# Policy is terminated because coverage is provided under the combined Medicaid and Health Choice 8A, Enhanced Mental Health and Substance Abuse Services

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# 1.0 Description of the Procedures, Products, or Services

This document describes policies and procedures that Medicaid-enrolled Health Choice providers must follow to receive reimbursement for covered enhanced benefit behavioral health services provided to eligible Health Choice recipients ages 6 through 18. It sets forth the basic requirements for qualified providers to bill mental health and substance abuse services to Health Choice.

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

**a.** *Rules for Mental Health, Developmental Disabilities and Substance Abuse Facilities and Services,* APSM 30-1

**b.** DMH/DD/SAS *Records Management and Documentation Manual,* APSM 45-2

**c.** DMH/DD/SAS *Person-Centered Planning Instruction Manual*

**d.** Chapter 122-C of the NC General Statutes, *Mental Health, Developmental Disabilities, and Substance Abuse Act of 1985*

# 2.0 Eligible Recipients

## 2.1 General Provisions

To be eligible, NC Health Choice (NCHC) recipients must be enrolled on the date of service.

This policy applies to a NCHC recipient who is 6 through 18 years of age and meets the coverage criteria in this policy.

# 3.0 When Procedures, Products, and Services Are Covered

## 3.1 General Criteria

Health Choice covers procedures, products, and services related to this policy when they are medically necessary and

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

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

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

**CPT codes, descriptors, and other data only are copyright 2010 American Medical Association. All rights reserved. Applicable FARS/DFARS apply**.

### 3.2 Specific Criteria

All Health Choice services are based upon a finding of medical necessity, which is determined by generally accepted North Carolina community practice standards as verified by independent Utilization Review consultants. There must be a current diagnosis reflecting the need for treatment. All covered services must be medically necessary for meeting specific preventive, diagnostic, therapeutic, and rehabilitative needs of the individual.

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

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

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

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

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

## 4.0 When Procedures, Products, and Services Are Not Covered

### 4.1 General Criteria

Procedures, products, and services related to this policy are not covered when

a. the recipient does not meet the eligibility requirements listed in **Section 2.0;**

b. the recipient does not meet the medical necessity criteria listed in **Section 3.0;**

c. the procedure, product, or service unnecessarily duplicates another provider's procedure; or

d. the procedure, product, or service is experimental, investigational, or part of a clinical trial.

## 5.0 Requirements for and Limitations on Coverage

### 5.1 Prior Approval

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

Mobile Crisis Management
Diagnostic Assessment
SAIOP

### 5.2 Prior Approval Requirements

The provider(s) shall submit to DMA's Utilization Review vendor the following:

a. the prior approval request; and

b. all health care records and any other records that support whether the NCHC recipient has met the specific criteria in **Subsection 3.2** of this policy.

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Utilization management of covered services is a part of the assurance of medically necessary service provision. Authorization, which is an aspect of utilization management, validates approval to provide a medically necessary covered service to eligible recipients.

## 5.3 Other Requirements or Limitations

All services have specific requirements and limitations on coverage. Additional information and exceptions to the information in this section may be found in the service definitions in **Attachment E** and in the authorities listed in **Section 1.0** of this policy.

### 5.3.1 Service Orders

Service orders are a mechanism to demonstrate medical necessity for a service and are based upon an assessment of each individual's needs. They are required for each individual service and may be written by a physician, licensed psychologist, nurse practitioner, or physician assistant.

- Backdating of service orders is not allowed. (Refer to **Attachment E, Service Definitions,** for the basic criteria to ensure medical necessity).
- Each service order must be signed and dated by the authorizing professional and must indicate the *date* on which the service was ordered.
- A service order must be in place *prior* to or on the day that the service is initially provided. Even if the recipient is retroactively eligible for Health Choice, the provider will not be able to bill Health Choice without a valid service order.

Service orders are valid for one year from the Date of Plan entered on a Person Centered Plan. Medical necessity must be reviewed, and services must be ordered at least annually, based on the Date of Plan. (Refer to the DMH/DD/SAS *Person-Centered Planning Instruction Manual* and the DMH/DD/SAS *Records Management and Documentation Manual* for additional information on service orders, signatures, and the Date of Plan).

### 5.3.2 Health Choice Service Summary

| Health Choice Service | Must be Ordered By |
|---|---|
| Day Treatment—Child and Adolescent | MD<br>DO<br>Licensed psychologist [that is, a Health Services Provider—Psychologist (HSP-P)]<br>NP<br>PA |
| Diagnostic/ Assessment | |
| Intensive In-home Services | |
| Mobile Crisis Management | |
| Multisystemic Therapy | |
| Partial Hospitalization | |
| Substance Abuse Intensive Outpatient Service | |
| Ambulatory Detoxification | |
| | |
| Outpatient Opioid Treatment | MD, DO |

### 5.3.3 Clinical/Professional Supervision

Covered services are provided to recipients by agencies that are directly enrolled in the Medicaid program and that employ Licensed Professionals (LPs), Qualified Professionals (QPs), Associate Professionals (APs), and Paraprofessionals. Clinical/professional supervision must be provided according to the supervision and staffing requirements outlined in each service definition. Medically necessary services delivered by Associate Professionals are delivered under the supervision and direction of the Licensed

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Professional or Qualified Professional. Medically necessary services delivered by Paraprofessionals are delivered under the supervision and direction of the Licensed Professional, Qualified Professional, or, when the service definition does not specify a more stringent supervision requirement, an Associate Professional. Supervision shall be provided at the frequency and for the duration indicated in the individualized supervision plan created for each Associate Professional and Paraprofessional upon hire. Each supervision plan must be reviewed annually.

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

The terms of employment with the directly enrolled provider agency must specify that each supervising professional is to provide adequate supervision for the Associate Professionals, Paraprofessionals, and other staff in the agency who are assigned to him or her. The provider agency must ensure that supervisory ratios meet any requirements that are specified in the service definition, are reasonable and ethical, and provide adequate opportunity for the supervising professional to effectively supervise the staff member(s) assigned. Documentation must be kept on file to support the supervision provided to Associate Professional and Paraprofessional staff in the delivery of medically necessary services.

### 5.3.4 Person Centered Plans

Services covered by this policy require a Person-Centered Plan. Refer to the service definitions in **Attachment E,** the DMH/DD/SAS *Person-Centered Planning Instruction Manual*, and the DMH/DD/SAS *Records Management and Documentation Manual* for specific information.

The primary reference document for person-centered planning and Person Centered Plans is the DMH/DD/SAS *Person-Centered Planning Instruction Manual*. The guidance offered throughout **Subsection 5.5** is derived from it.

#### 5.3.4.1 Person-Centered Planning

Person-centered planning is a process of determining real-life outcomes with individuals and developing strategies to achieve those outcomes. The process supports strengths, rehabilitation, and recovery and applies to everyone supported and served in the system. Person-centered planning provides for the individual with the disability to assume an informed and in-command role for life planning and for treatment, service, and support options. The individual with a disability, the legally responsible person, or both direct the process and share authority and responsibility with system professionals for decisions made.

For all individuals receiving services, it is important to include people who are important in the person's life, such as family members, the legally responsible person, professionals, friends, and others identified by the individual (for

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example, employers, teachers, and faith leaders). These individuals can be essential to the planning process and help drive its success. Person-centered planning uses a blend of paid, unpaid, natural, and public specialty resources uniquely tailored to the individual/family needs and desires. It is important for the person-centered planning process to explore and use all these resources.

**Before any service can be billed to Health Choice, a written Person Centered Plan for the delivery of medically necessary services must be in place.** The Person Centered Plan must be completed at the time the individual is admitted to a service. Information gathered from discussions with the person or family receiving services and others identified by them, along with recommendations and other information obtained from the comprehensive clinical assessment, together provide the foundation for the development of the Person Centered Plan.

If limited information is available at admission, staff should document on the Person Centered Plan whatever is known and update it when additional information becomes available.

#### 5.3.4.2 Person Centered Plan Reviews and Annual Rewriting

All Person Centered Plans must be updated as needed and must be rewritten at least annually.

At a minimum, the Person Centered Plan must be reviewed by the responsible professional based upon the following:

a. Target date or expiration of each goal

   Each goal on the Person Centered Plan must be reviewed separately, based on the target date associated with it. Short-range goals in the Person Centered Plan may never exceed 12 months from the Date of Plan.

b. Change in the individual's needs

c. Change in service provider

d. Addition of a new service

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

### 5.3.5 Documentation Requirements

The service record documents the nature and course of an individual's progress in treatment. In order to bill Health Choice, providers must ensure that their documentation is consistent with the requirements contained in this policy, including the service definitions in **Attachment E** and the DMH/DD/SAS *Records Management and Documentation Manual*.

#### 5.3.5.1 Responsibility for Documentation

The staff member who provides the service is responsible for accurately documenting the services billed to and reimbursed by Health Choice.

a. A Qualified Professional is not required to countersign service notes written by a staff person who does not have Qualified Professional status.

b. The staff person who provides the service must sign the written entry. The signature must include credentials (professionals) or a job title (paraprofessionals).

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#### 5.3.5.2 Contents of a Service Note

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

a. **Date** of service provision
b. **Name of service** provided (for example, Day Treatment)
c. **Type of contact** (face-to-face, phone call, collateral)
d. **Place of service** when required by service definition
e. **Purpose** of the contact as it relates to the goal(s) in the Person Centered Plan
f. **Description of the intervention** provided. Documentation of the intervention must accurately reflect treatment for the duration of time indicated. For case management–type services, a description of the case management activity fulfills this requirement.
g. **Duration** of service: Amount of time spent performing the intervention
h. **Assessment of the effectiveness** of the intervention and the recipient's progress toward his or her goal. For case management–type services, a description of the result or outcome of the case management activity fulfills this requirement.
i. **Signature** and credentials or job title of the staff member who provided the service.
j. **Each service note page must** be identified with the recipient's name, Health Choice identification number, and record number.

#### 5.3.5.3 Other Service Documentation Requirements

Frequency, format, and any other service-specific documentation requirements can be found in the service definitions in **Attachment E** or the DMH/DD/SAS *Records Management and Documentation Manual*.

## 6.0 Providers Eligible to Bill for the Procedure, Product, or Service

To be eligible to bill for procedures, products, and services related to this policy, providers shall

a. meet NCHC qualifications for participation;
b. be currently enrolled with NCHC; **AND**
c. bill only for procedures, products, and services that are within the scope of their clinical practice, as defined by the appropriate licensing entity.

### 6.1 General Criteria

Qualified provider agencies must be endorsed by the LMEs and directly enrolled with the Medicaid program for each service they wish to provide. The endorsement process includes a service-specific checklist and adherence to the following:

a. Rules for MH/DD/SA Facilities and Services
b. Confidentiality Rules
c. Client Rights Rules in Community MH/DD/SA Services
d. Records Management and Documentation Manual

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e. Implementation Updates to rules, revisions, and policy guidance

f. Person-Centered Plan Manual

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

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

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

## 6.2 Specific Criteria

### 6.2.1 Direct-Enrolled Providers

Staff members with the following classifications must be licensed or certified, as appropriate, according to North Carolina General Statutes and must practice within the scope of practice defined by the applicable practice board. They are able to enroll directly with Health Choice.

a. Licensed Professional Counselor

b. Licensed Clinical Addiction Specialist

c. Certified Clinical Supervisor

d. Licensed Marriage and Family Counselor

e. Licensed Clinical Social Worker

f. Doctor of Osteopathy

g. Licensed Psychologist

h. Licensed Psychological Associate

i. Nurse Practitioner

j. Licensed Psychiatrist

k. Licensed Physician

l. Certified Clinical Nurse Specialist (only if certified as an advanced practice psychiatric clinical nurse specialist)

### 6.2.2 Providers without Direct Enrollment

Staff members with the following classifications must be licensed or certified, as appropriate, according to North Carolina General Statutes and must practice within the scope of practice as defined by the applicable practice board. They are *not* able to enroll directly with Medicaid.

m. Certified Substance Abuse Counselor

n. Physician Assistant

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#### 6.2.3 North Carolina Administrative Code Requirements

The following staff members may provide services according to 10A NCAC 27G .0104—Staff Definitions:

a. Qualified Professional
b. Associate Professional
c. Paraprofessional

## 7.0 Additional Requirements

### 7.1 Compliance

Providers shall comply with all applicable federal, state, and local laws and regulations, including the Health Insurance Portability and Accountability Act (HIPAA) record retention requirements.

### 7.2 Audits and Compliance Reviews

DMH/DD/SAS and DMA (DHHS team) jointly conduct annual audits of a sample of Health Choice-funded mental health, developmental disabilities, and substance abuse services. The purpose of the Health Choice audit is to ensure that these services are provided to recipients in accordance with federal and state regulations and that the documentation and billing practices of directly enrolled providers demonstrate accuracy and integrity. It is a quality control process used to ensure that medical necessity has been determined and to monitor the quality of the documentation of services provided (in accordance with the authorities listed in **Section 1.0** of this policy). The LME may also conduct compliance reviews and monitor provider organizations under the authority of DMA.

Any deficiencies identified in an audit are forwarded to DMA's Program Integrity Section with the following information:

a. A report of findings that summarizes the issues identified;
b. time period covered by the review;
c. type of sampling; and
d. Copies of supporting documentation, showing the specific billing errors identified in the audit and including the recipient's name, Medicaid Identification Number, date(s) of service, procedure code, number of units billed in error, and reason for error.

Refunds or requests for withholdings from future payments should be sent to:

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

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## 8.0 Policy Implementation/Revision Information

**Original Effective Date:** July 1, 2010

**Revision Information:**

| Date | Section Revised | Change |
|---|---|---|
| 07/012/2010 | All sections and attachment(s) | Conversion of clinical coverage policy to transition administrative oversight of the Health Choice Program from the State Health Plan for Teachers and State Employees to the Division of Medical Assistance, pursuant to SL2009-451, Section 10.31.(a). |
| 03/01/2012 | All sections and attachment(s) | NC Health Choice Program Clinical Coverage Policies 2009.28, 2009.59 and 2009.60 are consolidated and revised to be equivalent to NC Medicaid Program Clinical Coverage Policy 8A pursuant to SL2011-145, Section 10.41(b). |
| 03/31/2013 | All sections and attachment(s) | Termination of NCHC policy which will be superseded by the Combined Template policy to comply with S.L. 2011-145,§ 10.41.(b). |

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# Attachment A: Claims-Related Information

Reimbursement requires compliance with all Medicaid and Health Choice guidelines, including obtaining appropriate referrals for recipients enrolled in the managed care programs.

## A. Claim Type

Professional (CMS-1500/837P transaction)

Institutional (UB-04/837I transaction)

## B. Diagnosis Codes

Providers must bill the ICD-9-CM diagnosis codes to the highest level of specificity that supports medical necessity.

## C. Procedure Code(s)

See **Attachment D, HCPCS Codes.**

## D. Modifiers

Providers are required to follow applicable modifier guidelines. See **Attachment D, HCPCS Codes.**

## E. Billing Units

Billing units vary by service. See **Attachment E, Service Definitions,** to determine the billing units for each service.

## F. Place of Service

Places of service will vary depending on the specific service rendered. They include but are not limited to the following: community settings such as home, school, shelters, work locations, and hospital emergency rooms; licensed substance abuse settings; and licensed crisis settings.

## G. Co-Payments

Co-payments vary by the specific service rendered. Refer to Section 12 of the *Basic Medicaid Billing Guide* at http://www.ncdhhs.gov/dma/basicmed/. Health Choice recipient identification cards also list all applicable co-payment amounts by service type.

## H. Reimbursement

Providers must bill their usual and customary charges. Health Choice providers are reimbursed at 100% of the Medicaid rate.

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# Attachment B: Goal Writing

**"A usefully stated objective *[goal]* is one that succeeds in communicating an intended result."** *[Mager, Preparing Instructional Objectives]*.

A strong, well-written goal will communicate three pieces of information: what the person will do (behavior); under what conditions the performance will occur (condition); and the acceptable level of performance (criteria).

**What the Person Will Do** refers to the **behavior, performance, or action** of the person for whom the goal is written. In services for people with disabilities, especially in the context of person-centered services, behavioral objectives/goals should be stated in positive, affirmative language.

**Under What Conditions the Performance Will Occur** is the part of the goal that describes the **action of the staff person** or **staff intervention**. Specifically address what assistance the staff person will provide, and/or what the staff person will do (if anything) to see that the behavior, performance, or action of the individual occurs. Here are some examples of conditions and interventions:

- With assistance from a staff person…
- When asked…
- With suggestions from a team member…
- With physical assistance…
- Given that Ellen has received instruction…
- Given that Jeremy has the phone book in front of him…
- Without any verbal suggestions…
- Given that a staff person has shown Jose where the detergent is…
- With no suggestions or demonstrations…

**Acceptable Level of Performance** refers to **criteria**. This means the goal must include a description of how "achievement" will be defined. In writing this part of the goal, always consider how the person or the people who know the person well define success. Performance may be overt, which can be observed directly, or it may be covert, which means it cannot be observed directly, but is mental, invisible, cognitive, or internal. *[Mager, Preparing Instructional Objectives]*.

**Measurable Goals** are most easily written by using words that are open to ***fewer interpretations***, rather than words that are open to *many interpretations*. Consider the following examples:

**a. Words open to many interpretations (TRY *NOT* TO USE THESE WORDS) are**

- to know
- to understand
- to really understand
- to appreciate
- to fully appreciate
- to grasp the significance of
- to enjoy
- to believe
- to have faith in
- to internalize

**b. Words open to fewer interpretations (USE THESE *TYPES* OF WORDS) are:**

- to write
- to recite

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- to identify
- to sort
- to solve
- to construct
- to build
- to compare
- to contrast
- to smile

**c.** Here are some **examples of goals** that are written using positive language and that include the elements above:

- With staff assistance ***[condition],*** Marsha will choose her clothing, based on the weather ***[performance],*** five out of seven days for the next three months ***[criteria].***
- Adam will identify places he can go in his free time ***[performance],*** without any suggestions from staff ***[condition],*** each Saturday morning for the next three months ***[criteria].***
- With gentle, verbal encouragement from staff ***[condition],*** Charles will not scream while eating ***[performance],*** two out of three meals, for five minutes each time, for the next two months ***[criteria].***
- Given that Rosa has received instructions ***[condition],*** she will call her therapist to make her own appointments ***[performance],*** as needed during the next four months ***[criteria].***
- With suggestions from a support team member ***[condition],*** Henry will write a letter to his father ***[performance],*** once a month for the next six months ***[criteria].***

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## Attachment C: Documentation—Best Practice Guidelines

Services that are billed to Health Choice must comply with Health Choice reimbursement guidelines, and all documentation must relate to goals in the individual's person-centered plan. To assist in assuring that these guidelines are met, the *Service Records Resource Manual for Area Programs and Contract Agencies, APSM 45-2A* recommends that documentation be:

a. **Accurate—**describing the facts as observed or reported;
b. **Timely**—recording significant information at the time of the event, to avoid inaccurate or incomplete information;
c. **Objective**—recording facts and avoiding drawing conclusions. Professional opinion must be phrased to clearly indicate that it is the view of the recorder;
d. **Specific, concise, and descriptive**—recording in detail rather than in general terms, being brief and meaningful without sacrificing essential facts, and thoroughly describing observation and other pertinent information;
e. **Consistent—**explaining any contradictions and giving the reasons for the contradictions;
f. **Comprehensive, logical, and reflective of thought processes**—recording significant information relative to an individual's condition and course of treatment/habilitation. Document pertinent findings, services rendered, changes in the person's condition, and response to treatment/habilitation, as appropriate. Include justification for initial services as well as continued treatment/ habilitation needs. Document reasons for any atypical treatment/ habilitation utilized.
g. **Clear**—recording meaningful information, particularly for other staff involved in the care/treatment of the individual. **Write in non-technical terms** to the extent possible.

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# Attachment D: HCPCS Codes

**Mobile Crisis Management**

| HCPCS Code | Description | Billing Unit |
|---|---|---|
| H2011 | Crisis intervention service, per 15 minutes | 1 unit =15 minutes |

**Diagnostic/Assessment**

| HCPCS Code | Description | Billing Unit |
|---|---|---|
| T1023 | Screening to determine the appropriateness of consideration of an individual for participation in a specified program, project or treatment protocol, per encounter | 1 unit =1 event |

**Intensive In-Home Services**

| HCPCS Code | Description | Billing Unit |
|---|---|---|
| H2022 | Community-based wrap-around services, per diem (intensive in-home services) | 1 unit =1 day |

**Multisystemic Therapy**

| HCPCS Code | Description | Billing Unit |
|---|---|---|
| H2033 | Multisystemic therapy for juveniles, per 15 minutes | 1 unit =15 minutes |

**Child and Adolescent Day Treatment**

| HCPCS Code | Description | Bill with Modifier | Billing Unit |
|---|---|---|---|
| H2012 | Behavioral health day treatment, per hour | HA | 1 unit =1 hour |

**Partial Hospitalization**

| HCPCS Code | Description | Bill with Modifier | Billing Unit |
|---|---|---|---|
| H0035 | Mental health partial hospitalization, treatment, less than 24 hours | | 1 unit =1 event |

**Substance Abuse Intensive Outpatient Program**

| HCPCS Code | Description | Billing Unit |
|---|---|---|
| H0015 | Alcohol and/or drug services; intensive outpatient | 1 unit = 1 event per day |

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| | | |
|---|---|---|
| | (treatment program that operates at lease 3 hours/day and at least 3 days/week and is based on an individualized treatment plan), including assessment, counseling; crisis intervention, and activity therapies or education | (3 hours minimum) |

**Ambulatory Detoxification**

| HCPCS Code | Description | Billing Unit |
|---|---|---|
| H0014 | Alcohol and/or drug services; ambulatory detoxification | 1 unit = 15 minutes |

**Opioid Treatment**

| HCPCS Code | Description | Billing Unit |
|---|---|---|
| H0020 | Alcohol and/or drug services; methadone administration and/or service (provision of the drug by a licensed program) | 1 unit = 1 event |

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# Attachment E: Service Definitions

## I. Mobile Crisis Management (MH/DD/SA): Service Definition and Required Components

Mobile Crisis Management involves all support, services and treatments necessary to provide integrated crisis response, crisis stabilization interventions, and crisis prevention activities. Mobile Crisis Management services are available to children age 6 through 18, at all times, 24/7/365. Crisis response provides an immediate evaluation, triage and access to acute mental health, developmental disabilities, and/or substance abuse services, treatment, and supports to effect symptom reduction, harm reduction, and/or to safely transition persons in acute crises to appropriate crisis stabilization and detoxification supports/services. These services include immediate telephonic response to assess the crisis and determine the risk, mental status, medical stability, and appropriate response.

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

For Health Choice Mobile Crisis Management services, a signed service order shall be completed by a physician, licensed psychologist, physician assistant, or nurse practitioner according to his or her scope of practice, and shall be accompanied by other documentation requirements outlined in this policy (DMA Clinical Coverage Policy 8A, *Enhanced Mental Health and Substance Abuse Services*). Each service order shall be signed and dated by the authorizing professional and shall indicate the *day* on which the service was ordered. A service order shall be in place prior to or on the day that the service is initially provided in order to bill Medicaid for the service. A verbal service order may be used to expedite the establishment or verification of medical necessity for this service in accordance with the *DMH/DD/SAS Records Management and Documentation Manual*. The service order shall be based on an individualized assessment of the recipient's needs.

**Provider Requirements**

Mobile Crisis Management services must be delivered by a team of practitioners employed by a mental health/substance abuse/developmental disability provider organization that meets the provider qualification policies and procedures established by DMH and the requirements of 10A NCAC 27I .0208 (Endorsement of Providers). These policies and procedures set forth the administrative, financial, clinical, quality improvement, and information services infrastructure necessary to provide services. Provider organizations must demonstrate that they meet these standards by being endorsed by the LME. Within one year of enrollment as a provider, the organization must have achieved national accreditation. (Providers who were enrolled prior to July 1, 2008, shall have achieved national accreditation within three years of their enrollment date.) The organization must be established as a legally recognized entity in the United States and qualified/registered to do business as a corporate entity in the State of North Carolina.

**Staffing Requirements**

Mobile Crisis Management services must be provided by a team of individuals that includes a QP according to 10A NCAC 27G .0104 and who must either be a nurse, clinical social worker or psychologist as defined in this administrative code. One of the team members must be a LCAS, CCS or a Certified Substance Abuse Counselor (CSAC). Each organization providing crisis management must have 24/7/365 access to a board certified or eligible psychiatrist. The psychiatrist **must** be available for face to face or phone consultation to crisis staff. A QP or AP with experience in Developmental Disabilities must be available to the team as well. Paraprofessionals with competency in crisis management may also be

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members of the crisis management team when supervised by the QP. A supervising professional must be available for consultation when a Paraprofessional is providing services.

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

- a minimum of 1 year's experience in providing crisis management services in the following settings: assertive outreach, assertive community treatment, emergency department or other service providing 24/7 response in emergent or urgent situations

**AND**

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

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

**Service Type/Setting**

Mobile Crisis Management is a direct and periodic service that is available at all times, 24/7/365. It is a "second level" service, in that other services should be billed before Crisis Management, as appropriate and if there is a choice. For example, if the recipient's outpatient clinician stabilized his/her crisis, the outpatient billing code should be used, not crisis management. If a Intensive In-Home Team worker responds and stabilizes his/her crisis, the Intensive In-Home Team billing code should be used.

Units will be billed in 15-minute increments.

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

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

**Note:** For all services, NCHC will deny payment for services delivered to inmates of public correctional institutions or secure juvenile detention centers.

**Program Requirements**

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

Mobile Crisis Management services must be capable of addressing all psychiatric, substance abuse, and developmental disability crises for all ages to help restore (at a minimum) an individual to his/her previous level of functioning.

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

For recipients new to the public system, Mobile Crisis Management must develop a Crisis Plan before discharge. This Crisis Plan should be provided to the individual, caregivers (if appropriate), and any agencies that may provide ongoing treatment and supports after the crisis has been stabilized. For

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recipients who are already receiving services, Mobile Crisis Management should recommend revisions to existing crisis plan components in Person Centered Plans, as appropriate.

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

Health Choice-covered services require utilization management by the statewide vendor.

**Entrance Criteria**
The recipient is eligible for this service when

A. the person and/or family are experiencing an acute, immediate crisis as determined by a crisis rating scale specified by DMH

**AND**

B. the person and/or family has insufficient or severely limited resources or skills necessary to cope with the immediate crisis

**OR**

C. the person and/or family members evidences impairment of judgment and/or impulse control and/or cognitive/perceptual disabilities

**OR**

D. the person is intoxicated or in withdrawal and in need of substance abuse treatment and unable to access services without immediate assistance

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

**Continued Stay Criteria**
The recipient's crisis has not been resolved or their crisis situation has not been stabilized, which may include placement in a facility-based crisis unit or other appropriate residential placement.

**Discharge Criteria**
Recipient's crisis has been stabilized and his/her need for ongoing treatment/supports has been assessed. If the recipient has continuing treatment/support needs, a linkage to ongoing treatment or supports has been made.

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

**Documentation Requirements**

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Minimum standard is a daily full service note that includes the recipient's name, Health Choice 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. Treatment logs or preprinted check sheets will not be sufficient to provide the necessary documentation. For recipients new to the public system, Mobile Crisis Management must develop a crisis plan before discharge.

**Service Exclusions**
In-Home Services, Multisystemic Therapy, Inpatient Hospitalization and Psychiatric Residential Treatment Facility except for the day of admission.

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# II. Diagnostic/Assessment (MH/DD/SA): Service Definition and Required Components

A Diagnostic/Assessment is an intensive clinical and functional face to face evaluation of a recipient's mental health, developmental disability, or substance abuse condition that results in the issuance of a Diagnostic/Assessment report with a recommendation regarding whether the recipient meets target population criteria, and includes an order for Enhanced Benefit services that provides the basis for the development of an initial Person Centered Plan. For substance abuse-focused Diagnostic/Assessment, the designated Diagnostic Tool specified by DMH must be used. In addition, any elements included in this service definition that are not covered by the tool must be completed.

The Diagnostic/Assessment must include the following elements:

A. a chronological general health and behavioral health history (includes both mental health and substance abuse) of the recipient's symptoms, treatment, treatment response and attitudes about treatment over time, emphasizing factors that have contributed to or inhibited previous recovery efforts;
B. biological, psychological, familial, social, developmental and environmental dimensions and identified strengths and weaknesses in each area;
C. a description of the presenting problems, including source of distress, precipitating events, associated problems or symptoms, recent progressions; and current medications
D. a strengths/problem summary which addresses risk of harm, functional status, co-morbidity, recovery environment, and treatment and recovery history;
E. diagnoses on all five axes of DSM-IV;
F. evidence of an interdisciplinary team progress note that documents the team's review and discussion of the assessment;
G. a recommendation regarding target population eligibility; and
H. evidence of recipient participation including families, or when applicable, guardians or other caregivers

This assessment will be signed and dated by the MD, DO, PA, NP, licensed psychologist and will serve as the initial order for services included in the PCP. Upon completion, the PCP will be sent to the LME for administrative review.

For additional services added after the development of the initial PCP, the order requirement for each service is included in the service definition.

**Provider Requirements**

Diagnostic/Assessments must be conducted by practitioners employed by a mental health/substance abuse/developmental disability provider meet the provider qualification policies, procedures, and standards established by DMH and the requirements of 10A NCAC 27G. These policies and procedures set forth the administrative, financial, clinical, quality improvement, and information services infrastructure necessary to provide services. Provider organizations must demonstrate that they meet these standards by being endorsed by the LME. Within one year of enrollment as a provider, the organization must have achieved national accreditation. (Providers who were enrolled prior to July 1, 2008, shall have achieved national accreditation within three years of their enrollment date.) The organization must be established as a legally recognized entity in the United States and qualified/registered to do business as a corporate entity in the State of North Carolina.

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

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

***Note:** For all services, NCHC will deny payment for services delivered to inmates of public correctional institutions or secure juvenile detention centers.

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

**Prior Approval/Utilization Management**
A recipient may receive one Diagnostic/Assessment per year. An assessment equals one event. Additional events require prior authorization from the statewide Utilization Review vendor. Utilization Management will be done by the state vendor or the DHHS-approved LME contracted with DMA.

**Entrance Criteria**
The recipient is eligible for this service when

A. there is a known or suspected mental health, substance abuse diagnosis, or developmental disability diagnosis

OR

B. initial screening/triage information indicates a need for additional mental health/substance abuse/developmental disabilities treatment/supports.

**Continued Stay Criteria**
Not applicable.

**Discharge Criteria**
Not applicable.

**Expected Outcomes**
A Diagnostic/Assessment determines whether the recipient is appropriate for and can benefit from mental health, developmental disabilities, and/or substance abuse services based on the recipient's diagnosis, presenting problems, and treatment/recovery goals. It also evaluates the recipient's level of readiness and motivation to engage in treatment. Results from a Diagnostic/Assessment include an interpretation of the assessment information, appropriate case formulation and an order for immediate needs and the development of Person Centered Plan. For substance abusers, a Diagnostic/Assessment recommends a level of placement using N.C. Modified A/ASAM criteria. This assessment will include signing the order for the initial PCP. That order will constitute the order for the services in the PCP.

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**Documentation Requirements**

The Diagnostic/Assessment must include the following elements:

A. a chronological general health and behavioral health history (includes both mental health and substance abuse) of the recipient's symptoms, treatment, treatment response and attitudes about treatment over time, emphasizing factors that
B. have contributed to or inhibited previous recovery efforts; biological, psychological, familial, social, developmental and environmental dimensions and identified strengths and weaknesses in each area;
C. a description of the presenting problems, including source of distress, precipitating events, associated problems or symptoms, recent progressions, and current medications
D. strengths/problem summary which addresses risk of harm, functional status, co-morbidity, recovery environment, and treatment and recovery history;
E. diagnoses on all five axes of DSM-IV;
F. evidence of an interdisciplinary team progress note that documents the team's review and discussion of the assessment;
G. a recommendation regarding target population eligibility; and
H. evidence of recipient participation including families, or when applicable, guardians or other caregivers.

**Service Exclusions/Limitations**

A recipient may receive one Diagnostic/Assessment per year. Any additional Diagnostic/Assessment within a 1-year period must be authorized by the DHHS-approved LME or the statewide vendor prior to the delivery of the service. Diagnostic/Assessment shall not be billed on the same day as Intensive In-Home or Multisystemic Therapy. If psychological testing or specialized assessments are indicated, they are billed separately using appropriate CPT codes for psychological, developmental, or neuropsychological testing.

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# III. Intensive In-Home Services:
# Service Definition and Required Components

**Service Definition and Required Components**

Intensive In-Home (IIH) service is a team approach designed to address the identified needs of children and adolescents, who due to serious and chronic symptoms of an emotional, behavioral, and/or substance use disorders, are unable to remain stable in the community without intensive interventions. This service may only be provided to individuals' ages 6 through 18. This medically necessary service directly addresses the recipient's mental health and/or substance-related diagnostic and clinical needs. The needs are evidenced by the presence of a diagnosable mental, behavioral, or emotional disturbance (as defined by DSM-IV-TR and its successors), with documentation of symptoms and effects reflected in the comprehensive clinical assessment and the Person Centered Plan. This team provides a variety of clinical rehabilitative interventions available 24 hours a day, 7 days a week, 365 days a year.

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

- reduce presenting psychiatric or substance abuse symptoms,
- provide first responder intervention to diffuse current crisis,
- ensure linkage to community services and resources, and
- prevent out of home placement for the child.

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

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

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

- Individual and family therapy
- Substance abuse treatment interventions
- Developing and implementing a home-based behavioral support plan with the youth and his or her caregivers
- Psychoeducation, which imparts information to the recipients, families, caregivers, and/or other individuals involved with the recipient's care about the recipient's diagnosis, condition, and treatment.

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- Intensive case management
  - assessment
  - planning
  - linkage and referral to paid and natural supports
  - monitoring and follow up
- Arranges for psychological and psychiatric evaluations
- Crisis management

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

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

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

**Provider Requirements**

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

- are currently certified as a Critical Access Behavioral Healthcare Agency (CABHA) according to 10A NCAC 22P;
- meet the provider qualification policies, procedures, and standards established by DMA;
- meet the provider qualification policies, procedures, and standards established by the Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS); and
- fulfill the requirements of 10A NCAC 27G.

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

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

**Staffing Requirements**

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

- one FTE team leader who is a Licensed Professional who has the knowledge, skills, and abilities required by the population and age to be served (may be filled by no more than two individuals). A provisionally licensed Qualified Professional actively seeking licensure may serve as the team leader conditional upon being fully licensed within 30 months from the effective date of this policy. For provisionally licensed team leaders hired after the effective date of this policy, the 30-month timeline begins at date of hire.

**AND**

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

**AND**

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

For IIH services focused on substance abuse interventions, the team shall include at least one Certified Clinical Supervisor (CCS), Licensed or Provisionally Licensed Clinical Addiction Specialist (LCAS), or Certified Substance Abuse Counselor (CSAC) as a member of the IIH team.

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

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

The team-to-family ratio shall not exceed 1:8 for each IIH team.

The team leader is responsible for the following:

- Providing individual and family therapy for each youth served by the team
- Designating the appropriate team staff such that specialized clinical expertise is applied as clinically indicated for each child
- Providing and coordinating the assessment and reassessment of the recipient's clinical needs
- Providing clinical expertise and guidance to the IIH team members in the team's interventions with the recipient

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- Providing the clinical supervision of all members of the team for the provision of this service. An individual supervision plan is required for all IIH team members exclusive of the Team Leader

Licensed or Qualified Professional has responsibility for the following:

- Coordinates and oversees the initial and ongoing assessment activities
- Convening the Child and Family Team for person-centered planning
- Completing the initial development and ongoing revision of the Person Centered Plan and ensuring its implementation
- Consulting with identified medical (for example, primary care and psychiatric) and non-medical (for example, DSS, school, DJJDP) providers, engaging community and natural supports, and including their input in the person-centered planning process
- Ensuring linkage to the most clinically appropriate and effective services including arranging for psychological and psychiatric evaluations
- Providing and coordinating behavioral health services and other interventions for the youth or other family members with other licensed professionals and Child and Family Team members.
- Monitoring and documenting the status of the recipient's progress and the effectiveness of the strategies and interventions outlined in the Person Centered Plan

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

- Participating in the person-centered planning process
- Assisting with implementing a home-based behavioral support plan with the youth and his or her caregivers as indicated in the Person Centered Plan
- Providing psychoeducation as indicated in the Person Centered Plan
- Assisting the team leader in monitoring and evaluating the effectiveness of interventions, as evidenced by symptom reduction and progress toward goals identified in the Person Centered Plan
- Assisting with crisis interventions
- Assisting the team leader in consulting with identified providers, engaging community and natural supports, and including their input in the person-centered planning process

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

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

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

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

**All IIH Team Staff**

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

**AND**

2. Within 90 days of hire to provide this service, all IIH staff shall complete the following training requirements:

   IIH staff must complete 24 hours* of training (a minimum of 3 days) in one of the designated therapies, practices or models below specific to the population(s) to be served by each IIH Team. The designated therapies, practices or models are as follows:
   - Cognitive Behavior Therapy or
   - Trauma-Focused Therapy (For Example: Seeking Safety, Trauma Focused CBT, Real Life Heroes) or
   - Family Therapy (For Example: Brief Strategic Family Therapy, Multidimensional Family Therapy, Family Behavior Therapy, Child Parent Psychotherapy, or Family Centered Treatment)
     a. Practices or models must be treatment focused, not prevention focused.
     b. Each practice or model chosen must specifically address the treatment needs of the population to be served by each IIH.
     c. Cognitive Behavior Therapy training must be delivered by a licensed professional.
     d. Trauma-focused therapy and family therapy training must be delivered by a trainer who meets the qualifications of the developer of the specific therapy, practice or model and meets the training standard of the specific therapy, practice or model. When no specific trainer qualifications are specified by the model then the training must be delivered by a licensed professional; or for family therapy, either an American Association for Marriage and Family Therapy (AAMFT) Approved Supervisor or a licensed professional may provide family therapy training.

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

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

   Non-licensed staff [Qualified Professionals and Associate Professionals] shall be trained in and provide only the aspects of these practice(s) or model(s) that do not require licensure and are within the scope of their education, training, and expertise. Non-licensed staff will practice under supervision according to the service definition. It is the responsibility of the licensed (or

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provisionally licensed, under supervision) supervisor and the CABHA Clinical Director to ensure that the non-licensed staff practice within the scope of their education, training, and expertise and are not providing any services that require licensure.

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

**AND**

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

**IIH Team Leaders**

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

**AND**

2. Within 90 days of hire to provide this service, all IIH Team Leaders shall complete all supervisory level training required by the developer of the designated therapy, practice or model. If no specific supervisory level training exists for the designated therapy, practice, or model, then all IIH Team Leaders must complete a minimum of 12 hours of clinical supervision training.

**All Non-Supervisory IIH Staff ( QPs and APs)**

In addition to the training required for all IIH staff, non-supervisory IIH staff , within 90 days of hire to provide this service, shall complete the following training requirements:

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

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

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

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

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

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| Time Frame | Training Required | Who | Total Minimum Hours Required |
|---|---|---|---|
| | ▪ To ensure the core fundamental elements of training specific to the modality** selected by the agency for the provision of services are implemented a minimum of 24 hours of the selected modality must be completed. | ▪ All IIH Staff | 24 hours |
| | ▪ All supervisory level training required by the developer of the designated therapy, practice or model with a minimum of 12 hours must be completed. | ▪ IIH Team Leaders | 12 hours |
| | | | |
| **Annually** | ▪ Follow up training and ongoing continuing education required for fidelity to chosen modality** (If no requirements are designated by developers of that modality, a minimum of 10 hours of continuing education in components of the selected modality must be completed.). | ▪ All IIH Staff | 10 hours** |

* Motivational Interviewing training must be provided by a Motivational Interviewing Network of Trainers (MINT) trainer.
**Modalities must be ONE of the following: Cognitive Behavioral Therapy, Trauma Focused Therapy, and Family Therapy.

**Total hours of training for the IIH staff:**

- IIH Staff other than Team Leader and QPs responsible for PCPs – **42 hrs plus required hours for selected model**
- QPs responsible for the PCP – **45 hours plus required hours for selected model**
- Team Leader – **45 hours plus required hours for selected model and supervisory training requirement**

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

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

***Note:** For all services, NCHC will deny payment for services delivered to inmates of public correctional institutions or secure juvenile detention centers.

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

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

**Program Requirements**

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

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

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

- direct clinical interventions as identified in the Person Centered Plan
- case management interventions (face-to-face, telephone time, and collateral contacts).

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

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

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

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

**Eligibility Criteria**

A recipient is eligible for this service when

A. There is an Axis I or II MH/SA diagnosis (as defined by the DSM-IV-TR or its successors), other than a sole diagnosis of developmental disability.

**AND**

B. Based on the current comprehensive clinical assessment, this service was indicated and outpatient treatment services were considered or previously attempted, but were found to be inappropriate or not effective.

**AND**

C. The youth has current or past history of symptoms or behaviors indicating the need for a crisis intervention as evidenced by suicidal/homicidal ideation, physical aggression toward others, self-injurious behavior, serious risk taking behavior (running away, sexual aggression, sexually reactive behavior, or substance use).

**AND**

D. The youth's symptoms and behaviors are unmanageable at home, school, or in other community settings due to the deterioration of his or her mental health or substance abuse condition, requiring intensive, coordinated clinical interventions.

**AND**

E. The youth is at imminent risk of out-of-home placement based on the child or adolescent's current mental health or substance abuse clinical symptomatology, or is currently in an out-of-home placement and a return home is imminent.

**AND**

F. There is no evidence to support that alternative interventions would be equally or more effective, based on North Carolina community practice standards (Best Practice Guidelines of the American Academy of Child and Adolescent Psychiatry, American Psychiatric Association, American Society of Addiction Medicine).

**Entrance Process**

A comprehensive clinical assessment that demonstrates medical necessity shall be completed prior to provision of this service. If a substantially equivalent assessment is available, reflects the current level of functioning**,** and contains all the required elements as outlined in community practice standards as well as in all applicable federal and state requirements, it may be used as part of the current comprehensive clinical assessment. Relevant diagnostic information shall be obtained and included in the Person Centered Plan.

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

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

Health Choice may cover up to 60 days for the initial authorization period, based on medical necessity.

After the initial authorization has been obtained, the team leader will convene the Child and Family Team, in partnership with the youth and his or her family, for the purpose of further developing the Person Centered Plan.

**Continued Service Criteria**
The desired outcome or level of functioning has not been restored, improved, or sustained over the time frame outlined in the youth's Person Centered Plan; or the youth continues to be at risk for out-of-home placement, based on current clinical assessment, history, and the tenuous nature of the functional gains.
**AND**
One of the following applies:

A. The recipient has achieved current Person Centered Plan goals, and additional goals are indicated as evidenced by documented symptoms.
B. The recipient is making satisfactory progress toward meeting goals and there is documentation that supports that continuation of this service will be effective in addressing the goals outlined in the Person Centered Plan.
C. The recipient is making some progress, but the specific interventions in the Person Centered Plan need to be modified so that greater gains, which are consistent with the recipient's premorbid level of functioning, are possible.
D. The recipient fails to make progress, or demonstrates regression, in meeting goals through the interventions outlined in the Person Centered Plan. The recipient's diagnosis should be reassessed to identify any unrecognized co-occurring disorders, and interventions or treatment recommendations should be revised based on the findings. This includes consideration of alternative or additional services.

**Discharge Criteria**
Any one of the following applies:

A. The recipient has achieved goals and is no longer in need of IIH services.
B. The recipient's level of functioning has improved with respect to the goals outlined in the Person Centered Plan, inclusive of a transition plan to step down to a lower level of care.
C. The recipient is not making progress or is regressing, and all reasonable strategies and interventions have been exhausted, indicating a need for more intensive services.
D. The recipient or legally responsible person no longer wishes to receive IIH services.
E. The recipient, based on presentation and failure to show improvement despite modifications in the Person Centered Plan, requires a more appropriate best practice treatment modality

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based on North Carolina community practice standards (for example, National Institute of Drug Abuse, American Psychiatric Association).

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

**Expected Clinical Outcomes**
The expected clinical outcomes for this service are specific to recommendations resulting from clinical assessments and meeting the identified goals in the recipient's Person Centered Plan.

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

- Decrease in the frequency or intensity of crisis episodes
- Reduction in symptomatology
- Child and family/caregivers' engagement in the recovery process
- Improved child functioning in the home, school and community settings
- Ability of the child and family/caregiver to better identify and manage triggers, cues, and symptoms
- Child's sustained improvement in developmentally appropriate functioning in specified life domains
- Child's utilization increased coping skills and social skills that mitigate life stresses resulting from the recipient's diagnostic and clinical needs
- Reduction of symptoms and behaviors that interfere with the child's daily living, such as negative effects of substance abuse or dependence, psychiatric symptoms, or both
- Decrease in delinquent behaviors when present
- Increased use of available natural and social supports by the child and family/caregivers

**Documentation Requirements**
Refer to DMA Clinical Coverage Policies and the DMH/DD/SAS *Records Management and Documentation Manual* for a complete listing of documentation requirements.

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

- Recipient's name
- Health Choice identification number
- Service Record Number
- Service provided (for example, IIH services)
- Date of service
- Place of service
- Type of contact (face-to-face, telephone call, collateral)
- Purpose of the contact
- Description of the provider's interventions
- Amount of time spent performing the intervention
- Description of the effectiveness of the interventions in meeting the recipient's specified goals as outlined in the Person Centered Plan
- Signature and credentials of the staff member(s) providing the service

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

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

**Prior Approval/Utilization Management**
Services are based upon a finding of medical necessity, shall be directly related to the recipient's diagnostic and clinical needs, and are expected to achieve the specific rehabilitative goals specified in the individual's Person Centered Plan. Medical necessity is determined by North Carolina community practice standards as verified by independent Health Choice Utilization Review.

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

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

For Health Choice, prior authorization by the approved Utilization Review vendor is required according to published policy. The vendor will evaluate the request to determine if medical necessity supports more or less intensive services.

Health Choice funds may cover up to 60 days for the initial authorization period based on the medical necessity documented in the individual's Person Centered Plan, the authorization request form, and supporting documentation. If continued IIH services are needed at the end of the initial authorization period, submit the Person Centered Plan and a new request for authorization reflecting the appropriate level of care and service to the NCHC-approved vendor. This should occur before the authorization expires.

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

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

The following are not billable under this service:

- Transportation time (this is factored in the rate)
- Any habilitation activities
- Any social or recreational activities (or the supervision thereof)
- Clinical and administrative supervision of staff, including team meetings (this is factored in the rate)

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

IIH services cannot be provided during the same authorization period as the following services: Mental Health/Substance Abuse Targeted Case Management, IDD Targeted Case Management, Multisystemic Therapy; Day Treatment; individual, group and family therapy; Substance Abuse Intensive Outpatient Program; child residential treatment services Level II Program Type through Level IV; or Psychiatric Residential Treatment Facility (PRTF).

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# IV. Multisystemic Therapy (MST): Service Definition and Required Components

Multisystemic Therapy (MST) is a program designed for youth generally between the ages 6 through 18 who have antisocial, aggressive/violent behaviors, are at risk of out-of-home placement due to delinquency and/or; adjudicated youth returning from out-of-home placement and/or; chronic or violent juvenile offenders, and/or youth with serious emotional disturbances or abusing substances and their families. MST provides an intensive model of treatment based on empirical data and evidence-based interventions that target specific behaviors with individualized behavioral interventions. The purpose of this program is to keep youth in the home by delivering an intensive therapy to the family within the home. Services are provided through a team approach to youth and their families. Services include: an initial assessment to identify the focus of the MST intervention; individual therapeutic interventions with the youth and family; peer intervention; case management; and crisis stabilization. Specialized therapeutic and rehabilitative 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.

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

This team approach is structured face-to-face therapeutic interventions to provide support and guidance in all areas of functional domains: adaptive, communication, psychosocial, problem solving, behavior management, etc. The service promotes the family's capacity to monitor and manage the youth's behavior.

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

**Provider Requirements**

MST services must be delivered by practitioners employed by a mental health/substance abuse provider organization that meets the provider qualification policies, procedures, and standards established by DMH and the requirements of 10A NCAC 27G. These policies and procedures set forth the administrative, financial, clinical, quality improvement, and information services infrastructure necessary to provide services. Provider organizations must demonstrate that they meet these standards by being endorsed by the LME. Within one year of enrollment as a provider, the organization must have achieved national accreditation. (Providers who were enrolled prior to July 1, 2008, shall have achieved national accreditation within three years of their enrollment date.) The organization must be established as a legally recognized entity in the United States and qualified/registered to do business as a corporate entity in the State of North Carolina.

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

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

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

***Note:** For all services, NCHC will deny payment for services delivered to inmates of public correctional institutions or secure juvenile detention centers.

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

Units will be billed in 15-minute increments.

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

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

**Prior Approval/Utilization Management**
Authorization by the statewide vendor is required. The amount, duration, and frequency of the service must be included in an individual's Person Centered Plan. The initial authorization for services may not exceed 30 days. Reauthorization for services may not exceed 120 days and is so documented in the Person Centered Plan and service record.

A maximum of 32 units of MST services can be provided in a 24-hour period. No more than 480 units of services can be provided to an individual in a 3-month period unless specific authorization for exceeding this limit is approved.

**Entrance Criteria**
A. There is an Axis I or II diagnosis present, other than a sole diagnosis of Developmental Disability.

**AND**

B. The youth should be between the ages of 6 through 18.

**AND**

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C. The youth displays willful behavioral misconduct (e.g., theft, property destruction, assault, truancy or substance use/abuse or juvenile sex offense), when in conjunction with other adjudicated delinquent behaviors

**AND**

D. The youth is at imminent risk of out-of-home placement or is currently in out-of-home placement due to delinquency and reunification is imminent within 30 days of referral.

**AND**

E. The youth has a caregiver that is willing to assume long term parenting role and caregiver who is willing to participate with service providers for the duration of the treatment.

**Continued Stay Criteria**

The desired outcome or level of functioning has not been restored, improved or sustained over the time frame outlined in the youth's Person Centered Plan or the youth continues to be at risk for relapse based on history or the tenuous nature of the functional gains or any one of the following apply:

A. Youth continues to exhibit willful behavioral misconduct.

**AND**

B. There is a reasonable expectation that the youth will continue to make progress in reaching overarching goals identified in MST in the first 4 weeks.

**OR**

C. Youth is not making progress; the Person Centered Plan must be modified to identify more effective interventions.

**OR**

D. Youth is regressing; the Person Centered Plan must be modified to identify more effective interventions.

**Discharge Criteria**

Youth's level of functioning has improved with respect to the goals outlined in the Person Centered Plan, or no longer benefits from this service. The decision should be based on one of the following:

A. Youth has achieved 75% of the Person Centered Plan goals, discharge to a lower level of care is indicated.
B. Youth is not making progress or is regressing, and all realistic treatment options within this modality have been exhausted.
C. The youth/family requests discharge and is not imminently dangerous to self or others
D. The youth requires a higher level of care (i.e., inpatient hospitalization or PRTF).

**Documentation Requirements**

Minimum standard is a daily full service note that includes the recipient's name, Health Choice identification number, date of service, purpose of contact, describes the provider's intervention, the time spent performing the intervention, the effectiveness of interventions and the signature of the staff providing the service.

**Expected Outcomes**

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

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**Service Exclusions/Limitations**
An individual can receive MST services from only one MST provider organization at a time.

MST services cannot be billed for individuals who are receiving Intensive In-Home Services, Day Treatment, individual, group or family therapy, SAIOP, or living in Level II–IV Child residential.

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# V. Child and Adolescent Day Treatment (MH/SA): Service Definition and Required Components

Day Treatment is a structured treatment service in a licensed facility for children or adolescents age 6 through 18 and their families that builds on strengths and addresses identified needs. This medically necessary service directly addresses the child's diagnostic and clinical needs, which are evidenced by the presence of a diagnosable mental, behavioral, and/or emotional disturbance (as defined by the DSM-IV-TR and its successors), with symptoms and effects documented in a comprehensive clinical assessment and the Person Centered Plan.

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

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

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

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

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

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

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

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

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

- Development of skills and replacement behaviors which can be practiced, applied, and continually addressed with treatment staff in a therapeutic and educational environment;
- Monitoring of psychiatric symptoms in coordination with the appropriate medical care provider;
- Identification and self-management of symptoms/behaviors;
- Development/improvement of social and relational skills;
- Enhancement of communication and problem-solving skills;
- Relapse prevention and disease management strategies;
- Individual, group and family counseling;
- Provision of strengths-based positive behavior supports; and
- Psychoeducation, and training of family, unpaid caregivers, and/or others who have a legitimate role in addressing the needs identified in the Person Centered Plan.

**Note:** Psychoeducation services and training furnished to family members and/or caregivers must be provided to, or directed exclusively toward the treatment of, the eligible individual. Psychoeducation imparts information to children, families, caregivers, and/or other individuals involved with the child's care about the child's diagnosis, condition, and treatment for the express purpose of fostering developmentally appropriate coping skills. These skills will support recovery and encourage problem solving strategies for managing issues posed by the child's condition. Psychoeducational activities are performed for the direct benefit of the recipient and help the child develop increasingly developmentally appropriate coping skills for handling problems resulting from their condition. The goal of psychoeducation is to reduce symptoms, improve functioning, and meet the goals outlined in the Person Centered Plan.

In partnership with the youth, his or her family, the legally responsible person (as applicable), and other service providers, a Child and Adolescent Day Treatment Qualified Professional is responsible for convening the Child and Family Team, which is the vehicle for the person-centered planning process. The Child and Family Team comprises those persons relevant to the child's successful achievement of service goals including, but not limited to, family members, mentors, school personnel, primary medical care provider, and members of the community who may provide support, structure, and services for the child. The Day Treatment provider works with other behavioral health service providers, as well as with identified medical (including primary care and psychiatric) and non-medical providers (for example, the county department of social services, school, the Department of Juvenile Justice and Delinquency Prevention), engages community and natural supports, and includes their input in the person-centered planning process. A Day Treatment Qualified Professional is responsible for developing, implementing,

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and monitoring the Person Centered Plan, which shall include a crisis plan. The Day Treatment provider is also responsible for documenting the status of the child's progress and the effectiveness of the strategies and interventions outlined in the Person Centered Plan.

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

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

- Assessing the child's needs for comprehensive services
- Convening Child and Family Team meetings to coordinate the provision of multiple services and the development of and revisions to the PCP
- Developing and implementing the Person Centered Plan
- Linking the child and/or family to needed services and supports (such as medical or psychiatric consultations)
- Monitoring the provision of services and supports
- Assessing the outcomes of services and supports
- Collaborating with other medical and treatment providers.

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

**Provider Requirements**

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

- meet the provider qualification policies, procedures, and standards established by the DMA;
- meet the provider qualification policies, procedures, and standards established by the Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS);
- fulfill the requirements of 10A NCAC 27G; and
- are currently certified as a Critical Access Behavioral Healthcare Agency (CABHA) according to 10A NCAC 22P..

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

The provider organization is responsible for obtaining authorization from Health Choice's approved vendor for medically necessary services identified in the Person Centered Plan. The Day Treatment

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provider organization shall comply with all applicable federal and state requirements. This includes but is not limited to North Carolina Department of Health and Human Services (DHHS) statutes, rules, policies, and Implementation Updates; Medicaid Bulletins; and other published instruction.

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

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

This service is delivered by the following staff:

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

**AND**

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

**AND**

- a minimum of one (1) additional FTE (Qualified Professional, Associate Professional, or Paraprofessional) for every 18 enrolled recipients beginning with the 18th enrolled recipient (for example, a program with 17 recipients does not need the additional FTE; a program with 21 recipients needs one additional FTE; and a program with 36 recipients needs two additional FTEs) .

**AND**

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

Although the Licensed Professional is in addition to the program's Qualified Professional to child ratio, he or she may serve, as needed, as one of the two staff when children are present.

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

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

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**Staff Training**

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

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

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

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

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

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

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

Total hours of training for the Day Treatment staff :

- Day Treatment Staff other than the QPs responsible for PCPs – **23 hours plus the additional training hours on the selected clinical model(s) or evidence-based treatment(s)**
- QPs responsible for the PCP – **26 hours plus the additional training hours on the selected clinical model(s) or evidence-based treatment(s)**

**Service Type/Setting**

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

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

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

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

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

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

**Program Requirements**

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

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

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

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

**Eligibility Criteria**

Children six through 18 are eligible for this service when:

A. There is an Axis I or II MH/SA diagnosis (as defined by the DSM-IV-TR or its successors), other than a sole diagnosis of a developmental disability.

**AND**

B. For children with a substance abuse diagnosis, the American Society of Addiction Medicine Patient Placement Criteria (ASAM-PPC) are met for Level II.1.

**AND**

C. Both of the following shall apply:
   1. Evidence that less restrictive MH/SA rehabilitative services in the educational setting have been unsuccessful as evidenced by documentation from the school (e.g., Functional Behavioral Assessment, Functional Behavioral Plan, Individual Education Plan, 504 Plan, behavior plans).
   2. The child exhibits behavior resulting in significant school disruption or significant social withdrawal.

**AND**

D. The child is experiencing mental health and/or substance abuse symptoms (not solely those related to an individual's diagnosis of developmental disability) related to his/her diagnosis that severely impair functional ability in an educational setting which may include vocational education.

**AND**

E. There is no evidence to support that alternative interventions would be equally or more effective, based on North Carolina community practice standards (Best Practice Guidelines of the American Academy of Child and Adolescent Psychiatry, American Psychiatric Association, American Society of Addiction Medicine).

**Entrance Process**

A comprehensive clinical assessment that demonstrates medical necessity shall be completed prior to provision of this service. If a substantially equivalent assessment is available, reflects the current level of functioning, and contains all the required elements as outlined in community practice standards as well as in all applicable federal and state requirements, it may be used as part of the current comprehensive clinical assessment. Relevant diagnostic information shall be obtained and included in the Person Centered Plan.

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

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Prior authorization is required prior to or on the first date of this service.To request the initial authorization, the Day Treatment provider must submit the Person Centered Plan with signatures and the required authorization request form to the Health Choice-approved vendor.

Health Choice funds may cover up to 60 days for the initial authorization period, based on medical necessity documented in the individual's Person Centered Plan, the authorization request form, and supporting documentation. Requests for reauthorization may be submitted by the Day Treatment Program provider.

In partnership with the youth, his or her family, the legally responsible person (as applicable), and other service providers, a Child and Adolescent Day Treatment Qualified Professional is responsible for convening the Child and Family Team monthly.

**Continued Service Criteria**
The desired outcome or level of functioning has not been restored, improved, or sustained over the time frame outlined in the youth's Person Centered Plan; or the youth continues to be unable to function in an appropriate educational setting, based on ongoing assessments, history, and the tenuous nature of the functional gains.

**AND**

One of the following applies:

A. The child has achieved current Person Centered Plan goals, and additional goals are indicated as evidenced by documented symptoms.
B. The child is making satisfactory progress toward meeting goals and there is documentation that supports that continuation of this service will be effective in addressing the goals outlined in the Person Centered Plan.
C. The child is making some progress, but the specific interventions in the Person Centered Plan need to be modified so that greater gains, which are consistent with the child's premorbid level of functioning, are possible.
D. The child fails to make progress, or demonstrates regression, in meeting goals through the interventions outlined in the Person Centered Plan. The child's diagnosis should be reassessed to identify any unrecognized co-occurring disorders, and interventions or treatment recommendations should be revised based on the findings. This includes consideration of alternative or additional services.

**Discharge Criteria**
Any one of the following applies:

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

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

**Expected Clinical Outcomes**
The expected clinical outcomes for this service are specific to recommendations resulting from clinical assessments and meeting the identified goals in the child's Person Centered Plan.

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

- Improved social, emotional, or behavioral functioning in an appropriate educational setting;
- Integration or reintegration into an appropriate educational or vocational setting;
- Reduced MH/SA symptomatology;
- Improvement of behavior, anger management, and/or developmentally appropriate coping skills;
- Development/improvement of social and relational skills;
- Enhancement of communication and problem-solving skills;
- Increased identification and self-management of triggers, cues, and symptoms and decreased frequency or intensity of crisis episodes;
- Engagement in the recovery process, for children with substance related disorders,
- Reduction of negative effects of substance use and/or psychiatric symptoms that interfere with the child's daily living
- Maintaining residence with a family or community based non-institutional setting (foster home, therapeutic family services);
- Reduction in behaviors that require juvenile justice involvement
- Increased use of available natural and social supports

**Documentation Requirements**
Refer to DMA Clinical Coverage Policies and the DMH/DD/SAS *Records Management and Documentation Manual* for a complete listing of documentation requirements.

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

- Child's name
- Service record number
- Health Choice identification number
- Service provided (for example, Day Treatment services)
- Date of service
- Place of service
- Other staff involved in the provision of the service
- Type of contact (face-to-face, telephone call, collateral)
- Purpose of the contact
- Description of the provider's interventions
- Amount of time spent performing the interventions
- Description of the effectiveness of the interventions in meeting the recipient's specified goals as outlined in the Person Centered Plan
- Signature and credentials of the staff member(s) providing the service (for paraprofessionals, position

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is required in lieu of credentials with staff signature)

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

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

**Prior Approval/Utilization Management**
Services are based upon a finding of medical necessity, must be directly related to the child's diagnostic and clinical needs, and are expected to achieve the specific rehabilitative goals specified in the individual's Person Centered Plan. Medical necessity is determined by North Carolina community practice standards as verified by independent Utilization Review vendor.

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

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

Health Choice funds may cover up to 60 days for the initial authorization period based on the medical necessity documented in the individual's Person Centered Plan, the authorization request form, and supporting documentation. Submit the reauthorization request before the initial authorization expires. NCHC funded services cover up to 60 days for reauthorization based on the medical necessity documented in the required Person Centered Plan, the authorization request form, and supporting documentation.

Services are billed in one hour increments.

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

The following are not billable under this service:

- Transportation time (this is factored in the rate)
- Any habilitation activities
- Child care
- Any social or recreational activities (or the supervision thereof)
- Clinical and administrative supervision of staff (this is factored in the rate)
- Educational instruction

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

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

- MH/SA Targeted Case Management
- Intensive In-Home Services;

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- Multisystemic Therapy;
- Individual, group and family therapy;
- Substance Abuse Intensive Outpatient Program;
- Child Residential Treatment services–Levels II (Program Type) through IV;
- Psychiatric Residential Treatment Facility (PRTF); or
- Inpatient hospitalization.

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

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# VI. Partial Hospitalization
# Service Definition and Required Components

Partial Hospitalization is a short-term service for acutely mentally ill children, age 6 through 18, which provides a broad range of intensive therapeutic approaches which may include: group activities/therapy, individual therapy, recreational therapy, community living skills/training, increases the individual's ability to relate to others and to function appropriately, coping skills, medical services. This service is designed to prevent hospitalization or to serve as an interim step for those leaving an inpatient facility. A physician shall participate in diagnosis, treatment planning, and admission/discharge decisions. Physician involvement shall be one factor that distinguishes Partial Hospitalization from Day Treatment Services.

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

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

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

**Service Type**
This is day/night service that shall be provided a minimum of 4 hours a day, 5 days a week, and 12 months a year. Service standards and licensure requirements are outlined in10A NCAC 27G .1100.

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

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

**Prior Approval/Utilization Management**
Authorization by the statewide vendor is required. The amount, duration, and frequency of the service must be included in a recipient's Person-Centered Plan. Initial authorization shall not exceed 7 days. Reauthorization shall not exceed 7 days. All utilization review activity shall be documented in the Provider's Service Plan.

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**Medical Necessity**
Must have Axis I or II diagnosis

**AND**

Level of Care Criteria, Level C/NCSNAP

**AND**

The consumer is experiencing difficulties in at least one of the following areas:

A. Functional impairment, crisis intervention/diversion/aftercare needs, and/or at risk for placement outside the natural home setting,

**AND**

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

**Service Order Requirement**
A Physician, PhD, Psychiatric Nurse Practitioners, Psychiatric Clinical Nurse Specialist within their scope of practice can order this service. The service must be ordered prior to or on the day the service is initiated.

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

A. Consumer has achieved initial service plan goals and additional goals are indicated,
B. Consumer is making satisfactory progress toward meeting goals.
C. Consumer is making some progress, but the service plan (specific interventions) need to be modified so that greater gains which are consistent with the consumer's premorbid level of functioning are possible or can be achieved.
D. Consumer is not making progress; the service plan must be modified to identify more effective interventions.
E. Consumer is regressing; the service plan must be modified to identify more effective interventions.

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

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

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

A. Past history of regression in the absence of PH is documented in the consumer record,

**OR**

B. The presence of a DSM-IV diagnosis that would necessitate a disability management approach. In the event, there are epidemiological sound expectations that symptoms will persist and that ongoing treatment interventions are needed to sustain functional gains.

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

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

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# VII. Substance Abuse Intensive Outpatient Program: Level II.1 Intensive Outpatient Services ASAM Patient Placement Criteria Service Definition and Required Components

**Service Definition and Required Components**

SA Intensive Outpatient Program (SAIOP) means structured individual and group addiction activities and services that are provided at an outpatient program designed to assist consumers, age 6 through 18 to begin recovery and learn skills for recovery maintenance. The program is offered at least 3 hours a day, at least 3 days a week, with no more than 2 consecutive days between offered services, and distinguishes between those individuals needing no more than 19 hours of structured services per week (ASAM Level II.1). The recipient must be in attendance for a minimum of 3 hours a day in order to bill this service. SAIOP services shall include a structured program consisting of, but not limited to, the following services:

1. Individual counseling and support;
2. Group counseling and support;
3. Family counseling, training or support;
4. Biochemical assays to identify recent drug use (e.g. urine drug screens);
5. Strategies for relapse prevention to include community and social support systems in treatment;
6. Life skills;
7. Crisis contingency planning;
8. Disease Management; and
9. 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 substance abuse/dependence or mental retardation/developmental disability and substance abuse/dependence.

SAIOP can be designed for homogenous groups of recipients e.g., individuals with co-occurring MH/SA disorders; individuals with HIV; or individuals with similar cognitive levels of functioning. Group counseling shall be provided each day SAIOP services are offered. SAIOP includes case management to arrange, link or integrate multiple services as well as assessment and reassessment of the recipient's need for services. SAIOP services also informs the recipient about benefits, community resources, and services; assists the recipient in accessing benefits and services; arranges for the recipient to receive benefits and services; and monitors the provision of services. Consumers may be residents of their own home, a substitute home, or a group care setting; however, the SAIOP must be provided in a setting separate from the consumer's residence. The program is provided over a period of several weeks or months.

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

**Provider Requirements**

SAIOP must be delivered by practitioners employed by a substance abuse provider organization that meet the provider qualification policies, procedures, and standards established by DMH and the requirements of 10A NCAC 27G. These policies and procedures set forth the administrative, financial, clinical, quality improvement, and information services infrastructure necessary to provide services. Provider organizations must demonstrate that they meet these standards by being endorsed by LME. Within one year of enrollment as a provider, the organization must have achieved national accreditation. (Providers who were enrolled prior to July 1, 2008, shall have achieved national accreditation within three years of

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their enrollment date.) The organization must be established as a legally recognized entity in the United States and qualified/registered to do business as a corporate entity in the State of North Carolina.

Organizations that provide SAIOP must provide "first responder" crisis response on a 24/7/365 basis to recipients who are receiving this service

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

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

**Program Requirements**
See Service Definition and Required Components.

**Prior Approval/Utilization Management**
Authorization by the statewide vendor is required. The amount, duration, and frequency of SAIOP Service must be included in an individual's authorized Person Centered Plan. Services may not be delivered less frequently than the structured program set forth in the service description above. Recipients may be seen for the initial 30 days of treatment without a prior authorization. Services provided after this initial 30 day "pass-through" period require authorization from the NCHC approved vendor. This pass-through is available only once per calendar year. Reauthorization shall not exceed 60 days. Under exceptional circumstances, one additional reauthorization up to 2 weeks can be approved. This service is billed with a minimum of 3 hours per day as an event.

**Entrance Criteria**
The recipient is eligible for this service when
A. There is an Axis I substance abuse disorder present;

**AND**

B. Level of Care Criteria, level II.1 NC Modified A/ASAM

**Continued Stay Criteria**
The desired outcome or level of functioning has not been restored, improved, or sustained over the time frame outlined in the recipient's Person Centered Plan or the recipient continues to be at risk for relapse based on history or the tenuous nature of the functional gains or any one of the following applies:
A. Recipient has achieved positive life outcomes that support stable and ongoing recovery, and additional goals are indicated.
B. Recipient is making satisfactory progress toward meeting goals.
C. Recipient is making some progress, but the Person Centered Plan (specific interventions) needs to be modified so that greater gains, which are consistent with the recipient's premorbid level of functioning, are possible or can be achieved.

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D. Recipient is not making progress; the Person Centered Plan must be modified to identify more effective interventions
E. Recipient is regressing; the Person Centered Plan must be modified to identify more effective interventions.

**Expected Outcomes**
The expected outcome of SAIOP is abstinence. Secondary outcomes (i.e., in *abstinent* patients) include: sustained improvement in health and psychosocial functioning, reduction in any psychiatric symptoms (if present), reduction in public health and/or safety concerns, and a reduction in the risk of relapse as evidenced by improvement in empirically supported modifiable relapse risk factors.

**Documentation Requirements**
Minimum standard is a daily full service note for each day of SAIOP that includes the recipient's name, Health Choice identification number, date of service, purpose of contact, describes the provider's staff interventions, the time spent performing the intervention, the effectiveness of interventions, and the signature and credentials of the staff providing the service. A documented discharge plan will be discussed with the recipient and included in the record.

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

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

**Service Exclusions/Limitations**
SAIOP cannot be billed during the same authorization as all detoxification services levels

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# VIII. Ambulatory Detoxification:
# Service Definition and Required Components

## Level I-D Ambulatory Detoxification without Extended On-Site Monitoring

**NC Modified ASAM Patient Placement Criteria**

**Service Definition and Required Components**
Ambulatory Detoxification Without Extended On Site Monitoring (Outpatient Detox) is an organized outpatient service delivered by trained clinicians who provide medically supervised evaluation, detoxification and referral services according to a predetermined schedule. Such services are provided in regularly scheduled sessions. The services are designed to treat the 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.

A service order for Ambulatory Detoxification Without Extended On Site Monitoring must be completed by a physician, licensed psychologist, physician's assistant or nurse practitioner according to their scope of practice prior to or on the day that the services are to be provided.

**Provider Requirements**
Ambulatory Detoxification Without Extended On Site Monitoring must be delivered by practitioners employed by a substance abuse provider that meet the provider qualification policies, procedures, and standards established by DMH and the requirements of 10A NCAC 27G. These policies and procedures set forth the administrative, financial, clinical, quality improvement, and information services infrastructure necessary to provide services. Within one year of enrollment as a provider, the organization must have achieved national accreditation. (Providers who were enrolled prior to July 1, 2008, shall have achieved national accreditation within three years of their enrollment date.) The organization must be established as a legally recognized entity in the United States and qualified/registered to do business in the State of North Carolina.

**Staffing Requirements**
Ambulatory Detoxification Without Extended On-Site Monitoring are staffed by physicians, who are available 24 hours a day by telephone and who conduct an assessment within 24 hours of admission. A registered nurse is available to conduct a nursing assessment on admission and oversee the monitoring of a patient's progress and medication. Appropriately licensed and credentialed staff are available to administer medications in accordance with physician orders and the services of counselors are available. Services must be provided by staff who meet the requirements specified for QP or AP status for Substance Abuse according to 10A NCAC 27G .0104, under the supervision of a LCAS or CCS.

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

**Entrance Criteria**
There is an Axis I diagnosis of substance abuse disorder present

**AND**

ASAM Level of Care Criteria Level I-D (NC criteria)

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**Prior Approval/Utilization Management**
Authorization by the statewide vendor is required. This service must be included in an individual's Person Centered Plan. Initial authorization is limited to seven days. Reauthorization is limited to a maximum of 3 days as there is a 10-day maximum for this service.

**Continued Stay/Discharge Criteria**
The patient continues in Ambulatory Detoxification Without Extended On-Site Monitoring until

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

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

**Documentation Requirements**
Minimum standard is a daily full service note for each day of Ambulatory Detoxification Without Extended On Site Monitoring that includes the recipient's name, Health Choice identification number, date of service, purpose of contact, describes the provider's interventions, the time spent performing the intervention, the effectiveness of interventions, and the signature and credentials of the staff providing the service. Detoxification rating scale tables e.g., Clinical Institute Withdrawal Assessment-Alcohol, Revised (CIWA-AR) and flow sheets (which include tabulation of vital signs) are used as needed, and a discharge plan which has been discussed with the recipient is also documented prior to discharge.

**Service Exclusions**
Cannot be billed the same day as any other service.

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# IX. Outpatient Opioid Treatment
# Service Definition and Required Components

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

**Guidelines**

A. Services in this type include methadone or buprenorphine administration for treatment **OR** maintenance.
B. Only direct face-to-face time with client to be reported.
C. Staff travel time to be reported separately.
D. Preparation/documentation time NOT reported.

**Payment Unit**

One daily unit.

**Therapeutic Relationship and Intervention**

Administration of methadone or other drug approved by the FDA for the treatment of opiate addiction in a licensed opioid treatment program. Administration of methadone to patients with opiate addiction disorders for purposes of methadone maintenance or detoxification is the only activity billable to Health Choice under this service code. Health Choice patients can only be approved to receive methadone.

**Structure of Daily Living**

Not applicable.

**Cognitive and Behavioral Skill Acquisition**

Not applicable.

**Service Type**

This is a periodic service. Methadone maintenance is the only opioid treatment for opiate addiction disorders that is Healt Choice billable.

**Resiliency/Environment Intervention**

Not applicable.

**Service Delivery Setting**

This service must be provided at a licensed Outpatient Treatment Program.

**Medical Necessity**

The recipient is eligible for this service when
An Axis I or II diagnosis is present

**AND**

ASAM ( American Society for Addiction Medicine) for Opioid Maintenance Therapy (OMT) Level of Service is met and/or other ASAM levels as indicated

**AND**

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Service is a part of an aftercare planning process (time limited step down or transitioning) and is required to avoid returning to a higher, more restrictive level of service.

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

**Prior Approval/Utilization Review Criteria**
Initial authorization shall not exceed 60 days. Reauthorization shall not exceed 180 days. All utilization review activity shall be documented in the Provider's Service Plan.

The desired outcome or level of functioning has not been restored, improved or sustained over the time frame outlined in the clients service plan or the consumer continues to be at risk for relapse based on history or the tenuous nature of the functional gains; **OR**

The client meets any of the specifications listed in the ASAM criteria for Dimension 5 Relapse, Continued Use or Continued Problem Potential for Opiod Maintenance Therapy.

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

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

**Service Maintenance Criteria**
If the client is functioning effectively with this service and discharge would otherwise be indicated, Opiod Treatment should be maintained when it can be reasonably anticipated that regression is likely to occur if the service is withdrawn. The decision should be based on any one of the following:

Past history of regression in the absence of Opiod Treatment is documented in the consumer record.

OR

The presence of a DSM-IV diagnosis that would necessitate a disability management approach. In the event that there is epidemiological sound expectations that symptoms will persist and that on going treatment interventions are needed to sustain functional gains.

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

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

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

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

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

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