organization, perceptual and motor development, cardiopulmonary status, and effective environmental adaptation. It includes evaluation to identify movement dysfunction, obtaining, interpreting and integrating information for program planning and treatment to prevent or compensate for functional problems. These services must be provided by a Physical Therapist as defined in 42 CFR 440.110 and be licensed pursuant to North Carolina State law or a licensed Physical Therapy Assistant under the supervision of a licensed Physical Therapist.

4.b.(9) Rehabilitative Services for Behavioral Health of EPSDT Eligible (continued)

(d) EPSDT Early Intervention Rehabilitative Services

Psychological: services are administering psychological and developmental tests, interpreting results, obtaining and integrating information about the child's behavior, child and family conditions related to learning, mental health and development, and planning and managing a program of psychological services, including psychological counseling, family counseling, consultation on child development, parent training and education programs. Qualifications of the practitioners who furnish psychological services are as follows: A Licensed Family and Marriage Counselor as defined in Article 18C of the Marital and Family Therapy Certification Act. A Licensed Clinical Social Worker (LCSW) or a Licensed Clinical Social Worker-Provisional (LCSW-P), under the supervision of an LCSW, in accordance with the Ethical Guidelines of the Social Worker Act (NCGS 90B) and the NASW Code of Ethics. A psychologist licensed by the NC Psychology Board, in accordance with the NC Psychology Act. A Licensed Professional Counselor (LPC) or a Licensed Professional Counselor Associate (LPCA), under the supervision of a LPC, in accordance with the Licensed Professional Counseling Act (NCGS 24).

Speech/Language: services to identify children with communicative or oropharyngeal disorders and delays in communication skills development, referral for medical or other professional services and the provision of services necessary for their rehabilitation. These services must be provided by a Speech Pathologist as defined in 42 CFR 440.110 and be licensed pursuant to North Carolina State law or, a Speech/Language Pathology Assistant who works under the supervision of an enrolled licensed Speech Pathologist. A Speech/Language Pathology Assistant (SLPA) must hold an Associate's degree in Speech/Language Pathology or a Bachelor's Degree from an accredited institution with specialized coursework in Speech/Language Pathology. A SLPA must also pass a competency test by the North Carolina Board of Examiners for Speech and Language Pathologists and Audiologists.

Clinical Social Work: services are evaluation of a child's living conditions and patterns or parent-child interaction, preparing a social or emotional assessment of the child within the family context, counseling parents and other family members, appropriate social skill-building with the child and parents, working with those problems in the child's living situation, and identifying community resources to enable the child and family to receive maximum benefit from services. These services may be provided by a Licensed Clinical Social Worker (LCSW) or a Licensed Clinical Social Worker-Provisional (LCSW-P) under the supervision of an LCSW, in accordance with the Ethical Guidelines of the Social Worker Act (NCGS 90B) and the NASW Code of Ethics.

Multidisciplinary Evaluations and Assessments: services are screening, evaluation, and assessment procedures used to determine a child's initial and continuing eligibility for Early Intervention services, the child's level of functioning in the developmental domains, and a medical perspective on the child's development.

4.b.(9) Rehabilitative Services for Behavioral Health of EPSDT Eligible (continued)  
(d) EPSDT Early Intervention Rehabilitative Services

This service is used to determine the child's strengths and needs, and services appropriate to meet those needs, as well as the resources and concerns of the family, and the supports and services necessary to enhance the family's capacity to meet their child's developmental needs. These services may be provided by a physician, a Pediatrician, or Physician's Assistant, in accordance with the scope of the NC Medical Practice Act, a Nurse Practitioner within the scope of the Nurse Practice Act ; a Registered Nurse licensed in the State of North Carolina, in accordance with the NC Board of Nursing; an Audiologist (described above) an Occupational Therapist (described above); a Physical Therapist (described above); a Nutritionist/Dietician (described above); a Psychologist (described above); a Speech Pathologist (described above); a Licensed Family and Marriage Counselor (described above); a Licensed Clinical Social Worker (LCSW) or a Licensed Clinical Social Worker-Provisional (LCSW-P) (described above); an Educational Diagnostician, with a master's degree in special education or related field, with at least six hours of coursework and two years of experience in educational/developmental testing, or a bachelor's degree in special education or related field, with at least six hours of coursework and three years of experience in educational/developmental testing. Examples of related fields include degrees in psychology or general education.

Community Based Rehabilitative Services: This service is provided to meet the cognitive, communication, social/emotional and adaptive development needs of the child.

The ITFS, in consultation with the IFSP team, will work with caregivers on planning and developing individualized intervention strategies for the child to extend opportunities to practice the following skills into everyday activities in the home, daycare or other community setting: thinking, problem solving and information processing skills, self-help skills, appropriate social behaviors and interactions, language skills, and gross and fine motor skills.

4.b.(9) Rehabilitative Services for Behavioral Health of EPSDT Eligible (continued)  
(d) EPSDT Early Intervention Rehabilitative Services

Providers of Community Based Rehabilitative Services are as follows: An individual with Infant, Toddler, and Family Specialist (ITFS) certification or a Infant, Toddler, and Family Associate (IFSA) working toward certification at the required rate. The ITFS must hold a Bachelor's degree or higher in a health, education, early childhood, or human service field or hold a Bachelor's degree or higher in a non-human service field but have four years of full-time, post-Bachelor's degree accumulated experience with the infant and toddler population, or are a Registered Nurse and hold a current North Carolina license. The IFSA must hold an Associate's degree or less in a health, education, early childhood, or other human service field. Both ITFS and IFSA must have at least 27 hours of coursework in health, education, or early childhood. The North Carolina Division of Public Health, through the Children's Developmental Services Agencies (CDSAs), documents and verifies the qualifications, training, and certification of the ITFS, verifies the valid licensure status (if applicable), and recommends the provider for Medicaid participation.

Services performed by the Infant, Toddler, and Family certified individual must be ordered by the physician, Psychologist, advanced practice nurse, or physician's assistant.

(8) Medicaid Services Provided in Schools

(a) Audiology

Services must be medically necessary and appear in the child's Individualized Education Plan. Covered services include:

Assessment services:

Service may include testing and/or clinical observation as appropriate for chronological or developmental age for one or more of the following areas of functioning, and shall yield a written report:

Auditory sensitivity, including pure tone air and bone conduction, speech detection, and speech reception thresholds, auditory discrimination in quiet and noise, impedance audiometry including tympanometry and acoustic reflex, hearing aid evaluation, central auditory function and auditory brainstem evoked response

Treatment services:

Service may include one or more of the following as appropriate:

Auditory training, speech reading and augmentative communication

Qualifications of Providers: Providers must meet the applicable requirements of 42 CFR 440.110. A provider shall have a valid license issued by the Board of Examiners for Speech and Language Pathologists and Audiologists.

(b) Occupational Therapy

Services must be medically necessary and appear in the child's Individualized Education Plan. Covered services include:

Assessment services

Service may include testing and/or clinical observation as appropriate for chronological or developmental age for one or more of the following areas of functioning, and shall yield a written report:

Activities of daily living assessment, sensorimotor assessment, neuromuscular assessment, fine motor assessment, feeding/oral motor assessment, visual perceptual assessment, perceptual motor development assessment, musculo-skeletal assessment, gross motor assessment, and functional mobility assessment.

Treatment services

Service may include one or more of the following as appropriate:

Activities of daily living training, sensory integration, neuromuscular development, muscle strengthening, and endurance training, feeding/oral motor training, adaptive equipment application, visual perceptual training, facilitation of gross motor skills, facilitation of fine motor skills, fabrication and application of splinting and orthotic.

devices, manual therapy techniques, sensorimotor training, functional mobility training, perceptual motor training.

Qualifications of Providers:

Providers must meet the applicable requirements of 42 CFR 440.110. Occupational therapy assessment services must be provided by a licensed occupational therapist. Occupational therapy treatment services must be provided by a licensed occupational or a licensed occupational therapist assistant under the supervision of a licensed occupational therapist.

(c) Physical Therapy Services

Services must be medically necessary and appear in the child's Individualized Education Plan. Covered services include:

Assessment services

Service may include testing and/or clinical observation as appropriate for chronological or developmental age for one or more of the following areas of functioning, and shall yield a written report:

Neuromotor assessment, range of motion, joint integrity and functional mobility, flexibility assessment, gait, balance, and coordination assessment, posture and body mechanics assessment, soft tissue assessment, pain assessment, cranial nerve assessment, clinical electromyographic assessment, nerve conduction, latency and velocity assessment, manual muscle test, activities of daily living assessment, cardiac assessment, pulmonary assessment, sensory motor assessment and feeding/oral motor assessment

Treatment services

Service may include one or more of the following as appropriate:

Manual therapy techniques, fabrication and application of orthotic devices, therapeutic exercise, functional training, facilitation of motor milestones, sensory motor training, cardiac training, pulmonary enhancement, adaptive equipment application, feeding/oral motor training, activities of daily living training, gait training, posture and body mechanics training, muscle strengthening, gross motor development, modalities, therapeutic procedures, hydrotherapy, manual manipulation

Qualifications of Providers:

Providers must meet the applicable requirements of 42 CFR 440.110. Physical therapy assessment services must be provided by a licensed physical therapist. Physical therapy treatment services must be provided by a licensed physical therapist or a licensed physical therapist assistant under the supervision of a licensed physical therapist.

(d) Psychological Services

Services must be medically necessary and appear in the child's Individualized Education Plan. Covered services include:

Assessment services

Service may include testing and/or clinical observation as appropriate for chronological or developmental age for one or more of the following areas of functioning, and shall yield a written report:

Cognitive, emotional/personality, adaptive behavior, behavior and perceptual or visual motor.

Treatment services

Service may include one or more of the following as appropriate:

Cognitive-behavioral therapy, rational-emotive therapy, family therapy, individual interactive psychotherapy using play equipment, physical devices, language interpreter or other mechanisms of non verbal communication and sensory integrative therapy

Qualifications of Providers:

Minimum qualifications for providing services are licensure as a psychological associate or practicing psychologist by the North Carolina State Board of Examiners of Practicing Psychologists, or licensure as a school psychologist by the NC Department of Public Instruction, and Licensed Clinical Social Workers. Licensed Clinical Social Workers and Licensed Psychologists must be able to provide documentation of appropriate training and experience, which qualified them to work with students in an educational setting.

(e) Speech

Services must be medically necessary and appear in the child's Individualized Education Plan. Covered services include:

Assessment services

Service may include testing and/or clinical observation as appropriate for chronological or developmental age for all the following areas of functioning and shall yield a written report: Receptive and expressive language, auditory memory, discrimination, and processing, vocal quality and resonance patterns, phonological development, pragmatic language, rhythm/fluency, oral mechanism, swallowing assessment, augmentative communication and hearing status based on pass/fail criteria

Treatment services

Service includes one or more of the following as appropriate:

Articulation therapy, language therapy; receptive and expressive language, augmentative communication training, auditory processing, discrimination, and training, fluency training, disorders of speech flow, voice therapy, oral motor training; swallowing therapy and speech reading.

Qualifications of Providers: Providers must meet the applicable requirements of 42 CFR 440.110. Clinicians must have the following credentials:

1. a valid license issued by the Board of Examiners for Speech and Language Pathologists and Audiologists, and
2. a Certificate of Clinical Competence (CCC) from the American Speech and Hearing Association;
  - A. have completed the equivalent educational requirements and work experience necessary for the CCC, or
  - B. have completed the academic program and is acquiring the supervised work experience to qualify for the CCC.

Treatment services may be performed by a Speech/Language Pathology assistant who works under the supervision of an enrolled licensed practitioner. A provider shall perform services within the scope of practice of speech pathology as defined by G.S. 90-293 as interpreted by the courts.

(f) Nursing Services:

Services must be medically necessary. The services must be provided in accordance with an Individualized Education Program or an Individual Family Service Plan. Nursing services must be those services that are in a written plan of care based on a physician, physician assistant or nurse practitioner's written order. The plan of care must be developed by a licensed registered nurse. Services include: assessments including referrals based on results, bladder catheterizations, suctioning, medication administration and management including observation for adverse reactions, response or lack of response to medication, informing the student about their medications, oxygen administration via tracheostomy and ventilator care, enteral feedings, emergency interventions, individual health counseling and instructions, and other treatments ordered by the physician and outlined in the plan of care.

Qualifications of Providers:

The Licensed Practical Nurse and Registered Nurse shall be licensed by the State of North Carolina to provide the services and practice within the NC Nursing Practice Act. Nursing services can be provided under 42 CFR 440.60 and on a restorative basis under 42 CFR 440.130 (d) including services delegated in accordance with the Nurse Practice Act to individuals trained to perform delegated acts by a Registered Nurse. Delegated staffs are school and contracted staff such as teachers, teacher assistants, therapists, school administrators, administrative staff, cafeteria staff and personal care aides.

- (9) Medicaid-eligible children from birth to age three who are referred to and/or determined to be eligible for the NC Infant-Toddler Program under Part C of the Individuals with Disabilities Education Act (IDEA) are eligible for services through the Children's Developmental Service Agency (CDSA). The CDSA is the local lead agency for the NC Infant-Toddler Program. At the request of the IDEA (LEA), the CDSA may perform evaluations on Preschoolers (age 3, 4 and 5). For children who are transitioning from the NC Infant-Toddler Program to Preschool services, eligibility may extend beyond the third birthday as long as there is a time-limited transition plan in place.

The following federally mandated services are provided under the IDEA, covered when medically necessary and the service is outlined in the child's Individual Family Service Plan (IFSP).

- (a) Services include:

Audiological: services to identify children with auditory impairment, using at risk criteria and appropriate audiologic evaluation procedures to determine the range, nature, and degree of hearing loss and communication functions. It includes referral for medical and other services necessary for the rehabilitation, provision of auditory training and aural rehabilitation, and determination of the child's need for amplification and its selection, use, and evaluation.

Nutrition: services that include conducting nutritional assessments, developing and monitoring appropriate plans to address the nutritional needs of the child, based on the findings of the nutritional assessment, and making referrals to appropriate community resources to carry out nutritional goals.

Occupational Therapy: services to address the functional needs of a child related to adaptive development, adaptive behavior and play, and sensory, motor, and postural development to improve the child's functional ability to perform tasks, including identification, assessment, intervention, adaptation of the environment, and selection of assistive and orthotic devices.

Physical Therapy: services to address the promotion of sensorimotor function through enhancement of musculoskeletal status, neurobehavioral organization, perceptual and motor development, cardiopulmonary status, and effective environmental adaptation. It includes evaluation to identify movement dysfunction, obtaining, interpreting and integrating information for program planning and treatment to prevent or compensate for functional problems.

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4.b(10) Dietary Evaluation and Counseling

Dietary evaluation and counseling are provided by a qualified nutritionist to Medicaid eligible children through age 20 identified as having high risk conditions by their health care provider, include but are not limited to:

- Nutrition assessment
- Development of an individualized care plan
- Diet therapy
- Counseling, education about needed nutrition habits/skills and follow-up

The high risk indicators used to assess the medical need for services for children through age 20 are as follows:

1. there is a chronic, episodic, or acute condition for which nutrition therapy is a critical component of medical management, including but not limited to:
  - a. inappropriate growth/weight gain such as inadequate weight gain, inappropriate weight loss, underweight, obesity, inadequate linear growth, or short stature
  - b. nutritional anemia
  - c. eating or feeding disorders that result in a medical condition such as failure to thrive, anorexia nervosa, or bulimia nervosa
  - d. physical conditions that impact growth and feeding such as very low birth weight, necrotizing enterocolitis, cleft palate, cerebral palsy, and neural tube defects
  - e. chronic or prolonged infections that have a nutritional treatment component such as HIV or hepatitis
  - f. genetic conditions that affect growth and feeding such as cystic fibrosis, Prader-Willi Syndrome, or Down Syndrome
  - g. chronic medical conditions such as cancer, chronic or congenital cardiac disease, hypertension, hyperlipidemia, gastrointestinal diseases, liver disease, pulmonary disease, malabsorption syndromes, renal disease, significant food allergies, and diseases of the immune system
  - h. metabolic disorders such as inborn errors of metabolism (PKU, galactosemia, etc.) and endocrine disorders (diabetes, etc.)
  - i. Non-healing wounds due to chronic conditions
  - j. Acute burns over significant body surface area
  - k. Metabolic Syndrome/Type 2 diabetes
  - l. a documented history of a relative of the first degree with cardiovascular disease and/or possessing factors that significantly increase the risk of cardiovascular disease such as a sedentary lifestyle, elevated cholesterol, smoking, high blood pressure, greater than ideal body weight.
2. There is a preventable condition for which nutrition/diet is the primary therapy.

Provider Qualifications

Medicaid enrolled providers who employ licensed dietitians/nutritionists or registered dietitians are eligible to provide dietary evaluation and counseling. It is the responsibility of the provider agency to verify in writing that staff meet the following qualifications:

1. a dietitian/nutritionist, currently licensed by the N.C. Board of Dietetics/Nutrition (provisional license is not acceptable)
2. a registered dietitian, currently registered with the Commission of Dietetic Registration (registration eligibility is not acceptable).

5. Physicians' Services

All medical services performed must be medically necessary and may not be experimental in nature. Medical necessity is determined by generally accepted North Carolina community practice standards as verified by independent Medicaid consultants.

- a. Routine physician examinations and screening tests are covered for adults and EPSDT recipients, which include adults and children in nursing facilities.
- b. Experimental – Medical care that is investigatory or an unproven procedure or treatment regimen that does not meet generally accepted standards of medical practice in North Carolina.

In evaluating whether a particular service is or is not experimental the agency will consider safety, effectiveness and common acceptance as verified through 1) scientifically validated clinical studies 2) medical literature research and 3) qualified medical experts.

- d. Injections are excluded when oral drugs may be used in lieu of injections.
- e. Therapeutic abortions are covered only in the case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by physician, place the woman in danger of death unless an abortion is performed; therapeutic abortions are also covered in cases of rape or incest.

TN No.: 11-049  
Supersedes  
TN No.: 06-014

Approval Date: 12-16-11

Effective Date: 10/01/2011

Optional Services 42 CFR 440.225 (Continued)

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Optional Services Limitation:

Combined optional services are limited to eight per recipient per State fiscal year. This limitation does not apply to EPSDT eligible children. Exceptions to the limit may be authorized by the State when additional visits are medically necessary.

6.a. Podiatrists' Services

- (1) Routine foot care is not covered except as a medical necessity.
- (2) Office visits to podiatrists are included in the optional services limit per recipient per State fiscal year.

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6.b. Optometrists' Services

(1) Routine eye exams and refractions are only covered for recipients under 21 years of age and are limited to once per year based on general medical practice as published in North Carolina Division of Medical Assistance's Medicaid clinical coverage policies on the Division's website at <http://www.dhhs.state.nc.us/dma/mp/mpindex.htm>. Additional eye refractions may be authorized by the State Medicaid Agency, based on medical necessity.

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Approval Date: 12/16/11

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Optional Services 42 CFR 440.225 (*Continued*)

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6.c. Chiropractors' Services

- (1) Chiropractic services are limited to manual manipulation of the spine to correct subluxation which has resulted in a neuromusculoskeletal condition for which manipulation is appropriate. X-rays are covered as part of the documentation associated with the definition of the musculoskeletal condition for which manual manipulation of the spine is appropriate. When an x-ray is used as part of the documentation of need for the services the x-ray must be taken within six months of the date of service.
- (2) Chiropractic services include only services provided by a chiropractor who is licensed by the State.
- (3) Chiropractic providers must meet the educational requirements as outlined in 42 CFR 410.21.
- (4) Office visits to chiropractors are included in the optional services limit per recipient per State fiscal year.

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Optional Services 42 CFR 440.225 (*Continued*)

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6.d. Other practitioners' services

- (1) Limitations for nursing practitioner services are on Page 12a of Attachment 3.1-A.1.
- (2) Licensed psychologists, licensed clinical social workers, licensed nurse practitioners, certified in child and adolescent psychiatry and licensed clinical nurse specialists certified in child and adolescent psychiatry can provide psychotherapeutic assessment and treatment services to EPSDT eligible children with a referral from the Carolina ACCESS primary care provider or the area Local Management Entity (LME). Prior approval shall be required for each psychiatric hospital outpatient visit after the 16<sup>th</sup> visit for recipients under age 21.
- (3) Physician Assistants:

Coverage Limitations for Physician Assistants:

Medical services must be performed in accordance with the physician assistant scope of practice determined by the State of North Carolina.

6.d. I. Other Practitioners' Services

A. Criteria For Medicaid Coverage Of Nurse Practitioner Services

Nurse practitioner services means that the services are:

- 1) provided in accordance with the scope of practice as defined by the State Board of Medical Examiners and Board of Nursing;
- 2) performed by nurse practitioners who are duly licensed to practice nursing and are approved by the State Board of Medical Examiners and Board of Nursing as “nurse practitioners”; and
- 3) performed under the supervision of a physician licensed in the State of practice.

B. Coverage Limitations For Nurse Practitioner Services

Medical services must be performed in accordance with the nurse practitioners scope of practice and signed protocols, as follows:

- 1) By Nurse Practitioners in an independent practice (i.e. not in the employ of a practitioner, clinic or other service provider for the provision of Nurse Practitioner services).
- 2) For DMA approved procedures developed for use by Nurse Practitioners.
- 3) Subject to the same coverage limitations as those in effect for Physicians.

6.d. I. Other Practitioners' Services (continued)

- C. For Medicaid eligible adults, services may be provided by licensed psychologists, licensed clinical social workers, clinical nurse specialists (psychiatric mental health advanced practice), and nurse practitioners (psychiatric mental health advanced practice), licensed psychological associates, licensed professional counselors, and licensed marriage and family therapists. Medicaid eligible adults may be self referred. Prior approvals shall be required for each psychiatric outpatient visit after the eighth visit for recipients age 21 years and over.

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7. Home Health

Home health services are provided by Medicare certified Home Health Agencies under a plan of care authorized by the patient's physician and in accordance with 42 CFR 440.70. Covered home health services include nursing services, services of home health aides, specialized therapies (speech therapy, physical therapy, occupational therapy) and medical supplies.

- a. Intermittent or Part-Time Nursing Services Furnished by a Medicare certified Home Health Agency.
  - (1) Care which is furnished only to assist the patient in meeting personal care needs is not covered.
  - (2) Intermittent or part-time nursing service by a registered nurse when no home health agency exists in the area is limited to a registered nurse employed by or under contractual arrangement with a local health department.

7. Home Health (*continued*)

b. Home Health Aide Services

The home health aide provides assistance to maintain health and to facilitate treatment of the illness or injury, under the supervision of a registered nurse and in accordance with 42 CFR 440.70.

A terminally ill beneficiary who elects hospice care waives Medicaid coverage of services by a home health aide under home health services.

7. Home Health (continued)

c. Medical supplies, equipment, and appliances suitable for use in the home.

1) Medical Supplies

Medical supplies are covered when medically necessary and suitable for use in the home in accordance with 42 CFR 440.70(a)(3). Medical supplies must be prescribed by a practitioner licensed according to North Carolina General Statute Chapter 90 under approved plan of care. These items will be covered when furnished by a Medicare Certified Home Health Agency, or by one of the following: an ME supplier; a PDN provider when providing PDN services (for supplies needed by a Division of Medical Assistance approved PDN patient) or by the PDN provider for medically necessary incontinent, ostomy and urological supplies (when no home health provider is available); a local lead agency for the Community Alternatives Program (CAP) for adults with disabilities and persons with mental retardation or developmental disabilities; or a local lead agency that provides case management for the Community Alternative Program for children. The “local lead agency” is the agency/facility in the county or counties that coordinates and manages the CAP program.

7. Home Health (*continued*)

c. Medical supplies, equipment, and appliances suitable for use in the home.

2) Medical Equipment

Medically necessary medical equipment (ME) is covered by the Medicaid program when prescribed by a licensed healthcare practitioner and supplied by a qualified ME provider in accordance with 42 CFR 440.70(c)(3). Prior approval must be obtained from the Division of Medical Assistance, or its designated agent.

To be a qualified provider, an entity must possess a state business license and a Board of Pharmacy permit, and be certified to participate in Medicare as a ME supplier, or be a Medicaid enrolled home health agency, a state agency, a local health department, a local lead agency for the Community Alternatives Program (CAP) for adults with disabilities and persons with mental retardation or developmental disabilities, or a local lead agency that provides case management for the Community Alternative Program for children.

The “local lead agency” is the agency/facility in the county or counties that coordinates and manages the CAP program.

Payment for medical equipment is limited to the official, approved ME list established by the Division of Medical Assistance. Additions, deletions or revisions to the ME list are approved by the Director of the Division of Medical Assistance upon recommendation of DMA staff. Only items determined to be medically necessary, effective and efficient are covered.

7. Home Health (*continued*)

c. Medical supplies, equipment, and appliances suitable for use in the home.

3) Home Infusion Therapy

Self-administered Home Infusion Therapy (HIT) is covered when it is medically necessary and provided through a Medicaid enrolled HIT agency as prescribed by a physician. "Self-administered" means that the patient and/or an unpaid primary caregiver is capable, able, and willing to administer the therapy following teaching and with monitoring. An agency must be a home care agency licensed in North Carolina for the provision of infusion nursing services to qualify for enrollment as a Home Infusion Therapy Provider.

The following therapies are included in this coverage when self-administered:

- i. Total parenteral nutrition
- ii. Enteral nutrition
- iii. Intravenous chemotherapy
- iv. Intravenous antibiotic therapy
- v. Pain management therapy, including subcutaneous, epidural, intrathecal, and intravenous pain management therapy

7. Home Health (*continued*)

- d. Specialized Therapies provided by a Medicare Certified Home Agency.
  - 1) Speech therapy, physical therapy and occupational therapy when ordered by the physician as a medically necessary part of the patient's care.
  - 2) Services are provided within accepted national standards and best practice guidelines for each type of therapy. Qualifications for therapy staff are in accordance with those outlined in 42 CFR 440.110.
  - 3) Services are provided only in the patient's home.

8. Private Duty Nursing Services

Medically necessary private duty nursing (PDN) services are provided under the direction of the recipient's physician in accordance with 42 CFR 440.80 and prior approval by the Division of Medical Assistance, or its designee.

Residents who are in adult care homes are not eligible for this service. This exclusion does not violate comparability requirements as adult care home residents do not have the medical necessity for continuous nursing care. According to State regulations for adult care homes, people are not to be admitted for professional nursing care under continuous medical supervision and residents who develop a need for such care are to be placed elsewhere. In addition, recipients in hospitals, nursing facilities, intermediate care facilities for the mentally retarded, rehabilitation centers, and other institutional settings are not eligible for this service. PDN services are not covered while an individual is being observed or treated in a hospital emergency room or similar environment.

This service is only approvable based on the need for PDN services in the patient's private residence. An individual with a medical condition that necessitates this service normally is unable to leave the home without being accompanied by a licensed nurse and leaving the home requires considerable and taxing effort. An individual may utilize the approved hours of coverage outside of his/her residence during those hours when the individual's normal life activities take the patient out of the home. The need for nursing care to participate in activities outside of the home is not a basis for authorizing PDN services or expanding the hours needed for PDN services.

Medicaid will not reimburse for Personal Care Services, Skilled Nursing Visits, or Home Health Aide Services provided during the same hours of the day as PDN services.

Medicaid Payments for PDN are made only to agencies enrolled with the Division of Medical Assistance as providers for the service. An enrolled provider must be a State licensed home care agency within North Carolina that is approved in its license to provide nursing services within the State. PDN services shall be rendered by a licensed registered nurse (RN) or licensed practical nurse (LPN) who is licensed by the North Carolina Board of Nursing and employed by a licensed home care agency.

A member of the patient's immediate family (spouse, child, parent, grandparent, grandchild, or sibling, including corresponding step and in-law relationship) or a legally responsible person who maintains their primary residence with the recipient may not be employed by the provider agency to provide PDN services reimbursed by Medicaid.

Mandatory Services 42 CFR 440.230

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Mandatory services visits are provided in accordance with 42 CFR 440.230 per recipient per State fiscal year. Exceptions to a visit limitation may be authorized by the State when additional visits are medically necessary. The mandatory services visit limit is 22. This limitation does not apply to EPSDT eligible children.

9. Clinic Services

All medical services performed must be medically necessary and may not be experimental in nature.

- a. Only services furnished by or under the direction of a physician or dentist are covered.
- b. Clinic services for which physicians or dentists file directly for payment are not covered.
- c. Services specifically covered under other Medicaid programs, e.g., Family Planning or EPSDT, are not reimbursable under the clinic program.
- d. Office visits in a clinic setting are included in the visit limit per recipient per State fiscal year. This limitation does not apply to adults 21 and over receiving mental health services subject to independent utilization review.

e. End-Stage Renal Disease (ESRD) Facility Services

The following End-Stage Renal Disease services are covered:

- (1) Maintenance hemodialysis and peritoneal dialysis treatments are covered when they are provided by a Medicaid enrolled ESRD hospital-based renal dialysis center or free-standing ESRD facility.
  - a. Hemodialysis is defined as the removal of certain elements from the blood by virtue of the difference in the rates of their diffusion through a semi-permeable membrane while the blood is being circulated outside the body. Three sessions per week are generally provided.
  - b. Peritoneal dialysis is defined as a process by which waste products and excess fluids are removed from the blood when the body's own kidneys have failed. But unlike hemodialysis where the blood passes through a machine, peritoneal dialysis is done inside the body. Two types of peritoneal dialysis are covered:
    - (i) Continuous cycling peritoneal dialysis (CCPD), is a continuous dialysis process which uses a machine to make automatic exchanges at night.
    - (ii) Continuous ambulatory peritoneal dialysis (CAPD), which does not require a machine. CAPD is a continuous dialysis process that uses the patient's peritoneal membrane as a dialyzer. CCPD and CAPD are furnished on a continuous basis, not in discrete sessions.
- (2) Training in peritoneal self-dialysis for beneficiaries and individuals who will assist a beneficiary in peritoneal self-dialysis is covered.

Provider Qualifications

A dialysis center or free-standing facility must provide a letter of Certification as a Medicare provider from the Centers for Medicare and Medicaid Services (CMS).

10. Dental Services

All dental services performed must be medically necessary and may not be experimental in nature. Medical necessity is determined by generally accepted North Carolina community practice standards as verified by independent Medicaid consultants.

- a. Routine dental examinations and screening tests are covered for adults and EPSDT recipients, which include adults and children in nursing facilities.
- b. Experimental – Dental care that is investigatory or an unproven procedure or treatment regimen that does not meet generally accepted standards of medical practice in North Carolina.

In evaluating whether a particular service is or is not experimental the agency will consider safety, effectiveness and common acceptance as verified through 1) scientifically validated clinical studies 2) dental literature research and 3) qualified dental experts.

- c. The services requiring prior approval are: complete dentures, partial dentures, complete and partial denture relines, orthodontic services, periodontal services, elective root canal therapy, and complex or extensive oral maxillo-facial surgical procedures. Emergency services are exempt from prior approval. The Division of Medical Assistance will have the responsibility of prior authorization of dental services.
- d. Endodontic treatment is covered for anterior teeth only.
- e. Experimental appliances are non-covered services.
- f. Payment for full mouth x-ray series is allowed only once every five (5) years.
- g. Replacement of complete dentures may be made once every ten years. Replacement of partial dentures may be made once every eight years. Replacement after the expiration of fewer than ten years for complete dentures and after fewer than eight years for partial dentures may be made with prior approval if failure to replace the dentures will cause an extreme medical problem or irreparable harm. Initial reline of dentures may only be made if six months have elapsed since receipt of dentures. For an immediate denture, the initial reline may be approved and rendered earlier than six months from denture delivery if the provider determines that healing of extraction sites is essentially complete and a reline is necessary to ensure proper fit and function of the denture. Subsequent relines are allowed only at five year intervals; if failure to reline in fewer than five years will cause an extreme medical problem or irreparable harm, relines may be made with prior approval. Standard procedures and materials shall be used for full and partial dentures.
- h. The state assures that EPSDT eligible clients have access to 1905(A) services not specifically listed in the state plan when they are medically necessary.

12.a. Prescribed Drugs

- (1) Limited to rebateable legend drugs, Insulin and selected rebateable over the counter (OTC) drugs designated per the North Carolina Division of Medical Assistance policy on Over the Counter Medications, criteria listed in General Clinical Coverage Policy No. A2. Prior authorization is required for certain high-cost drugs which are subject to overutilization or abuse per the North Carolina Division of Medical Assistance Policy for Prior Authorization, General Clinical Coverage Policy No. A3.
- (2) For Non MAC (Maximum Allowable Cost) drugs, a prescription designated by a brand or trade name for which one or more equivalent drugs are available shall be considered to be an order for the drug by its generic name, except when the prescriber personally indicates in their own handwriting on the prescription order brand name "medically necessary". For MAC drugs, the prescriber must write in their own handwriting on the face of the prescription brand name "medically necessary". The Department may prevent substitution of a generic equivalent drug when the net cost to the State of the brand-name drug, after consideration of all rebates, is less than the cost of the generic equivalent. The Department will ensure that the preferred brand-name name drug is not on the Federal Upper Limit or State Maximum Allowable Cost lists in order to maintain lesser of logic pricing of prescription drug claims.

12. a. Prescribed Drugs *continued*

- (3) The Department may establish authorizations, limitations, and reviews for specific drugs, drug classes, brands, or quantities in order to manage effectively the Medicaid pharmacy program. This may include limitations on monthly brand-name and generic prescriptions as well as restrictions on the total number of medications, except that the Department may not impose limitations on brand-name medications for which there is a generic equivalent in cases where the prescriber has determined at the time the drug is prescribed, that the brand-name drug is medically necessary and has written on the prescription order the phrase "medically necessary". The Department may impose prior authorization requirements on brand-name drugs for which the phrase "medically necessary" is written on the prescription.
- (4) Drugs for which Medical Assistance reimbursement is available are limited to the following:

Covered outpatient drugs of any manufacturer which has entered into and complies with an agreement under Section 1927(a) of the Act which are prescribed for a medically accepted indication.

A preferred drug list or other restrictions such as Prior Authorization (PA) must permit coverage of participating manufacturers' drugs. In addition, prior authorization must be obtained from the Medicaid agency or its authorized agent for any drug on the prior authorization list before Medicaid reimbursement is available. The state provides for response by telephone or other telecommunication device within twenty-four (24) hours of a request for prior authorization. The state also provides for the dispensing of at least a seventy-two (72) hour supply of a covered outpatient prescription drug in an emergency situation (effective July 1, 1991).

12.a. Prescribed Drugs (continued)

Effective January 1, 1991 Medicaid will cover only drugs of participating manufacturers except 1-A drugs, where State process for approval must be described. (Because of extenuating circumstances waiver, the State may cover non-participating manufacturers' drugs for claims with date of service through March 31, 1991.)

The state will comply with the reporting requirements for State utilization information and on restrictions to coverage.

If the state has "existing" agreements, these will operate in conformance with law, and for new agreements, require CMS approval. The State must also agree to report rebates from separate agreements.

The State must allow manufacturer to audit utilization data.

The unit rebate amount is confidential and cannot be disclosed for purposes other than rebate invoicing and verification.

State Plan Under Title XIX of the Social Security Act  
Medical Assistance Program  
State: NORTH CAROLINA

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12.a. Prescribed Drugs (continued)

- (4) DESI drugs and any identical, similar or related products or combinations of these products are not covered.
- (5) Supplemental Medicaid Drug Rebate Agreements

A rebate agreement between the State and a drug manufacturer for drugs provided to the Medicaid population, submitted to CMS on December 30, 2009 and entitled, "State of North Carolina Magellan Medicaid Administration\_National Medicaid Pooling Initiative (NMPI)," has been authorized by CMS.

The State assures compliance with Section 1927 of the Social Security Act. Drugs of federal rebate participating manufacturers are covered. Policies for the supplemental rebate program for Medicaid beneficiaries are as follows:

- a) Supplemental rebates received by the State in excess of those required under the national drug rebate agreement will be shared with the Federal government on the same percentage basis as applied under the national rebate agreement.
- b) Supplemental rebates are for the Medicaid population only.
- c) The State will be negotiating supplemental rebates in addition to the federal rebates provided for in Title XIX. Rebate agreements between the State and a pharmaceutical manufacturer will be separate from the federal rebates.
- d) All drugs covered by the program, irrespective of placement on the recommended drug list, will comply with the provisions of the national drug rebate agreement.
- e) The State is in compliance with reporting requirements for utilization and restrictions to coverage. Pharmaceutical manufacturers may audit utilization data. The unit rebate amount is confidential and cannot be disclosed for purposes other than rebate invoicing and verification.
- f) Participation in the Magellan Medicaid Administration\_National Medicaid Pooling Initiative (NMPI) will not limit the State's ability to negotiate state-specific supplemental rebate agreements for specific drug classes that are not part of the NMPI. These agreements must be authorized by CMS.

12.a. Prescribed Drugs (continued)

- (7) Drugs of manufacturers who do not participate in the supplemental rebate program will be made available to Medicaid recipients through prior authorization (PA). Payment of supplemental rebates results in a drug being included on the PDL and/or the recommended drug list.

Certain products may be limited by on-line clinical or fiscal edits to monitor appropriate utilization and secure cost savings.

North Carolina is establishing a Preferred Drug List (PDL) with PA for drugs not included on the PDL pursuant to 42 USC § 1396r-8. PA is established for certain drug classes, particular drugs or medically accepted indication for uses and doses.

The State will appoint a Pharmacy and Therapeutics Committee or utilize the drug utilization review committee in accordance with Federal law.

The State ensures that the PDL is consistent with Medicaid goals and objectives. The State will seek continuity of care of patients who were stabilized on previously prescribed, non-preferred medications. The PDL will address needs of recipients with special and complex medical conditions.

The Program complies with PA requirements set forth in Section 1927(d)(5) of the Social Security Act pertaining to PA programs.

The State ensures that during the contracting process all payments, the methodology for determining payments, and any other information regarding costs and incentives and the PDL development are disclosed by the vendor. Information includes any and all payment from manufacturers, distributors and other entities involved in the sale of pharmaceuticals.

The State will conduct an annual evaluation with a public report of any multi-state or state-specific PDL, PA or supplemental rebate agreement regarding the cost savings associated with the State participation and impact on related services such as hospitalizations.

- (8) In accordance with 42 CFR 431.54 and the Medicaid State Plan section 4.10, the State has the authority to lock-in recipients who over-utilize Medicaid services. The State will lock Medicaid enrollees into a single pharmacy and prescriber when the Medicaid enrollee's utilization of selected medications meets the lock-in criteria approved by the North Carolina Physicians Advisory Group.

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State Plan Under Title XIX of the Social Security Act  
Medical Assistance Program  
State: NORTH CAROLINA

Medicaid Program: Requirements Relating to Covered Outpatient Drugs for the Categorically Needy  
**12.a. PRESCRIBED DRUGS**

Citation (s)	Provision (s)
USC 1935(d)(1)	Effective January 1, 2006, the Medicaid agency will not cover any Part D drug for full-benefit dual eligible individuals who are entitled to receive Medicare benefits under Part A or Part B.

TN No.: 06-001  
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TN No.: NEW

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State Plan Under Title XIX of the Social Security Act  
Medical Assistance Program  
State: NORTH CAROLINA

Medicaid Program: Requirements Relating to Covered Outpatient Drugs for the Categorically Needy

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**12.a. PRESCRIBED DRUGS continued**

Citation (s)

USC 1927(d)(2) and  
1935(d)(2)

Provision (s)

The Medicaid agency provides coverage for the following excluded or otherwise restricted drugs or classes of drugs, or their medical uses to all Medicaid recipients, including full benefit dual eligible beneficiaries under the Medicare Prescription Drug Benefit – Part D.

(1) The following excluded drugs are covered:

(a) Non-prescription drugs

North Carolina (NC) will only cover selected rebateable over the counter (OTC) products when not covered by the prescription drug plans (PDPs). Examples of OTC drugs covered are: Insulin products, non-sedating antihistamines e.g. Loratadine OTC and Claritin OTC, proton pump inhibitors e.g. Prilosec OTC.

State Plan Under Title XIX of the Social Security Act  
Medical Assistance Program  
State: NORTH CAROLINA

Medicaid Program: Requirements Relating to Covered Outpatient Drugs for the Categorically Needy

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**12.a. PRESCRIBED DRUGS continued**

Citation (s)	Provision (s)
USC 1927(d)(2) and 1935(d)(2)	(2) The following excluded drugs are not covered: (a) Agents when used for anorexia, weight loss, weight gain (b) Agents when used to promote fertility (c) Agents when used for cosmetic purposes or hair growth (d) Covered outpatient drugs which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee (e) Agents when used for the symptomatic relief of cough and colds. All legend products that contain expectorants or cough suppressants. Examples are: expectorant/antitussive combination, antihistamine/decongestant/antitussive combination, antihistamine/decongestant/expectorant combination, antihistamine/decongestant/expectorant/antitussive combination, antihistamine/expectorant combination, antihistamine/antitussive, antitussive/decongestant/analgesic/ expectorant, and antitussive/decongestant/analgesic. (f) All legend vitamins and mineral products, except prenatal vitamins and fluoride.

12.b Dentures

See Attachment 3.1-A.1 Page 13d under “Dental Services” Section 10.g. for denture, partial denture and relines limitations.

- 12.c Medically necessary orthotic and prosthetic devices are covered by the Medicaid program when prescribed by a qualified licensed healthcare practitioner and supplied by a qualified provider. Only items determined to be medically necessary, effective and efficient are covered. Items which require prior approval are indicated by an asterisk beside the HCPCS code on the Orthotic and Prosthetic Fee Schedule. This fee schedule is located at [www.dhhs.state.nc.us/dma/fee/fee.htm](http://www.dhhs.state.nc.us/dma/fee/fee.htm).

A qualified orthotic and prosthetic device provider must be approved by the Division of Medical Assistance. The provider requirements are published in Medicaid Clinical Coverage Policies on the NC Division of Medical Assistance website ([www.dhhs.state.nc.us/dma/dme/5B.pdf](http://www.dhhs.state.nc.us/dma/dme/5B.pdf)).

Prior approval is required for certain orthotic and prosthetic devices. The decision to require prior approval for a specific procedure, product or service and the requirements that must be met for prior approval are based on evaluation of the factors such as: utilization; efficacy; safety; potential risk to patients; potential for misuse or abuse; high cost; the availability of more cost effective or equivalent procedures, products and services; and legislative mandate. High cost is cost in comparison to other covered items and related maintenance. Such a designation would usually be arrived at by a team of DMA staff from fiscal, programmatic and Program Integrity areas. Whether the recipient gets the item or not is dependent on the rationale for medical need and the unavailability of another less costly item that would adequately address the need. Session Law 2004-124 states “medically necessary prosthetics and orthotics are subject to prior approval and utilization review.” Specific prior approval requirements are published in Medicaid Clinical Coverage Policies on the NC Division of Medical Assistance website ([www.dhhs.state.nc.us/dma/dme/5B.pdf](http://www.dhhs.state.nc.us/dma/dme/5B.pdf)).

*\*EPDST Orthotic and Prosthetic Information is located at: Attachment 3.1-A.1, Page 7b.*

12.d Eyeglasses

- (1) All visual aids require prior approval.
- (2) No eyeglass frames other than frames made of zylonite, metal or combination zylonite and metal shall be covered.
- (3) Eyeglass repair or replacement, or any other service costing five dollars \$5.00 or less, shall not be covered.

**13. d. Diagnostic, Screening, Treatment, Preventive and Rehabilitative Services**

These services are available to categorically needy and medically needy recipients. Services provided under this section are provided by licensed practitioners (within their scope of practice as determined by the North Carolina Practice Acts per discipline) or programs/agencies for the mentally ill and substance abusers certified as meeting the program standards of the Commission on Mental Health, Developmental Disabilities and Substance Abuse Services or as Critical Access Behavioral Health Care Agencies (CABHA), and directly enrolled in Medicaid. See Section 4.b.(8) in this Attachment 3.1-A.1 for a description of a CABHA. Staff of the agency providing services will also meet requirements set forth in Federal regulations or the requirements for one of the three categories described in the North Carolina Practice Act.

Critical Access Behavioral Health Agencies (CABHA):

Critical Access Behavioral Health Agencies (CABHA), for profit, not for profit, public, or private behavioral health care, behavioral health services provider agencies, will be certified by the North Carolina Department of Health and Human Services (the Department) as meeting the following staffing, and operational certification requirements.

A Critical Access Behavioral Health Agency must meet all statutory, rule and policy requirements for Medicaid mental health and substance abuse service provision and monitoring; be determined to be in good standing with the Department; and have a three year (or longer) accreditation from an accrediting body recognized by the Secretary of the Department of Health and Human Services. State statutory requirements regulating the provision of mental health and substance abuse services are in North Carolina General Statute, Chapter 122C; administrative rules relating to these services are in 10A NCAC 27 and clinical policy requirements are specified in Medicaid Clinical Policy Section 8. Medicaid and enrollment policy require compliance with Federal Medicaid Policy relating to confidentiality, record retention, fraud and abuse reporting and education, documentation, staff qualifications and compliance with clinical standards for each service.

Required staff for a CABHA includes a Medical Director; a Clinical Director and a Quality Management/Training Director. Each CABHA is required to offer at a minimum the following five services:

1. Comprehensive clinical assessment, which is defined as a face to face evaluative review by a qualified licensed practitioner, of a recipient's medical, psychological, familial, social and psychiatric treatment history; current mental status and functioning, strengths, natural supports, current treatment and medication regime, for the purpose of developing a diagnostic formulation of the recipient's treatment needs and treatment plan; may be provided under Diagnostic Assessment, (Attachment 3.1-A.1, Page 15a.1) or under Behavioral Health Rehabilitative Services (Pages 15a.16 -17).
2. Medication management, defined as pharmacologic management including review of medication use, both current and historical if indicated; evaluation of symptoms being treated, side effects and effectiveness of current medication(s), adjustment of medications if indicated, and prescription provided by a medical professional practicing within the scope of his or her licensure; may be provided under Physician Services, Attachment 3.1-A.1, Page 7h or under Behavioral Health Rehabilitative Services, Page 15a.16-17.
3. Outpatient therapy, defined as outpatient psychotherapy including individual insight oriented, behavior modifying, and/or supportive psychotherapy; interactive psychotherapy; family psychotherapy; and group psychotherapy. Service can be billed by all licensed clinicians according to their scope of practice, as indicated in Attachment 3.1-A.1 on Page 15a.16-17.
4. At least two additional mental health and/or substance abuse services from the list below for which the agency has been credentialed from the Local Management Entity in the same region where it provides the services and which provide a continuum of service which is age and disability specific. There is a description of each of the services, including who provides the services and their qualifications in the State plan, in Attachment 3.1-A.1, on the Pages as indicated below:

**13. d. Diagnostic, Screening, Preventive, Treatment and Rehabilitative Services (continued)**

These services must include two or more of the following as described in Attachment 3.1-A.1 of the State's plan on the pages indicated:

Services	Page Reference
Intensive In-Home (IIH)	Page 7c.6
Community Support Team (CST)	Page 15a.6
Substance Abuse Intensive Outpatient Program (SAIOP)	Pages 7c.8 & 15a.9-A
Substance Abuse Comprehensive Outpatient Treatment (SACOT)	Page 15a.10
Child and Adolescent Day Treatment	Page 7c.4
Psychosocial Rehabilitation (PSR)	Page 15a.3
Assertive Community Treatment Team (ACTT)	15a.7
Multi-Systemic Therapy (MST)	Page 7c.7
Partial Hospitalization (PH)	Pages 7c.5 & 15a.4
Substance Abuse Medically Monitored Community Residential Treatment	Page 15a.11-A
Substance Abuse Non-Medical Community Residential Treatment	Page 15a.11
Outpatient Opioid Treatment	Page 15a.9
(Therapeutic Foster Care) Child Residential Level II – Family Type	Page 15a.19
Child Residential Level II – Program Type	Page 15a.19
Child Residential Level III and IV	Page 15a.20

CABHAs and non-CABHA agencies may provide Comprehensive Clinical Assessments, Medication Management, and Outpatient Therapy.

Only CABHAs will be able to provide Community Support Team, Intensive In-Home, Child and Adolescent Day Treatment (both for individuals under 21) after December 31, 2010.

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**13. d. Diagnostic, Screening, Preventive, Treatment and Rehabilitative Services (continued)**

CABHAs must coordinate with other provider participants, Carolina Access and other primary care providers to improve the coordination of services within the Local Management Entity's community of providers.

Rehabilitative Services include the following:

- A. Medically necessary diagnostic evaluations or assessments (Diagnostic Assessment) identify the existence, nature and extent of illness. The services may include a systematic appraisal of mental, psychological, physical, behavioral, functional, social, economic and/or intellectual limitations and resources of the individual in order to determine the nature and extent of illness. This information will be used in the formulation of an individualized person centered plan for the recipient in accordance with 42 CFR 430.130(a).
- B. Other medically necessary diagnostic, screening, treatment, preventive and rehabilitative (ODSPR) services for the mentally ill, developmentally disabled and substance abusers are covered benefits when medically necessary. Screening services means the use of standardized tests given under medical direction. Diagnostic, preventive, or rehabilitative services must be ordered by a physician, licensed psychologist, physician's assistant or nurse practitioner practicing within the scope of his/her practice according to Chapter 90 of the North Carolina General Statutes in accordance with 42 CFR 430.130(d).

Covered services are provided to recipients in their residence or in a community setting other than in a public institution (IMD), jail or detention facility.

The following services will be covered when a determination is made that the service will meet specific behavioral health needs of the recipient. Specific services must ameliorate diagnosable conditions or prevent the anticipated deterioration of the patient's condition. Family services must be to the exclusive benefit of the Medicaid eligible beneficiary, and is designed to address a specific rehabilitative goal.

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13. D. Diagnostic, Screening, Treatment, Preventive and Rehabilitative Services  
Description of Services

(i) Psychotherapy Services:

For the complete description of the service providers, their qualifications, service limitations and service descriptions, see Attachment 3.1-A pages 15a.16 and 15a.7

(ii) Diagnostic Assessment

This is a clinical face-to-face evaluation of a beneficiary's MH/DD/SAS condition that will establish a need for the enhanced benefit package of services. It is a team service and must include evaluations by either, a physician, physician assistant, nurse practitioner or licensed psychologist who can sign an order for services and a licensed or certified practitioner with expertise in MH/DD/SAS as appropriate and consist of the following:

- a chronological general health and behavioral health history (includes both mental health and substance abuse) 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; biological, psychological, familial, social, developmental and environmental dimensions and identified strengths and weaknesses in each area;
- a description of the presenting problems, including source of distress, precipitating events, associated problems or symptoms, recent progressions, and current medications;
- a strengths/problem summary which addresses risk of harm, functional status, co-morbidity, recovery environment, and treatment and recovery history;
- diagnoses on all five (5) axes of DSM-IV;
- evidence of an interdisciplinary team progress note that documents the team's review and discussion of the assessment;
- a recommendation regarding target population eligibility; and
- evidence of beneficiary participation including families, or when applicable, guardians or other caregivers.

Documentation must include the following elements:

- a chronological general health and behavioral health history (includes both mental health and substance abuse) 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; biological, psychological, familial, social, developmental and environmental dimensions and identified strengths and weaknesses in each area;
- a description of the presenting problems, including source of distress, precipitating events, associated problems or symptoms, recent progressions, and current medications;
- strengths/problem summary which addresses risk of harm, functional status, co-morbidity, recovery environment, and treatment and recovery history;
- diagnoses on all five (5) axes of DSM-IV;
- evidence of an interdisciplinary team progress note that documents the team's review and discussion of the assessment;

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13. D. Diagnostic, Screening, Treatment, Preventive and Rehabilitative Services (Continued)

Provider Agency Qualifications and Qualifications for Staff Employed by Agencies  
Enrolled with Medicaid.

*Please refer to chart included with this SPA for staff qualifications for each specific service.*

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**Staff Qualifications for Each Specific Service.**

Service	Agency Qualifications		Staff Qualifications					
			Authorization	See Definitions for QP, AP, PP in Text of SPA:		Medical Coverage		
	Licensed	Credentialed	Service Ordered by: MD, Nurse Practitioner, Physicians Assistant or PhD Psychologist	Qualified Professional (QP), includes SA Professionals	Under Supervision of a Qualified Professional:		Medical Oversight/ Participation by:	
	All facilities must be 16 beds or less				Associate Professional	Para-Professional	Psychiatrist/MD	Registered Nurse* RNs are considered QPs as well
Psychosocial Rehabilitation	X	X	X	X	X	X		
Partial Hospitalization	X	X	X	X	X	X	X	
Mobile Crisis Management		X		X (Nurse, LCSW or Psychologist)		X	X (Must be available for face to face or tel. Consult)	
Community Support Team (adults)		X	X	X (required)	X	X		
Assertive Community Treatment (ACTT) <i>minimum required per team</i>		X	X	X		X (includes certified peer specialist)	X	X
Professional Treatment Services in a Facility Based Crisis Program	X	X	X	X	X	X	X	
Opioid Treatment	X	X	X				Must be provided by RN, LPN, Pharmacist or MD	
Substance Abuse (SA) Intensive Outpatient	X		X	X	X	X		
SA Comprehensive Output Treatment	X	X	X	X	X	X	Recipients must have access to MD assessment and tx.	

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**Staff qualifications for each specific service. (Continued)**

Service	Agency Qualifications		Staff Qualifications					
			Authorization	See Definitions for QP, AP, PP in Text of SPA:			Medical Coverage	
	Licensed		Credentialed	Service Ordered by: MD, Nurse Practitioner, Physicians Assistant or PhD Psychologist			Qualified Professional (QP), includes SA Professionals	
SA Non-Medical Community Residential Tx	X	X	X	X	X	X		
SA Medically Monitored Residential Tx	X	X	X	X	X	X	X	X
Ambulatory Detoxification	X	X	X	X	X	X	X (provides assessment w/n 24 hrs.)	X (provides admission assessment /monitors tx)
Non-hospital Medical Detoxification	X	X	X	X	X	X	X (provides assessment w/n 24 hrs.)	X (provides admission assessment /monitors tx)
Medically Monitored or Alcohol Drug Addiction Tx Center Detoxification/ Crisis Stabilization	X	X	X	X	X	X	X Service delivered by medical and nursing staff/24 hour medically supervised evaluation and withdrawal management	

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13. D. Diagnostic, Screening, Treatment, Preventive and Rehabilitative Services (Continued)

Provider Agency Qualifications:

The Community Intervention Service provider has met the requirements either with:

The required Licensure through the Division of Health Service Regulation (DHSR); and /or Credentialing through the PIHP indicating that the provider is in compliance with requirements for the specific service per service specific Credentialing protocols.

These pre-requisites must be completed prior to enrollment with the Division of Medical Assistance (DMA). Additionally, providers must be accredited by a national accrediting body within three years of enrollment into Medicaid; per requirement during this SPA's effective dates.

Qualifications for Staff Employed by Agencies Enrolled with Medicaid

- i) Paraprofessional  
"Paraprofessional" within the mental health and substance system means an individual who has a GED or high school diploma (or no GED or high school diploma if employed prior to November 1, 2001). Supervision shall be provided by a qualified professional or associate professional with the population served.
- ii) Associate Professional (AP)  
"Associate Professional" within the mental health and substance abuse services system means an individual who is a:
  - graduate of college or university with a Masters degree in a human service field and less than one year of full time post-graduate mental health or substance abuse experience with the population served or a substance abuse professional with less than one year of full-time, post-graduate degree supervised experience in alcoholism and drug abuse counseling. Supervision shall be provided by a qualified professional with the population served until the individual meets one year of experience; or
  - graduate of college or university with a bachelor's degree in a human service field with less than two years of full-time post-bachelor's degree mental health or substance abuse experience with the population served, or a substance abuse professional with less than two years post bachelor's degree accumulated supervised experience in alcoholism and drug abuse counseling. Supervision shall be provided by a qualified professional with the population served until the individual meets two years of experience; or
  - graduate of a college or university with a bachelor's degree in a field other than human services with less than four years of full-time, post bachelor's degree accumulated supervised experience in mental health or substance abuse with the population served. Supervision shall be provided by a qualified professional with the population served until the individual meets four years of experience; or

13. D. Diagnostic, Screening, Treatment, Preventive and Rehabilitative Services (Continued)

- registered nurse who is licensed to practice in the State of North Carolina by the North Carolina Board of Nursing with less than four years of full-time accumulated experience in mental health or substance abuse with the population served. Supervision shall be provided by a qualified professional with the population served until the individual meets four years of experience.
- (iii) Qualified Professional (QP)
- “Qualified Professional” within the mental health and substance abuse system means:
- an individual who holds a license, provisional license, certificate, registration or permit issued by the governing board regulating a human service profession, except a registered nurse who is licensed to practice in the State of North Carolina by the North Carolina Board of Nursing, who also has four years of full-time accumulated experience in MH/SA with the population served; or
  - a graduate of a college or university with a Masters degree in a human service field and one year of full-time, post-graduate degree experience with the population served or a substance abuse professional with one year of full-time, post-graduate degree accumulated supervised experience in alcoholism and drug abuse counseling; or
  - a graduate of college or university with a bachelor’s degree in a human service field and two years of full-time, post-bachelor’s degree experience with the population served or a substance abuse professional who has two years full-time, post-bachelor’s degree accumulated supervised alcoholism and drug abuse counseling; or
  - a graduate of a college or university with a bachelor’s degree in a field other than human services with four years of full-time, post-bachelors degree accumulated MH/SA experience with the population served.

This category includes Substance Abuse Professional, Certified Substance Abuse Counselors (CSAC), Certified Clinical Supervisor (CCS), Licensed Clinical Addictions Specialist (LCAS)\*

The full descriptions of categories of providers are found in the North Carolina Administrative Code.

13. D Diagnostic, Screening, Treatment, Preventive and Rehabilitative Services (Continued)

Supervision is provided as described below:

Covered services are provided to recipients by agencies directly enrolled in the Medicaid program which employ qualified professionals, associate professional and paraprofessionals. Medically necessary services delivered by associate and paraprofessionals are delivered under the supervision and direction of the qualified professional. The qualified professional personally works with consumers to develop the person centered individualized treatment plan and meets with consumers periodically during the course of treatment to monitor the services being delivered and to review the need for continued services. The supervising qualified professional assumes professional responsibility for the services provided by associate and paraprofessionals and spends as much time as necessary directly supervising services to ensure that recipients are receiving services in a safe and efficient manner in accordance with accepted standards of practice. The terms of the qualified professional's employment with the directly enrolled agency providing service ensures that the qualified professional is adequately supervising the associate and paraprofessionals. The agencies ensure that supervisory ratios are reasonable and ethical and provide adequate opportunity for the qualified professional to effectively supervise the associate and paraprofessional staff assigned. Documentation is kept to support the supervision provided to associate and paraprofessional staff in the delivery of medically necessary services.

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13. D. Diagnostic, Screening, Treatment, Preventive and Rehabilitative Services (*continued*)  
Description of Services (42 CFR 30.130(a))

(iv) Psychosocial Rehabilitation

Psychosocial Rehabilitation (PSR) is a service designed to help adults with psychiatric disabilities regain and/or restore an individual to his/her best age-appropriate functional level according to an individualized treatment plan, which addresses the adult's assessed needs. The activities included in PSR shall be included in the treatment plan and intended to achieve the identified beneficiary's treatment plan goals or objectives. Components that are not provided or directed exclusively toward the treatment of the beneficiary are not eligible for Medicaid reimbursement

The service components include:

- Behavioral intervention and management, including anger management.
- Assisting the individual to develop daily living skills specific to managing their own home, including managing their money, medications, and using community resources and other self care requirements.
- Assisting in the restoration of social skills, adaptive skills, enhancement of communication and problem solving skills, monitoring of changes in psychiatric symptoms/or functioning.
- Assisting the individual and family members or other collaterals to identify strategies or treatment options associated with the individual's mental illness, with the goal of minimizing the negative effects of mental illness symptoms or emotional disturbances or associated environmental stressors which interfere with the individual's daily living, financial management, housing, academic and/or employment progress, personal recovery or resilience, family and/or interpersonal relationships, and community integration.
- Participation in and utilization of strengths based planning and treatments which include assisting the individual and family members or other collaterals with identifying strengths and needs, resources, natural supports and developing goals and objectives to utilize personal strengths, resources, and natural supports to address functional deficits associated with their mental illness.
- Individual supportive counseling, solution focused interventions, emotional and behavioral management, and problem behavior analysis with the individual, with the goal of assisting the individual with developing and implementing social, interpersonal, self care, daily living and independent living skills to restore stability, to support functional gains, and to adapt to community living.

Services provided at a work site must not be job task oriented. Any services or components of services the basic nature of which are to supplant housekeeping, homemaking, or basic services for the convenience of a person receiving covered services (including housekeeping, shopping, child care, and laundry services) are non-covered.

The Psychosocial Rehabilitation program shall be under the direction of a person who meets the requirements specified for Qualified Professional status. The Qualified Professional is responsible for supervision of other program staff which may include Associate Professionals and Paraprofessionals. All staff must have the knowledge, skills, and abilities required by the population and age to be served.

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13. D. Diagnostic, Screening, Treatment, Preventive and Rehabilitative Services (continued)  
Description of Services (42 CFR 30.130(a))

Qualified Professional (QP): In addition to the following components, the QP may provide any activity listed under Associate Professional or Paraprofessional: developing, implementing, and monitoring the Person Centered Plan; behavioral interventions/management; social and other skill restoration, adaptive skill training; enhancement of communication and problem solving skills, anger management, family support, medication monitoring, monitoring of changes in psychiatric symptoms/or functioning.

Associate Professional (AP): In addition to the following components, the AP may provide the activities listed under Paraprofessionals: behavioral interventions/management; social and other skill restoration, adaptive skill training; restoration of communication and problem solving skills, anger management, family support, medication monitoring, monitoring of changes in psychiatric symptoms/or functioning.

Paraprofessional: The Paraprofessional may provide restoration of skills needed for community living, use of leisure time, prevocational activities and pursuit of needed education services.

**Operating Requirements:**

Each facility shall have a designated program director. A minimum of one staff member on-site to each eight or fewer beneficiaries in average daily attendance shall be maintained.

PSR is available for a period of 5 or more hours per day. There should be a supportive, therapeutic relationship between providers and the beneficiary. It is provided in a licensed facility with staff to beneficiary ratio of 1:8. This service is provided to outpatients by a mental health organization that meets State licensure requirements, and providers of the services will meet the appropriate Federal requirements or the State requirements. Documentation must include: a weekly full service note that includes the beneficiary's name, Medicaid identification number, date of service, purpose of contact, describes the provider's interventions, includes the time spent performing the interventions, effectiveness of the intervention, and the signature of the staff providing the service. This service must be ordered by an MD, NP, PA or PhD psychologist. Prior approval will be required by the designated Medicaid vendor. This initial prior approval process will ensure that the level of the service is appropriate and concurrent reviews will determine the ongoing medical necessity for the service or the need to move up or down the continuum of services to another level of care.

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13. D. Diagnostic, Screening, Treatment, Preventive and Rehabilitative Services (continued)  
Description of Services (42 CFR 30.130(a))

- (v) Partial Hospital (PH)  
This is a short term service for acutely mentally ill adults which provides a broad range of intensive therapeutic approaches which may include:
- Individual/group therapies,
  - Increase the individual's ability to relate to others,
  - Community living skills/training,
  - Coping skills,
  - Medical services; and
  - This is used as a step up to inpatient or a step down from inpatient.

Physician involvement is required. This service must be offered at a minimum of 4 hours per day, 5 days/week. Clinical criteria (medical necessity criteria for admission and continued stay) are embedded in the service definition. Documentation must include: a daily full service note that includes the beneficiary's name, Medicaid identification number, date of service, purpose of contact, describes the provider's interventions, time spent performing the intervention, effectiveness of the intervention, and the signature of the staff providing the service. The service must be ordered by a physician, licensed psychologists, physician's assistant or nurse practitioner and prior approval will be required via the statewide UR vendor or by an approved LME contracted with the Medicaid Agency and meeting the same standards and requirements as the statewide vendor. This initial prior approval process will ensure that the level of the service is appropriate and concurrent reviews will determine the ongoing medical necessity for the service or the need to move up or down the continuum of services to another level of care.

**Service Operations Requirements:**

Staff shall include at least one qualified mental health professional.

- (a) Each facility serving minors shall have:
- (1) A program director who has a minimum of two years experience in child or adolescent services and who has educational preparation in administration, education, social work, nursing, psychology or a related field; and
  - (2) one staff member present if only one beneficiary is in the program, and two staff members present when two or more beneficiaries are in the program.
- (b) each facility shall have a minimum ratio of one staff member present for every six beneficiaries at all times.
- (c) a physician shall participate in diagnosis, treatment planning, and admission and discharge decisions. This physician shall be a psychiatrist unless a psychiatrist is unavailable or for other good cause cannot be obtained.

13. D. Diagnostic, Screening, Treatment, Preventive and Rehabilitative Services (continued)  
Description of Services

(vi) Mobile Crisis Management

This involves all supports, services and treatments necessary to provide integrated crisis response, crisis stabilization interventions and crisis prevention activities. It is available 24/7/365 and provides immediate evaluation, triage and access to acute mh/dd/sas services, treatment, supports to effect symptom reduction, harm reduction and/or to safely transition persons in acute crisis to the appropriate environment for stabilization. It is provided by a team that includes a Qualified Professional who must be a nurse, a clinical social worker or psychologist. Teams include substance abuse professionals, and a psychiatrist must be available for face to face or telephone consults. Paraprofessionals with crisis management experience may also be included on the team but must work under the supervision of a professional. Experience with the appropriate disability group is required and 20 hours of crisis intervention training within the first 90 days of employment is necessary. The maximum length of the service is 24 hours per episode and prior authorization will be required via the statewide UR vendor or by an approved LME contracted with the Medicaid Agency and meeting the same standards and requirements as the statewide vendor after the first 8 hours for the remaining 16 hours. Documentation must include: a service note that includes the recipient's name, Medicaid identification number, date of service, purpose of contact, describes the provider's interventions, includes the time spent performing the interventions, effectiveness of the intervention, and the signature of the staff providing the service.

NOTE: This has a limitation because the service requires stabilization or movement into an environment that can stabilize.

**13. d. Diagnostic, Screening, Preventive, Treatment and Rehabilitative Services (continued)**  
**Description of Services**

(vii) Community Support Team (CST) - (adults)

Services provided by this team consist of mental health and substance abuse services and supports necessary to assist adults in achieving rehabilitation and recovery goals. It assists individuals to gain access to necessary services; reduce psychiatric and addiction symptoms; and develop optimal community living skills. The services include assistance and support to individuals in crisis situation; service coordination; psycho education and support for individuals and their families; independent living skills; development of symptom monitoring and management skills, monitoring medications and self-medication.

- Assist individuals to gain access to necessary services to reduce psychiatric and addiction symptoms,
- Assistance and support for individuals in crisis situations,
- Service coordination,
- Psycho-education,
- Individual restorative interventions for development of interpersonal, community coping and independent living skills; and
- Monitoring medications and self medication.

Documentation must include: a service note that includes the recipient's name, Medicaid identification number, date of service, purpose of contact, describes the provider's interventions, includes the time spent performing the interventions, effectiveness of the intervention, and the signature of the staff providing the service.

The CST provider assumes the role of advocate, broker, coordinator and monitor of the service delivery system on the behalf of the recipient. The service must be ordered and prior approval will be required. A CST team will be comprised of 3 staff persons one of which is the team leader and must be a QP. The other two may be a QP, AP or a paraprofessional. The team maintains a consumer to practitioner ratio of no more than fifteen consumers per staff person. All staff providing this service must have a minimum of one year documented experience with the adult population and completion of a minimum of twenty hours of crisis management and community support team service definition required within the first 90 days of hire. Clinical criteria are imbedded in the definition as well as service limitations to prevent duplication of services. It must be ordered by either, a physician, physician assistant, nurse practitioner or licensed psychologist. After December 31, 2010, this service can only be provided by and billed by a Critical Access Behavioral Health Care Agency (CABHA). Prior approval will be required via the statewide UR vendor or by an approved LME contracted with the Medicaid Agency and meeting the same standards and requirements as the statewide vendor. This initial prior approval process will ensure that the level of the service is appropriate and concurrent reviews will determine the ongoing medical necessity for the service or the need to move up or down the continuum of services to another level of care.

**NOTE:** This service is used as an intervention to avoid need for a higher level of care or as a step down from a higher level of care. It is an ACTT "lite" service.

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13. D. Diagnostic, Screening, Treatment, Preventive and Rehabilitative Services (continued)  
Description of Services

(viii) Assertive Community Treatment (ACT)

Assertive Community Treatment (ACT) is defined as an individual-centered, recovery-oriented mental health service delivery model for facilitating community living, psychosocial rehabilitation and recovery for persons who have the most severe and persistent mental illnesses, have severe symptoms and impairments, and have not benefited from traditional outpatient programs. ACT is a multi-disciplinary, self-contained clinical team approach with team members providing long-term intensive care in natural community settings. The team provides all mental health services rather than referring individuals to different mental health providers, programs, and other agencies.

The team provides evaluations (an assessment to determine the extent of the problems), outpatient treatment, case management, and community based services (described below) for individuals with mental health and substance abuse diagnoses. Interventions include the following, with a focus on achieving a maximum reduction of physical or mental disability and restoration of a beneficiary to his/her best possible functional level.

- Service coordination
- Crisis assessment and intervention
- Symptom assessment and management
- Individual counseling and psychotherapy, including cognitive and behavioral therapy
- Medication monitoring, administration and documentation
- Substance abuse treatment
- Working with beneficiaries to regain and restore skills to function and have social and interpersonal relationships as well as participate in community-based activities including leisure and employment
- Support and consultation to families and other major supports

ACT is available 24/7/365, in any location except jails, detention centers, clinic settings and hospital inpatient settings. Beneficiary-to-staff ratio is eight-to-one with a maximum of nine-to-one. Documentation must include a service note that includes the beneficiary's name, Medicaid identification number, date of service, purpose of contact, describes the provider's interventions, includes the time spent performing the interventions, effectiveness of the intervention, and the signature of the staff providing the service.

Minimum staff per team includes the following: a Licensed Professional, RN, QP, paraprofessional staff, certified peer specialist, and a psychiatric care provider role filled at least part-time by a physician for a minimum of 16 hours per week for every 60 beneficiaries for the largest teams and a smaller ratio for smaller teams of no less than 16 hours per 50 beneficiaries. The remainder of the psychiatric care provider time may be fulfilled by a nurse practitioner or a physician assistant. The team will provide a median rate of two contacts per week across all individuals served by that team. (This is billed per diem; the claims system is set so it will not reimburse for more than 4 in 1 month.).

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State Plan Under Title XIX of the Social Security Act  
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State: NORTH CAROLINA

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13. D. Diagnostic, Screening, Treatment, Preventive and Rehabilitative Services (continued)

Description of Services

(viii) Assertive Community Treatment Team (ACTT) (continued)

The service is intended to provide support and guidance in all functional domains to enhance the beneficiary's ability to remain in the community. No other periodic mental health services can be billed in conjunction with this service. This service must be ordered by an MD, NP, PA or PhD psychologist. Evidenced based best practices for this service have been incorporated into the service definitions. Providers of (ACT) under the State Plan must demonstrate fidelity to the latest Tool for Measurement of Act (TMACT) models of care. This will ensure that all providers maintain fidelity to the current fidelity model as it is updated. Clinical criteria are also included in the definition. Prior approval will be required via the statewide UR vendor or by an approved LME-PIHP contracted with the Medicaid Agency and meeting the same standards and requirements as the statewide vendor. This initial prior approval process will ensure that the level of the service is appropriate and concurrent reviews will determine the ongoing medical necessity for the service or the need to move up or down the continuum of services to another level of care.

Staff Program Operations Requirements

- (a) Team composition. The team shall be interdisciplinary in order to carry out the varied activities needed to meet the complex needs of clients and shall include:
- (1) a qualified professional, appropriate to the diagnosis of the clients being served;
  - (2) a registered nurse;
  - (3) an MD (at least .25 FTE per 50 clients); and
  - (4) one or more paraprofessional staff trained to meet the needs presented by the facility's client population.
- (b) Team qualifications. Each member of the team shall be privileged and supervised based on their training, experience, and qualifications.

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13. D. Diagnostic, Screening, Treatment, Preventive and Rehabilitative Services (continued)  
Description of Services

(ix) Professional Treatment Services in Facility-Based Crisis Programs (FBC)

This existing service serves as an alternative to hospitalization for recipients who have mental illness/ substance abuse disorder. It is a 24 hour residential facility that provides support and crisis services in a community setting. The services are provided under the supervision of a physician with interventions implemented under the physician direction. The purpose is to implement intensive treatment, behavioral management, interventions or detoxification protocols, to stabilize the immediate problems and to ensure the safety of the individual.

- Evaluation (assesses condition),
- Intensive treatment,
- Stabilization (behavioral management),
- Monitoring response to interventions; and
- Provide linkage for other services.

It is offered 7 days/week and must be provided in a licensed facility. At no time will the staff to recipient ratio be less than 1:6 for adult mental health recipients, 1:9 for substance abuse recipients. This is a short term service that does not exceed 15 days and cannot exceed a total of 30 days in a 12 month period. Documentation must include: a daily full service note that includes the recipient's name, Medicaid identification number, date of service, purpose of contact, describes the provider's interventions, includes the time spent performing the interventions, effectiveness of the intervention, and the signature of the staff providing the service. Prior approval will be required via the statewide UR vendor or by an approved LME contracted with the Medicaid Agency and meeting the same standards and requirements as the statewide vendor at the end of 7 days, if additional days are needed. This initial prior approval process will ensure that the level of the service is appropriate and concurrent reviews will determine the ongoing medical necessity for the service or the need to move up or down the continuum of services to another level of care. This service must be provided in a facility with 16 beds or less. Medicaid reimburses only treatment costs.

13. D. Diagnostic, Screening, Treatment, Preventive and Rehabilitative Services (continued)  
Description of Services

(ix) Professional Treatment Services in Facility-Based Crisis Programs (FBC) (continued)

Program Operations Requirements

- (a) Each facility shall maintain staff to client ratios that ensure the health and safety of clients served in the facility.
- (b) Staff with training and experience in the provision of care appropriate to the needs of clients shall be present at all times when clients are in the facility.
- (c) The facility shall have the capacity to bring additional staff on site to provide more intensive supervision, treatment, or management in response to the needs of individual clients.
- (d) The treatment of each client shall be under the supervision of a physician, and a physician shall be on call on a 24-hour per day basis.
- (e) Each direct care staff member shall have access at all times to qualified professionals who are qualified in the disability area(s) of the clients with whom the staff is working.
- (f) Each direct care staff member shall be trained and have basic knowledge about mental illnesses and psychotropic medications and their side effects; mental retardation and other developmental disabilities and accompanying behaviors; the nature of addiction and recovery and the withdrawal syndrome; and treatment methodologies for adults and children in crisis.
- (g) Staff supervision shall be provided by a qualified professional as appropriate to the client's needs

13. D. Diagnostic, Screening, Treatment, Preventive and Rehabilitative Services (continued)  
Description of Services

(x) Opioid Treatment

This existing service is provided through the LMEs for the treatment of Opioid addiction in conjunction with the provision of rehabilitation and medical services. It is provided only for treatment and/or maintenance. The program must be licensed and must meet the Federal Guidelines for this program. Providers will be direct enrolled. It is provided by an RN, LPN, Pharmacist or MD. This service must be ordered by an MD, NP, PA or PhD psychologist. Prior approval will be required via the statewide UR vendor or by an approved LME contracted with the Medicaid Agency and meeting the same standards and requirements as the statewide vendor. This initial prior approval process will ensure that the level of the service is appropriate and concurrent reviews will determine the ongoing medical necessity for the service or the need to move up or down the continuum of services to another level of care.

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13. D. Diagnostic, Screening, Treatment, Preventive and Rehabilitative Services (continued)  
Description of Services

(xi) Substance Abuse Intensive Outpatient (SAIOP)

This service provides motivational enhancement and engagement, therapies for recovery, random alcohol/ drug testing, and strategies for relapse prevention, including community and/or other strategies for relapse preventions. These therapies include:

- Individual counseling and support,
- Group counseling and support,
- Family counseling and support,
- Biochemical assays to identify recent drug use (e.g. urine drug screens),
- Strategies for relapse prevention: community and social support systems in treatment,
- Crisis contingency planning,
- Disease management; and
- Treatment support activities that have been adapted or specifically designed for persons with physical disabilities, persons with co-occurring disorders of mental illness and substance abuse/dependence or mental retardation/developmental disabilities and substance abuse/dependence.

SAIOP must be available for a minimum of 3 hours per day. It is operated out of a licensed substance abuse facility but can be provided in a variety of settings. The maximum face to face ratio is an average of not more than 12 recipients to 1 direct service staff based on average daily attendance. This service can only be provided by qualified substance abuse professional staff with the following licenses or certifications: persons who meet the requirements specified for Certified Clinical Supervisor (CCS); Licensed Clinical Addiction Specialist (LCAS); and Certified Substance Abuse Counselor (CSAC). Services may also be provided by staff who meet the requirements specified for QP or AP status for Substance Abuse, under the supervision of a LCAS or CCS. Paraprofessional level providers who meet the requirements for Paraprofessional status and who have the knowledge, skills, and abilities required for the population and age of persons receiving services may deliver SAIOP, under the supervision of a LCAS or CCS. Paraprofessional level providers may not provide services in lieu of on-site service provision by a qualified professional, LCAS, CCS, or CSAC.

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. The maximum face-to-face staff-to-client ratio is not more than 12 adult consumers to 1 QP based on an average daily attendance. The ratio for adolescents will be 1:6. Documentation must include: a daily full service note that includes the recipient's name, Medicaid identification number, date of service, purpose of contact, describes the provider's interventions, includes the time spent performing the interventions, effectiveness of the intervention, and the signature of the staff providing the service. This service must be ordered by an MD, NP, PA or PhD psychologist. Prior approval will be required via the statewide UR vendor or by an approved LME contracted with the Medicaid Agency and meeting the same standards and requirements as the statewide vendor. This initial prior approval process will ensure that the level of the service is appropriate and concurrent reviews will determine the ongoing medical necessity for the service or the need to move up or down the continuum of services to another level of care.

13. D. Diagnostic, Screening, Treatment, Preventive and Rehabilitative Services (continued)  
Description of Services

(xii) Substance Abuse Comprehensive Outpatient Treatment (SACOT)

This periodic service is a time-limited, multifaceted service approach for adults who require structure and support to achieve and sustain recovery. It emphasizes reduction in use and abuse of substances and/or continued abstinence, the negative consequences of substance abuse, development of a support network necessary to support necessary life style changes, and the continued commitment to recovery. The individual components of the services include:

- Individual counseling and support,
- Group counseling and support,
- Family counseling and support,
- Biochemical assays to identify recent drug use (e.g. urine drug screens),
- Strategies for relapse prevention to include community and social support systems in treatment,
- Crisis contingency planning,
- Disease management; and
- Treatment support activities that have been adapted or specifically designed for persons with physical disabilities, pr persons with co-occurring disorders of mental illness and substance abuse/dependence or mental retardation/developmental disabilities and substance abuse/dependence.

This service must operate at least 20 hours per week and offer a minimum of 4 hours of scheduled services per day with availability of at least 5 days per week with no more than a 2 day lapse between services. Documentation must include: a daily full service note that includes the recipient's name, Medicaid identification number, date of service, purpose of contact, describes the provider's interventions, includes the time spent performing the interventions, effectiveness of the intervention, and the signature of the staff providing the service. Staff must meet the requirements for CCS, LCAS and CSAC or a QP, AP or paraprofessional. Recipients must have ready access to psychiatric assessment and treatment services when warranted by the presence of symptoms indicating a co-occurring disorder. This service must be ordered by an MD, NP, PA or PhD psychologist. Prior approval will be required via the statewide UR vendor or by an approved LME contracted with the Medicaid Agency and meeting the same standards and requirements as the statewide vendor. This initial prior approval process will ensure that the level of the service is appropriate and concurrent reviews will determine the ongoing medical necessity for the service or the need to move up or down the continuum of services to another level of care.

13. D. Diagnostic, Screening, Treatment, Preventive and Rehabilitative Services (continued)  
Description of Services

(xiii) Substance Abuse Non-Medical Community Residential Treatment

This is a 24 hour residential recovery program professionally supervised that works intensively with adults. It is a licensed rehabilitation facility with 16 beds or less without medical nursing/monitoring, with a planned program of professionally directed evaluation, care and treatment for the restoration of functioning for persons with an addictions disorder. Programs include assessment/referral, individual and group therapy, family recovery, recovery skills training, case management, disease management, symptoms monitoring, medication monitoring and self-management of symptoms. Services in the person centered plan will be adapted to the client's developmental and cognitive level. Staff requirements are CCS, LCAS and CSAC; or a QP, AP or paraprofessional (staff definitions are included at the end of this document). Medical necessity is defined in the body of the definition and utilization review will be required. Documentation must include: a daily full service note that includes the recipient's name, Medicaid identification number, date of service, purpose of contact, describes the provider's interventions, time spent performing the intervention, effectiveness of the intervention, and the signature of the staff providing the service. This service will not be billed on the same day as any other mh/dd/sas service. Medicaid will not pay room and board; will pay only the treatment component. This service must be ordered by an MD, NP, PA or PhD psychologist. Prior approval will be required via the statewide UR vendor or by an approved LME contracted with the Medicaid Agency and meeting the same standards and requirements as the statewide vendor. This initial prior approval process will ensure that the level of the service is appropriate and concurrent reviews will determine the ongoing medical necessity for the service or the need to move up or down the continuum of services to another level of care. This is a short term service that cannot be provided for more than 30 days in a 12 month period.

13. D. Diagnostic, Screening, Treatment, Preventive and Rehabilitative Services (continued)  
Description of Services

(xiv) Substance Abuse Medically Monitored Residential Treatment

This is a 24 hour non-hospital, medically monitored facility with 16 beds or less, with 24 hour medical/nursing monitoring where a planned program of professionally directed evaluation, care and treatment for the restoration of functioning for persons with alcohol and other drug problems/addictions occurs. This facility is not a detoxification facility but the focus is on treatment after detoxification has occurred.

- Non hospital rehabilitation facility,
- Assessments,
- Monitoring of patient's progress and medication administration,
- Treatment relating to restoration of functioning (sustained improvement in health and psychosocial functioning, reduction of psychiatric symptoms when present, and reduction in risk of relapse); and
- First responder for crisis intervention.

It is staffed by Certified Clinical Supervisor, Licensed Clinical Addiction Specialist and Certified Substance Abuse Counselor's, QPs, APs and paraprofessionals with training and expertise with this population. Documentation must include: a daily full service note that includes the recipient's name, Medicaid identification number, date of service, purpose of contact, describes the provider's interventions, includes the time spent performing the interventions, effectiveness of the intervention, and the signature of the staff providing the service. This service must be ordered by an MD, NP, PA or PhD psychologist. Prior approval will be required via the statewide UR vendor or by an approved LME contracted with the Medicaid Agency and meeting the same standards and requirements as the statewide vendor. This initial prior approval process will ensure that the level of the service is appropriate and concurrent reviews will determine the ongoing medical necessity for the service or the need to move up or down the continuum of services to another level of care. This is a short term service that cannot be provided for more than 30 days in a 12 month period.

13. D. Diagnostic, Screening, Treatment, Preventive and Rehabilitative Services (continued)  
Description of Services

(xv) Ambulatory Detoxification

Ambulatory detox is an organized service delivered by trained practitioners who provide medically supervised evaluations, detoxification and referral services in a licensed facility, according to a predetermined schedule. These services are provided in regularly scheduled sessions by a CCS, LCAS, QP or AP. A physician is available 24/7 to conduct an assessment within 24 hours of admission. A registered nurse is available to conduct a nursing assessment on admission and oversee the monitoring of patient's progress and medications. Documentation must include: a service note that includes the recipient's name, Medicaid identification number, date of service, purpose of contact, describes the provider's interventions, time spent performing the intervention, effectiveness of the intervention, and the signature of the staff providing the service. This service must be ordered by an MD, NP, PA or PhD psychologist. Prior approval will be required via the statewide UR vendor or by an approved LME contracted with the Medicaid Agency and meeting the same standards and requirements as the statewide vendor. This initial prior approval process will ensure that the level of the service is appropriate and concurrent reviews will determine the ongoing medical necessity for the service or the need to move up or down the continuum of services to another level of care.

13. D. Diagnostic, Screening, Treatment, Preventive and Rehabilitative Services (continued)  
Description of Services

(xvi) Non-Hospital Medical Detoxification

Medically monitored detoxification is an organized service by medical and nursing professionals that provides for 24 hour medically supervised evaluations and withdrawal management in a licensed permanent facility affiliated with a hospital or in a freestanding facility of 16 beds or less. It is staffed by CCS, LCAS, CSAC, QP, AP and paraprofessionals. A physician is available 24 hours a day by telephone and 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 patient's progress and medications. Specifics of clinical criteria are included in the definition. The focus of this service is detoxification. Documentation must include: a daily full service note that includes the recipient's name, Medicaid identification number, date of service, purpose of contact, describes the provider's interventions, includes the time spent performing the interventions, effectiveness of the intervention, and the signature of the staff providing the service. This service must be ordered by an MD, NP, PA or PhD psychologist. Prior approval will be required via the statewide UR vendor or by an approved LME contracted with the Medicaid Agency and meeting the same standards and requirements as the statewide vendor. This initial prior approval process will ensure that the level of the service is appropriate and concurrent reviews will determine the ongoing medical necessity for the service or the need to move up or down the continuum of services to another level of care. This is a short term service that cannot be provided for more than 30 days in a 12 month period.

13. D. Diagnostic, Screening, Treatment, Preventive and Rehabilitative Services (continued)  
Description of Services

(xvii) Medically Monitored or Alcohol Drug Addiction Treatment Center Detoxification  
(ADATC)/Crisis Stabilization

This is an organized service delivered by medical and nursing personnel that provides 24 hour medically supervised evaluation and withdrawal management in a licensed permanent facility with 16 or less beds. Services are delivered under a defined set of physician approved policies and physician monitored procedures and clinical protocols. Recipients are often in crisis due to co-occurring severe substance-related mental disorders and are in need of short term intensive evaluation, treatment intervention or behavioral management to stabilize the acute or crisis situation.

- Medically supervised evaluation and withdrawal management,
- Intensive evaluation,
- Treatment interventions,
- Behavioral management to stabilize the acute or crisis situation; and
- Established protocols are established to transfer patients, with severe biomedical conditions who are in need of medical services beyond the capacity of the facility, to the appropriate level of care.

The service has restraint and seclusion capabilities. Recipients are carefully evaluated to ensure they do not need a different level of care. A registered nurse is available to conduct a nursing assessment on admission and oversee the monitoring of patient's progress and medications on an hourly basis. Appropriately licensed and credentialed staff is available to administer medications in accordance with physician's orders. Clinical criteria (medical necessity criteria for admission and continued stay) are imbedded in the definition. Documentation must include: a daily full service note that includes the recipient's name, Medicaid identification number, date of service, purpose of contact, describes the provider's interventions, time spent performing the intervention, effectiveness of the intervention, and the signature of the staff providing the service. This service must be ordered by an MD, NP, PA or PhD psychologist. Prior approval will be required via the statewide UR vendor or by an approved LME contracted with the Medicaid Agency and meeting the same standards and requirements as the statewide vendor. This initial prior approval process will ensure that the level of the service is appropriate and concurrent reviews will determine the ongoing medical necessity for the service or the need to move up or down the continuum of services to another level of care. This is a short term service that cannot be provided for more than 30 days in a 12 month period.

13. D. Behavioral Health Rehabilitative Services (continued)  
Provider Qualifications for Staff Employed by Agencies Enrolled with Medicaid

Supervision is provided as described below:

Covered services are provided to recipients by agencies directly enrolled in the Medicaid program which employ qualified professionals, associate professional and paraprofessionals. Medically necessary services delivered by associate and paraprofessionals are delivered under the supervision and direction of the qualified professional. The qualified professional personally works with consumers to develop the person centered individualized treatment plan and meets with consumers periodically during the course of treatment to monitor the services being delivered and to review the need for continued services. The supervising qualified professional assumes professional responsibility for the services provided by associate and paraprofessionals and spends as much time as necessary directly supervising services to ensure that recipients are receiving services in a safe and efficient manner in accordance with accepted standards of practice. The terms of the qualified professional's employment with the directly enrolled agency providing service ensures that the qualified professional is adequately supervising the associate and paraprofessionals. The agencies ensure that supervisory ratios are reasonable and ethical and provide adequate opportunity for the qualified professional to effectively supervise the associate and paraprofessional staff assigned. Documentation is kept to support the supervision provided to associate and paraprofessional staff in the delivery of medically necessary services.

13. E. Behavioral Health Rehabilitative Services (continued)

Provider Qualifications for Staff Employed by Agencies Enrolled with Medicaid

Providers will meet either the appropriate Federal regulations or the requirements for one of the three categories described on pages 15a.14 and 15a.15.

- i) Paraprofessional  
“Paraprofessional” within the mental health and substance system means an individual who has a GED or high school diploma (or no GED or high school diploma if employed prior to November 1, 2001). Supervision shall be provided by a qualified professional or associate professional with the population served.
- ii) Associate Professional (AP)  
“Associate Professional” within the mental health and substance abuse services system means an individual who is a:
  - graduate of college or university with a Masters degree in a human service field and less than one year of full time post-graduate mental health or substance abuse experience with the population served or a substance abuse professional with less than one year of full-time, post-graduate degree supervised experience in alcoholism and drug abuse counseling. Supervision shall be provided by a qualified professional with the population served until the individual meets one year of experience; or
  - graduate of college or university with a bachelor’s degree in a human service field with less than two years of full-time post-bachelor’s degree mental health or substance abuse experience with the population served, or a substance abuse professional with less than two years post bachelor’s degree accumulated supervised experience in alcoholism and drug abuse counseling. Supervision shall be provided by a qualified professional with the population served until the individual meets two years of experience; or
  - graduate of a college or university with a bachelor’s degree in a field other than human services with less than four years of full-time, post bachelor’s degree accumulated supervised experience in mental health or substance abuse with the population served. Supervision shall be provided by a qualified professional with the population served until the individual meets four years of experience; or
  - registered nurse who is licensed to practice in the State of North Carolina by the North Carolina Board of Nursing with less than four years of full-time accumulated experience in mental health or substance abuse with the population served. Supervision shall be provided by a qualified professional with the population served until the individual meets four years of experience.

13. E. Behavioral Health Rehabilitative Services (continued)  
Provider Qualifications for Staff Employed by Agencies Enrolled with Medicaid

(iii) Qualified Professional (QP)

“Qualified Professional” within the mental health and substance abuse system means:

- an individual who holds a license, provisional license, certificate, registration or permit issued by the governing board regulating a human service profession, except a registered nurse who is licensed to practice in the State of North Carolina by the North Carolina Board of Nursing, who also has four years of full-time accumulated experience in mh/sa with the population served; or
- a graduate of a college or university with a Masters degree in a human service field and one year of full-time, post-graduate degree experience with the population served or a substance abuse professional with one year of full-time, post-graduate degree accumulated supervised experience in alcoholism and drug abuse counseling; or
- a graduate of college or university with a bachelor’s degree in a human service field and two years of full-time, post-bachelor’s degree experience with the population served or a substance abuse professional who has two years full-time, post-bachelor’s degree accumulated supervised alcoholism and drug abuse counseling; or
- a graduate of a college or university with a bachelor’s degree in a field other than human services with four years of full-time, post-bachelors degree accumulated mh/sa experience with the population served.

This category includes Substance Abuse Professional, Certified Substance Abuse Counselors (CSAC), Certified Clinical Supervisor (CCS), Licensed Clinical Addictions Specialist (LCAS) \*

The full descriptions of categories of providers are found in the North Carolina Administrative Code

Supervision is provided as described below:

Covered services are provided to recipients by agencies directly enrolled in the Medicaid program which employ qualified professionals, associate professional and paraprofessionals. Medically necessary services delivered by associate and paraprofessionals are delivered under the supervision and direction of the qualified professional. The qualified professional personally works with consumers to develop the person centered individualized treatment plan and meets with consumers periodically during the course of treatment to monitor the services being delivered and to review the need for continued services. The supervising qualified professional assumes professional responsibility for the services provided by associate and paraprofessionals and spends as much time as necessary directly supervising services to ensure that recipients are receiving services in a safe and efficient manner in accordance with accepted standards of practice. The terms of the qualified professional’s employment with the directly enrolled agency providing service ensures that the qualified professional is adequately supervising the associate and paraprofessionals. The agencies ensure that supervisory ratios are reasonable and ethical and provide adequate opportunity for the qualified professional to effectively supervise the associate and paraprofessional staff assigned. Documentation is kept to support the supervision provided to associate and paraprofessional staff in the delivery of medically necessary services.

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13. D. Behavioral Health Rehabilitative Services (*continued*)

Provider Qualifications for Staff Employed by Agencies Enrolled with Medicaid

Services under this section are provided by licensed practitioners or programs/agencies for the mentally ill, developmentally disabled and substance abusers, certified/licensed as clinical addiction specialists (LCAS) and clinical supervisors (CCS) meeting the program standards of the Commission on Mental Health, Developmental Disabilities and Substance Abuse Services; and who are directly enrolled with Medicaid. These services are available to categorically needy and medically needy beneficiaries.

Services may be provided by:

Licensed or certified psychologists, licensed clinical social workers, licensed clinical social worker associates, certified clinical nurse specialists in psychiatric mental health advanced practice, nurse practitioners certified in psychiatric mental health advanced practice, licensed psychological associates, licensed professional counselors, licensed professional counselor associates, licensed marriage and family therapists, licensed marriage and family therapist associates, certified/licensed clinical addictions specialists, licensed clinical addictions specialist associates, and certified/licensed clinical supervisors.

For individuals under 21, the first 16 visits are unmanaged visits. Unmanaged visits are defined as services that do not require prior approval by a utilization review vendor under the fee for service delivery system. For individuals under 21, Medicaid policy does require that the child or adolescent be referred for these services through the child's Community Care of North Carolina primary care physician, a Medicaid enrolled psychiatrist or the Local Management Entity (LME). The referral is not limited to the primary care physician but does include a choice of referral sources. The referral is requested by the practitioner offering services and is indicated on the request for reimbursement. The reason for the requirement for a referral for children and adolescents is to promote coordination of care including medical and behavioral health services when indicated for this population.

For individuals 21 years and older, the first 8 visits are unmanaged visits. Unmanaged visits are defined as services that do not require prior approval by a utilization review vendor under the fee for service delivery system. Medicaid eligible adults (21 years and older) may be self-referred.

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13. D. Behavioral Health Rehabilitative Services (*continued*)

Provider Qualifications for Staff Employed by Agencies Enrolled with Medicaid

Services include the following:

1. Outpatient Psychotherapy services are individual psychotherapy, family psychotherapy; and group psychotherapy. Psychotherapy, as defined in the current American Medical Association's Current Procedural Terminology (CPT) Manual is the treatment for mental illness as well as substance use disorders in which the clinician through therapeutic communication attempts to alleviate the emotional disturbances and reverse or change maladaptive patterns of behavior. Individual psychotherapy is psychotherapy provided with the licensed clinician and the recipient on a one to one face-to-face basis. Family psychotherapy is psychotherapy provided with the licensed clinician and one or more family members face-to-face. Group psychotherapy is psychotherapy provided with the licensed clinician and more than one recipient face to face. Psychotherapy services may be provided in a variety of settings and psychotherapy may be practiced utilizing a variety of models many of whom have significant evidence backing their efficacy. These models include Behavior Therapy, Cognitive Therapy, Psychodynamic Therapy, Cognitive Behavioral Therapy, and Person-Centered Therapy. Cognitive Therapy is a treatment model that focuses on challenging and changing distorted thinking in order to regain and restore the beneficiary's level of social and emotional functioning and engagement in the community. Psychodynamic Therapy is a treatment model that assumes dysfunctional behavior is caused by unconscious internal conflicts. The focus of treatment is to gain insight into unconscious motives of behavior in order to regain and restore the beneficiary's level of social and emotional functioning and engagement in the community. Cognitive Behavioral Therapy is a treatment model that assumes that maladaptive thinking patterns cause maladaptive behavior as well as negative emotions. The treatment focuses on changing the recipient's thoughts in order to change behavior as well as emotions in order to regain and restore the beneficiary's level of social and emotional functioning and engagement in the community. Person-Centered Therapy is a nondirective treatment model in which the clinician helps the beneficiary increase understanding and awareness of attitudes, feelings, and behavior, in order to regain and restore the beneficiary's level of social and emotional functioning and engagement in the community.

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13. D. Behavioral Health Rehabilitative Services (*continued*)

Provider Qualifications for Staff Employed by Agencies Enrolled with Medicaid

All psychotherapy services are only for the benefit of Medicaid recipients. These services can be furnished by all the North Carolina licensed and certified clinicians listed below. These North Carolina licensed and certified clinicians are: licensed-psychologists, licensed clinical social workers, certified clinical nurse specialists in psychiatric mental health advanced practice, nurse practitioners certified in psychiatric mental health advanced practice, licensed psychological associates, licensed professional counselors, licensed marriage and family therapists, licensed clinical addictions specialists, and certified clinical supervisors. Each of the above listed clinicians is licensed by their respective occupational licensing board and is credentialed to practice independently and it is within their scope of practice to provide individual psychotherapy, family psychotherapy, and group psychotherapy.

2. Psychological testing (e.g., Minnesota Multiphasic Personality Inventory, Rorschach, and Wechsler Adult Intelligence Scale) includes written, visual, or verbal evaluations administered to assess the cognitive and emotional functioning of recipients. Developmental testing (e.g., Developmental Screening Test, Bayley Scales of Infant and Toddler Development, Mullen Scales of Early Learning) includes assessment of motor, language, social, adaptive and/or cognitive functioning by standardized developmental instruments. Neuro-behavioral testing (e.g., Halstead-Reitan, Wechsler Memory Scales, and Wisconsin Card Sorting Test) includes standard tests designed to evaluate different aspects of the functioning of the central nervous system, including attention, motor performance, perceptual coding, learning, memory and affect.

These services can only be furnished by PhD and Master's Level Psychologist, licensed in the State of North Carolina." These individuals have, within the scope of their practice, the ability to perform psychological testing, developmental testing, and neurobehavioral testing. However, each individual psychologist must also have the training and experience required in order to ethically provide each of these assessments according to the requirements of the North Carolina Psychology Board.

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13. D. Behavioral Health Rehabilitative Services (*continued*)

Provider Qualifications for Staff Employed by Agencies Enrolled with Medicaid

Psychological testing, developmental testing, and neuro-behavioral testing should result in recommendations regarding the need for rehabilitative treatment which may include outpatient services and should result in recommendations for type, duration, frequency, or amount of rehabilitative services.

- B. All disciplines are licensed or credentialed by the State as mental health clinicians and can practice independently with oversight by their individual boards. Nurse Practitioners must have oversight by the Medical Board, while Licensed Psychological Associates must have supervision by a PhD to bill certain services. This type of requirement does not exist for the other disciplines.

Certified/Licensed Clinical Supervisors (CCS) and Certified/Licensed Clinical Addictions Specialists (CCAS) requirements have been approved by the Division of Mental Health/Developmental Disabilities/Substance Abuse Services and are able to practice independently to provide counseling services only.

- C. Behavioral assessment and counseling codes may be furnished and billed by all clinicians. CPT codes or counseling codes should be used to define services provided not based on discipline.

- C. High Risk Intervention services for EPSDT eligible children are provided under this section. The services comprise a treatment component package, which may be provided in supervised residential settings. A physician or a Ph.D. psychologist orders these services. A treatment plan must be in place. The population served is for children under 21 years of age that have mental health or substance abuse service needs. This service would only be provided for the developmentally disabled population less than 21 years of age if they have a dual diagnosis, MR along with MI or SA, and medical necessary services are needed for MI/SA. The CFR reference is CFR 42 440. 130. The residential living situation is not compensated for room and board.

High Risk Intervention services has four levels of care.

#### Level I

Level I is a low to moderate structured and supervised environment level of care provided in a family setting. Services provided include: mentoring, minimal staff/support/supervision in all identified need areas, minimal assistance with adaptive skill training in all functional domains, behavioral interventions for mildly disruptive behaviors, minimal assistance with community integration activities, and stress management. Modeling, providing positive reinforcement when needed, teaching social skills, daily living skills, anger management, family living skills and communication skills are all part of the treatment component.

#### Level II

Level II is a moderate to high structured supervised environment level of care provided in a group home (a minimum of one staff is required per four consumers at all times) or a family setting (one or two consumers per home). This service in the family or program settings includes all of Level I elements plus provision of a more intensive corrective relationship in which therapeutic interactions are dominant. There is a higher level of supervision and structure. Provider requirements for Program Type Residential Treatment is a high school education/GED or an associate degree with one year experience; or a four-year degree in the human service field; and / or must meet requirements established by the state personnel system or equivalent for job classifications.

Skills and competencies of this service provider must be at a level, which offer psychoeducational relational support, behavioral modeling interventions and supervision. Additionally, special training of the caregiver is required in all aspects of sex offender specific treatment. A qualified professional is also available oncall. Implementation of therapeutic gains is to be the goal of the placement setting.

### Level III

Level III is a highly structured and supervised environment level of care in a program setting only. All elements of Family/Program-Type Residential Treatment (Levels I, II) are provided plus intensified structure, supervision, and containment of frequent and highly inappropriate behavior. This setting is typically defined as being “staff secure”. Staff is present and available at all times of the day, including overnight awake.

A minimum of one staff is required per four consumers at all times. Staffing requirements are: minimal requirement is a high school diploma/GED, associate degree with one year experience; or a four-year degree in the human service field and / or a combination of experience, skills, and competencies that is equivalent. Skills and competencies of this service provider must be at a level which offer psychoeducational relational support, and behavioral modeling interventions and supervision and / or must meet requirements established by the state personnel system or equivalent for job classifications. These preplanned, therapeutically structured interventions occur as required in all aspects of sex offender specific treatment. Implementation of therapeutic gains is to be the goal of the placement setting. Additionally, consultative and treatment services at a Qualified Professional level shall be available no less than four hours per week. This staff may include a social worker, psychologist, or a psychiatrist. These services must be provided at the facility.

### Level IV

Level IV is a level of care provided in a physically secure, locked environment in a program setting. All elements of Level III care are included in Level IV plus ability to to manage intensive levels of aggressiveness. Supervision is continuous. Staff is present and available at all times of the day, including overnight awake. A minimum of two direct care staff are required per six consumers at all times. Additionally, consultative and treatment services at a Qualified Professional level shall be available no less than eight hours per week. Staffing provisions apply as with Level III. Provider requirements are as follows: minimal requirement is a high school diploma / GED, associate degree with one year experience or a four-year degree in the human service field and / or a combination of experience, skills and competencies that is equivalent.

Skills and competencies of this service provider must be at a level that include structured interventions in a contained setting to assist the consumer in acquiring control over acute behaviors. In addition, special training of the caregiver is required in all aspects of sex offender specific treatment; and /or the provider must meet requirements established by the state personnel system or the equivalent for job classifications. Implementation of therapeutic gains is to be the goal of the placement setting.

14.b Services for Individuals Age 65 or Older in Institutions for  
Mental Disease

(1) Inpatient Hospital Services

The state agency may grant a maximum of three administrative days to arrange for discharge of a patient to a lower level-of-care. With prior approval by the State Medicaid Agency, the hospital may be reimbursed for days in excess of the three administrative days at the statewide average rate for the particular level-of-care needed in the event a lower level-of-care bed in a Medicaid approved health care institution is not available. The hospital must, however, make every effort to place the

recipient in an appropriate institution within the three day administrative time allowance.

(3) Intermediate care facility services.

(a) Prior approval is required in the following circumstances:

- (1) All admissions to intermediate care facilities.
- (2) All utilization Review Committee recommendations that require change in the level of care; however, these recommendations will be taken into consideration at the time of review.
- (3) Patients seeking Title XIX assistance in an intermediate care facility who were previously private pay or insured by a third party carrier.
- (4) When a patient is discharged from an intermediate care facility to a lower level of care or to his own home, and later returns to a level of care that requires prior approval.
- (5) When a Medicaid patient's benefits are terminated for 90 days or more before reinstatement, even though the patient remains in the same facility.

(b) Circumstances that DO NOT Require Prior Approval for Intermediate Care:

- (1) An approved patient who is hospitalized and returns to the previously approved level of care.
- (2) An approved ICF patient who leaves the facility for an overnight stay provided the absence is authorized by the attending physician.
- (3) The Independent Professional Review Team recommends a change in level of care. These recommendations will be accepted.

- (c) The form approved for ICF placement is valid for 60 days. If a patient has not been placed during this period of validity, the state or its designated agency should be contacted. At this time, the reviewing nurse will re-evaluate the form and determine if more current information is needed.

15. Intermediate Care Facility Services

Limitations and prior approval same as described in Item 14.b.(3).

- a. Intermediate Care Services Including Such Services in a Public Institution for the Mentally Retarded

Limitations and prior approval same as described in Item 14.b.(3).

16. Inpatient Psychiatric Facility Services for Individuals Under 21

The state agency may grant a maximum of three administrative days to arrange for discharge of a patient to a lower level-of-care. With prior approval by the State Medicaid Agency, the hospital may be reimbursed for days in excess of the three administrative days at the statewide average rate for the particular level of care needed in the event a lower level-of-care bed in a Medicaid approved health care institution is not available. The hospital must, however, make every effort to place the recipient in an appropriate institution within the three day administrative time allowance.

Admissions for all out of state psychiatric hospitals including those enrolled as border psychiatric hospitals are subject to prior approval for necessity to go out of state. Services in out-of-state hospitals are provided only to the same extent and under the same conditions as medical services provided in North Carolina.

23.a. Transportation

Services provided by an ambulance provider under the Medicaid program must be demonstrated to be medically necessary and are subject to limitations described herein. Medical necessity is indicated when the patient's condition is such that any other means of transportation would endanger the patient's health. Ambulance transportation is not considered medically necessary when any other means of transportation can be safely utilized.

- a. Emergency ambulance transportation for the client to receive immediate and prompt medical services arising in an emergency situation. Emergency transportation to a physician's office is covered only if all the following conditions are met:
  - (1) The patient is enroute to a hospital.
  - (2) There is medical need for a professional to stabilize the patient's condition.
  - (3) The ambulance continues the trip to the hospital immediately after stabilization.
- b. Non-emergency ambulance transportation to and from a physician directed office/clinic or other medical facility in which the individual is an inpatient is covered in the following situations:
  - (1) Medical necessity is indicated when the use of other means of transportation is medically contraindicated because it would endanger the patient's health. This refers to clients whose medical condition requires transport by stretcher.
  - (2) Client is in need of medical services that cannot be provided in the place of residence.
  - (3) Return transportation from a facility which has capability of providing total care for every aspect of injury/disease to a facility which has fewer resources to offer highly specialized care.
- c. In order to claim Medicaid reimbursement, providers of ambulance services must be able to document that ambulance services were medically necessary.
  - (1) The UB-92 claim form must describe the recipient's medical condition at the time of transport by using appropriate condition codes to demonstrate that transportation by any other means would be medically inappropriate.
  - (2) A legible copy of the ambulance call report to support the condition codes used must be kept on file by the provider for five (5) years which indicates:
    - a. the purpose for transport,
    - b. the treatments,
    - c. the patient's response; and
    - d. the patient's condition that sufficiently justifies transport by stretcher was medically necessary.
- d. Prior approval is required for non-emergency transportation for recipients to receive out-of-state services or to return to North Carolina or nearest appropriate facility.

23.d. Skilled Nursing Facility Services for Patients Under 21 Years of Age

Limitations and prior approval same as described in Item 4.a. Skilled Nursing Facility Services.

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**24f. Personal Care Services:**

**SERVICES**

Personal care services (PCS) include a range of human assistance provided to persons of all ages with disabilities and chronic conditions to enable them to accomplish tasks that they would ordinarily do for themselves if they were not disabled. These PCS are intended to provide person-to-person, hands-on assistance by a PCS direct care worker in the beneficiary's home or residential setting with common activities of daily living (ADLs) that, for this program are eating, dressing, bathing, toileting, and mobility. PCS also include: assistance with instrumental activities of daily living (IADLs), such as light housekeeping tasks, when directly related to the approved ADLs and the assistance is specified in the beneficiary's plan of care. PCS is provided by a direct care worker who is employed by a licensed home care agency, or by a residential facility licensed as an adult care home, family care home, supervised living facility, or combination home, and who meets the qualifications specified on Attachment 3.1-A.1, Pages 23-29, section c.

In addition to the specified assistance with ADLs and IADLs, qualified PCS direct care workers may also provide Nurse Aide I and Nurse Aide II tasks as specified on Attachment 3.1-A.1, Pages 23-29, section c., pursuant to the North Carolina Board of Nursing as described in 21 NCAC 36.0403 and as specified in the beneficiary's approved plan of care.

**ELIGIBILITY**

**To qualify for PCS, an adult or child must:**

- Be referred for PCS by his or her primary care or attending physician;
- Be medically stable;
- Not require monitoring, (observation resulting in intervention), supervision (precautional observation) or ongoing care from a licensed health care professional; and

**Require hands-on assistance with at least:**

- a. Three of the five qualifying ADLs at the limited level; or
- b. Two of the five qualifying ADLs, one of which is at the extensive level; or
- c. Two of the five qualifying ADLs, one of which is at the full dependency level.

Recipients not qualifying for additional PCS hours under EPSDT may qualify for up to 50 additional hours of Medicaid PCS assistance by a physician attestation that the Medicaid recipients meets the eligibility criteria provided in Session Law 203-306, Section 10.99F.(c)(3) and (a-d) below:

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24f. **Personal Care Services (continued):**

- (a) Requires an increased level of supervision (precautional observation) as assessed during an independent assessment conducted by State Medicaid Agency or entity designated by State Medicaid Agency;
- (b) Requires caregivers with training or experience in caring for individuals who have a degenerative disease characterized by irreversible memory dysfunction, that attacks the brain and results in impaired memory, thinking, and behavior, including gradual memory loss, impaired judgment, disorientation, personality change, difficulty learning, and the loss of language skills;
- (c) Regardless of setting, requires a physical environment that addresses safety and safeguards the beneficiary because of the recipient's gradual memory loss, impaired judgment, disorientation, personality change, difficulty learning, and loss of language skill; and
- (d) Medical documentation or verifiable information provided by a caregiver obtained during the independent assessment reflects a history of escalating safety concerns related to inappropriate wandering, ingestion, aggressive behavior, and an increased incidence of falls.

Each ADL is scored at one of five levels of self-performance or assistance. Totally Able and Cueing/Supervision levels of need do not entail hands-on assistance and are not qualifying levels of need for PCS. The three qualifying levels of need are Limited Hands-On Assistance, Extensive Hands-On Assistance, and Full Dependence.

**The five levels of need are defined as follows:**

- Totally Able- Beneficiary is able to self-perform 100 percent of activity, with or without aides or assistive devices, and without supervision or assistance setting up supplies and environment.
- Cueing/Supervision- Beneficiary is able to self-perform 100 percent of activity, with or without aides or assistive devices, and requires supervision, monitoring, or assistance retrieving or setting up supplies or equipment.
- Limited Hands-On Assistance- Beneficiary is able to self-perform more than 50 percent of activity and requires hands-on assistance to complete remainder of activity.
- Extensive Hands-On Assistance- Beneficiary is able to self-perform less than 50 percent of activity and requires hands-on assistance to complete remainder of activity.
- Full Dependence- Beneficiary is unable to perform any of the activity and is totally dependent on another to perform all of the activity.

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**24f. Personal Care Services (continued):**

**Service Limitations:**

1. Up to 130 hours per month for adults,
2. Up to 60 hours per month for children. Pursuant to section 1905(r)(5) of the Social Security Act, the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit requires that states provide all medically necessary services coverable under the Medicaid program to EPSDT eligible children. Hours above the 60 hours may be provided to children through the EPSDT allowance; and
  - Services levels must be re-assessed and re-authorized at least annually.

**Service Exclusions:**

- a. Services provided in an unauthorized location;
- b. Services provided by unauthorized individuals or providers;
- c. The beneficiaries primary need is housekeeping or homemaking;
- d. The IADLs performed are not directly related to the approved ADLs or as specified in the beneficiaries plan of care;
- e. In the event that the services provided in a month exceed a beneficiary's authorized monthly limit, services that exceed the authorized level will not be reimbursed;
- f. The services provided are not in accordance with the person-centered plan of care;
- g. Companion sitting or leisure time activities;

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1. Continuous monitoring or ongoing beneficiary supervision except when approved under the EPSDT program based on a determination of medical necessity;
  2. Financial management;
  3. Errands; and
  4. Personal care or home management tasks for other residents of the household

North Carolina assures that personal care services do not include, and FFP is not available for, services to individuals residing in institutions for mental disease (IMD).

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24f. **Personal Care Services (cont.):**

**PERSONAL CARE SERVICES (PCS) AGENCY/ENTITY AND DIRECT CARE WORKER  
QUALIFICATIONS**

- a. **Each PCS agency/entity must be enrolled with NC Medicaid.**
- b. To ensure that the PCS direct care workers are properly supervised, and that PCS services are available in a range of settings, and not as a limitation on the availability of services; PCS Agency/Entity providers are required to perform the following activities to comply with state laws and rules:
1. Complete background checks on all employees;
  2. Conduct trainings;
  3. Monitor quality of care;
  4. Develop a beneficiary plan of care; and
  5. Ensure that PCS direct care workers work under ~~the~~ supervision as specified in licensure requirements;

PCS agency/entity and direct care worker qualifications continue on Attachment 3.1-A.1, Pages 23-29.

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**PERSONAL CARE SERVICES (PCS) AGENCY /ENTITY & DIRECT CARE WORKER QUALIFICATIONS (continued)**

c. PCS agency/entity provider definitions and direct care worker minimum qualifications, minimum training requirements, and additional staffing requirements are as follows:

	<b>AGENCY/ENTITY PROVIDER</b>				
	<b>ADULT CARE HOME</b>	<b>FAMILY CARE HOME</b>	<b>COMBINATION HOME</b>	<b>SUPERVISED LIVING</b>	<b>HOME CARE AGENCIES</b>
<b>Agency/Entity Provider Definitions</b>	Adult Care Homes licensed as a residential facility as defined under 131D-2 101 (1a) and licensed by the State of North Carolina as an adult care home or family care home or; a combination home as defined in G.S. 131E-101(1a).	Adult care homes that provide care to two to six unrelated residents are commonly called family care homes. G.S. 131D-2.1	In accordance to G.S. 131E-101, a combination home, as distinguished from a nursing home, means a facility operated in part as a nursing home, and which also provides residential care for aged or disabled persons whose principal need is a home with the shelter or personal care their age or disability requires. Services to the resident in an adult care home bed within the combination home are distinct from NF beds	A group home licensed under G.S. 122C and under 10A NCAC 27G .5601 as a supervised living facility for two or more adults whose primary diagnosis is mental illness, a developmental disability, or substance abuse dependency	Home care agencies as defined under G.S. 131E-136 (2) and licensed by the State of North Carolina as a home care agency under 10A NCAC 13J;"Home care agency" means a private or public organization that provides home care services.

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PERSONAL CARE SERVICES (PCS) AGENCY /ENTITY & DIRECT CARE WORKER QUALIFICATIONS (continued)

	AGENCY/ENTITY PROVIDER				
	ADULT CARE HOME	FAMILY CARE HOME	COMBINATION HOME	SUPERVISED LIVING	HOME CARE AGENCIES
			in that services do not meet the NF level of care criteria, MDS process is not used, cannot be billed at the NF case rate, and any medical care is incidental. An adult care home bed in a combination home provides the residential care to aged or disabled who demonstrate unmet needs for personal care. While medical care is incidental services center on unmet activities of daily living such as assistance with bathing, dressing, toileting, ambulation, and eating.		
<b>Direct Care Worker Minimum Qualifications</b>	18 years of age or; high school graduates or equivalent	18 years of age or; high school graduates or equivalent	18 years of age or; high school graduates or equivalent	18 years of age or; high school graduates or equivalent	18 years of age or; high school graduates or equivalent
PCS Direct Care Worker_Minimal Training Requirements	<ol style="list-style-type: none"> <li>1) Beneficiary rights;</li> <li>2) Confidentiality and Privacy Practices;</li> <li>3) Personal Care Skills               <ol style="list-style-type: none"> <li>a) Assistance with Bathing</li> <li>b) Assistance with Toileting</li> </ol> </li> </ol>	<ol style="list-style-type: none"> <li>1) Beneficiary rights;</li> <li>2) Confidentiality and Privacy Practices;</li> <li>3) Personal Care Skills               <ol style="list-style-type: none"> <li>a) Assistance with Bathing</li> <li>b) Assistance with Toileting</li> </ol> </li> </ol>	<ol style="list-style-type: none"> <li>1) Beneficiary rights;</li> <li>2) Confidentiality and Privacy Practices;</li> <li>3) Personal Care Skills               <ol style="list-style-type: none"> <li>a) Assistance with Bathing</li> <li>b) Assistance with Toileting</li> </ol> </li> </ol>	<ol style="list-style-type: none"> <li>1) Beneficiary rights;</li> <li>2) Confidentiality and Privacy Practices;</li> <li>3) Personal Care Skills               <ol style="list-style-type: none"> <li>a) Assistance with Bathing</li> <li>b) Assistance with Toileting</li> </ol> </li> </ol>	<ol style="list-style-type: none"> <li>1) Beneficiary rights;</li> <li>2) Confidentiality and Privacy Practices;</li> <li>3) Personal Care Skills               <ol style="list-style-type: none"> <li>a) Assistance with Bathing</li> <li>b) Assistance with Toileting</li> </ol> </li> </ol>

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**PERSONAL CARE SERVICES (PCS) AGENCY /ENTITY & DIRECT CARE WORKER QUALIFICATIONS (continued)**

	AGENCY/ENTITY PROVIDER				
	ADULT CARE HOME	FAMILY CARE HOME	COMBINATION HOME	SUPERVISED LIVING	HOME CARE AGENCIES
	c) Assistance with Mobility d) Assistance with Dressing e) Assistance with Eating 4) Training about providing care to individuals with impaired judgment, disorientation, loss of language skills, inappropriate behaviors, like wandering that are resulting from the exacerbation of dementia 5) Documentation and Reporting of beneficiary accidents and incidents; 6) Recognizing and Reporting Signs of Abuse and Neglect; 7) Infection Control	c) Assistance with Mobility d) Assistance with Dressing e) Assistance with Eating 4) Training about providing care to individuals with impaired judgment, disorientation, loss of language skills, inappropriate behaviors, like wandering that are resulting from the exacerbation of dementia 5) Documentation and Reporting of beneficiary accidents and incidents; 6) Recognizing and Reporting Signs of Abuse and Neglect; 7) Infection Control	c) Assistance with Mobility d) Assistance with Dressing e) Assistance with Eating 4) Training about providing care to individuals with impaired judgment, disorientation, loss of language skills, inappropriate behaviors, like wandering that are resulting from the exacerbation of dementia 5) Documentation and Reporting of beneficiary accidents and incidents; 6) Recognizing and Reporting Signs of Abuse and Neglect; 7) Infection Control	c) Assistance with Mobility d) Assistance with Dressing e) Assistance with Eating 4) Training about providing care to individuals with impaired judgment, disorientation, loss of language skills, inappropriate behaviors, like wandering that are resulting from the exacerbation of dementia 5) Documentation and Reporting of beneficiary accidents and incidents; 6) Recognizing and Reporting Signs of Abuse and Neglect; 7) Infection Control	b) Assistance with Mobility c) Assistance with Dressing d) Assistance with Eating 4) Training about providing care to individuals with impaired judgment, disorientation, loss of language skills, inappropriate behaviors, like wandering that are resulting from the exacerbation of dementia 5) Documentation and Reporting of beneficiary accidents and incidents; 6) Recognizing and Reporting Signs of Abuse and Neglect; 7) Infection Control

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PERSONAL CARE SERVICES (PCS) AGENCY /ENTITY & DIRECT CARE WORKER QUALIFICATIONS (continued)

	AGENCY/ENTITY PROVIDER				
	ADULT CARE HOME	FAMILY CARE HOME	COMBINATION HOME	SUPERVISED LIVING	HOME CARE AGENCIES
<b>Additional Staffing Qualifications</b>	<p><b>1. Personal Care Aide:</b> Personal Care Aides providing services in the Adult Care Home must meet the staff orientation, training, competency, and continuing education requirements specified in licensure requirements, including successful completion of an 80-hour personal care training and competency evaluation program established by DHHS. The training must be successfully completed within six months of hiring.</p>	<p><b>1. Personal Care Aide:</b> Personal Care Aides providing services in the Adult Care Home must meet the staff orientation, training, competency, and continuing education requirements specified in licensure requirements, including successful completion of an 80-hour personal care training and competency evaluation program established by DHHS. The training must be successfully completed within six months of hiring.</p>	<p><b>1. Personal Care Aide:</b> Personal Care Aides providing services in the Adult Care Home must meet the staff orientation, training, competency, and continuing education requirements specified in licensure requirements, including successful completion of an 80-hour personal care training and competency evaluation program established by DHHS. The training must be successfully completed within six months of hiring.</p>	<p><b>1. Paraprofessionals:</b> Staff must meet the requirements for paraprofessionals in 10A NCAC 27G.0200. Staff must have a high school diploma or GED. Staff must meet participant specific competencies as identified by the participant's person-centered planning team and documented in the Person Centered Plan. Staff must successfully complete First Aid, CPR and DMH/DD/SAS Core Competencies and</p>	<p><b>1. Personal Care Aides:</b> Personal Care Aides providing services <b>for</b> the Home Care Agencies must meet the staff orientation, training, competency, and continuing education requirements specified in licensure requirements. <b>Home Care Agency: 10A NCAC 13J</b> <a href="http://www.ncdhhs.gov/dhsr/ahc/rules.html">http://www.ncdhhs.gov/dhsr/ahc/rules.html</a> In-home aides shall follow instructions for client care written by the health care practitioner required for the services provided. In-home aide duties may help with prescribed exercises which the client and in-home aides have been taught by a health care practitioner licensed pursuant to G.S. 90; provide or assist with personal care (i.e., bathing, care of mouth, skin and hair); assist with ambulation; assist client with self-administration of medications which are ordered by a physician or other person authorized by state law to prescribe; perform incidental household services which are essential to the client's care at home; and record and report changes in the client's condition, family situation or needs to an appropriate health care practitioner.</p>

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**PERSONAL CARE SERVICES (PCS) AGENCY /ENTITY & DIRECT CARE WORKER QUALIFICATIONS (continued)**

AGENCY/ENTITY PROVIDER				
ADULT CARE HOME	FAMILY CARE HOME	COMBINATION HOME	SUPERVISED LIVING	HOME CARE AGENCIES
2. Nurse Aide I: Nurse Aides at this level are listed on the North Carolina Nurse Aide Registry and perform basic nursing skills and personal care activities. Nurse Aide I activities are delegated by a licensed nurse based on	2. Nurse Aide I: Nurse Aides at this level are listed on the North Carolina Nurse Aide Registry and perform basic nursing skills and personal care activities. Nurse Aide I activities are delegated by a licensed nurse based on the knowledge, skill,	2. Nurse Aide I: Nurse Aides at this level are listed on the North Carolina Nurse Aide Registry and perform basic nursing skills and personal care activities. Nurse Aide I activities are delegated by a	required refresher training. Paraprofessionals providing this service must be supervised by a Qualified Professional. Supervision must be provided according to supervision requirements specified in 10A NCAC 27G.0204 and according to licensure or certification requirements of the appropriate discipline. Must have a criminal record check A healthcare registry check is required in accordance with 10A NCAC 27G.0200	2. Nurse Aide I: Nurse Aides at this level are listed on the North Carolina Nurse Aide Registry and perform basic nursing skills and personal care activities. Nurse Aide I activities are delegated by a licensed nurse based on the knowledge, skill, training, and competence of the individual aide. Nurse Aides at this level must successfully complete an orientation program specific to the employing facility, and must successfully complete a training and competency evaluation approved by DHHS. The training and competency evaluation program must be successfully completed within four months of the employment date. During the four month

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	<b>AGENCY/ENTITY PROVIDER</b>				
	<b>ADULT CARE HOME</b>	<b>FAMILY CARE HOME</b>	<b>COMBINATION HOME</b>	<b>SUPERVISED LIVING</b>	<b>HOME CARE AGENCIES</b>
	the knowledge, skill, training, and competence of the individual aide. Nurse Aides at this level must successfully complete an orientation program specific to the employing facility, and must successfully complete a training and competency evaluation approved by DHHS. The training and competency evaluation program must be successfully completed within four months of	training, and competence of the individual aide. Nurse Aides at this level must successfully complete an orientation program specific to the employing facility, and must successfully complete a training and competency evaluation	licensed nurse based on the knowledge, skill, training, and competence of the individual aide. Nurse Aides at this level must successfully complete an orientation program specific to the employing facility, and must successfully complete a training and competency evaluation		period, the individual is assigned, and performs under supervision, only tasks for which he or she has demonstrated competence.

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	AGENCY/ENTITY PROVIDER				
	ADULT CARE HOME	FAMILY CARE HOME	COMBINATION HOME	SUPERVISED LIVING	HOME CARE AGENCIES
	the employment date. During the four month period, the individual is assigned, and performs under supervision, only tasks for which he or she has demonstrated competence.	approved by DHHS. The training and competency evaluation program must be successfully completed within four months of the employment date. During the four month period, the individual is assigned, and performs under supervision, only tasks for which he or she has demonstrated competence.	approved by DHHS. The training and competency evaluation program must be successfully completed within four months of the employment date. During the four month period, the individual is assigned, and performs under supervision, only tasks for which he or she has demonstrated competence.		

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**PERSONAL CARE SERVICES (PCS) AGENCY /ENTITY & DIRECT CARE WORKER QUALIFICATIONS (continued)**

	AGENCY/ENTITY PROVIDER				
	ADULT CARE HOME	FAMILY CARE HOME	COMBINATION HOME	SUPERVISED LIVING	HOME CARE AGENCIES
	<p><b>3. Nurse Aide II:</b> Nurse Aides at this level are authorized to perform more complex nursing skills with emphasis on sterile technique in elimination, oxygenation, and nutrition, after successful completion of state-approved Nurse Aide II training program and competency evaluation program.</p>	<p><b>3. Nurse Aide II:</b> Nurse Aides at this level are authorized to perform more complex nursing skills with emphasis on sterile technique in elimination, oxygenation, and nutrition, after successful completion of state-approved Nurse Aide II training program and competency evaluation program.</p>	<p><b>3. Nurse Aide II:</b> Nurse Aides at this level are authorized to perform more complex nursing skills with emphasis on sterile technique in elimination, oxygenation, and nutrition, after successful completion of state-approved Nurse Aide II training program and competency evaluation program.</p>	<p><b>3. Nurse Aide II:</b> Nurse Aides at this level are authorized to perform more complex nursing skills with emphasis on sterile technique in elimination, oxygenation, and nutrition, after successful completion of state-approved Nurse Aide II training program and competency evaluation program.</p>	<p><b>3. Nurse Aide II:</b> Nurse Aides at this level are authorized to perform more complex nursing skills with emphasis on sterile technique in elimination, oxygenation, and nutrition, after successful completion of state-approved Nurse Aide II training program and competency evaluation program.</p>