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Note: Information in Sections 1.0 through 8.0 in Policy 8A supersedes information found in the attachments. Service definitions (Attachment E) are currently undergoing revision. Please check the DMA policy index page (<http://www.ncdhhs.gov/dma/mp/>) frequently to see updates as they become available.

1.0 Description of the Service

This document describes policies and procedures that Local Management Entities (LMEs) and direct-enrolled providers must follow to receive reimbursement for covered enhanced benefit behavioral health services provided to eligible Medicaid recipients. It sets forth the basic requirements for qualified providers to bill mental health and substance abuse services to Medicaid.

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

2.0 Eligible Recipients

2.1 General Provisions

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

2.2 Retroactive Eligibility

Occasionally, individuals become retroactively eligible for Medicaid while receiving covered services.

Retroactively eligible recipients are entitled to receive Medicaid-covered services and to be reimbursed by the provider for all money paid during the period of eligibility, with the exception of any third-party payments or cost-sharing amounts. The qualified provider may file for reimbursement with Medicaid for these services. (Refer to 10A NCAC 22J. 0106.)

2.3 EPSDT Special Provision: Exception to Policy Limitations for Recipients under 21 Years of Age

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

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or procedures for Medicaid recipients under 21 years of age **if** the service is **medically necessary health care** to correct or ameliorate a defect, physical or mental illness, or a

condition [health problem] identified through a screening examination** (includes any evaluation by a physician or other licensed clinician). This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his/her health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems. Medically necessary services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the recipient's physician, therapist, or other licensed practitioner; the determination process does not delay the delivery of the needed service; and the determination does not limit the recipient's right to a free choice of providers.

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

- a. that is unsafe, ineffective, or experimental/investigational.
- b. that is not medical in nature or not generally recognized as an accepted method of medical practice or treatment.

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

****EPSDT and Prior Approval Requirements**

- a. If the service, product, or procedure requires prior approval, the fact that the recipient is under 21 years of age does NOT eliminate the requirement for prior approval.
- b. IMPORTANT ADDITIONAL INFORMATION about EPSDT and prior approval is found in the Basic Medicaid Billing Guide, sections 2 and 6, and on the EPSDT provider page. The Web addresses are specified below.

Basic Medicaid Billing Guide: <http://www.ncdhhs.gov/dma/basicmed/>

EPSDT provider page: <http://www.ncdhhs.gov/dma/epsdt/>

3.0 When Procedures, Products, and Services Are Covered

IMPORTANT NOTE: EPSDT allows a recipient less than 21 years of age to receive services in excess of the limitations or restrictions below and without meeting the specific criteria in this section when such services are **medically necessary health care services** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem]; that is, documentation shows how the service, product, or procedure will correct or improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

EPSDT DOES NOT ELIMINATE THE REQUIREMENT FOR PRIOR APPROVAL IF PRIOR APPROVAL IS REQUIRED. For additional information about EPSDT and prior approval requirements, see **Subsection 2.3** of this policy.

3.1 General Criteria

Medicaid 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.

3.2 Specific Criteria

All Medicaid services are based upon a finding of medical necessity, which is determined by generally accepted North Carolina community practice standards as verified by independent Medicaid 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.

For detailed information on coverage criteria and service requirements for other types of services, please refer to the following clinical coverage policies. All are linked from <http://www.ncdhhs.gov/dma/mp/mpindex.htm>.

- 8B, *Inpatient Behavioral Health Services*
- 8C, *Outpatient Behavioral Health Services Provided by Direct-Enrolled Providers*
- 8D-1, [*Psychiatric Residential Treatment Facilities for Children under the Age of 21*](#)
- 8D-2, *Residential Treatment Services*
- 12A, *Case Management Services for Adults and Children At Risk of Abuse, Neglect, or Exploitation*.

4.0 When Procedures, Products, and Services Are Not Covered

IMPORTANT NOTE: EPSDT allows a recipient less than 21 years of age to receive services in excess of the limitations or restrictions below and without meeting the specific criteria in this section when such services are **medically necessary health care services** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem]; that is, documentation shows

how the service, product, or procedure will correct or improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

EPSDT DOES NOT ELIMINATE THE REQUIREMENT FOR PRIOR APPROVAL IF PRIOR APPROVAL IS REQUIRED. For additional information about EPSDT and prior approval requirements, see **Subsection 2.3** of this policy.

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

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.

IMPORTANT NOTE: EPSDT allows a recipient less than 21 years of age to receive services in excess of the limitations or restrictions below and without meeting the specific criteria in this section when such services are **medically necessary health care services** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem]; that is, documentation shows how the service, product, or procedure will correct or improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

EPSDT DOES NOT ELIMINATE THE REQUIREMENT FOR PRIOR APPROVAL IF PRIOR APPROVAL IS REQUIRED. For additional information about EPSDT and prior approval requirements, see **Subsection 2.3** of this policy.

5.1 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 in order to bill Medicaid for the service. Even if the recipient is retroactively eligible for Medicaid, the provider will not be able to bill Medicaid without a valid service order.

Service orders are valid for one year from the Date of Plan entered on a Person Centered Plan. 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.)

5.2 Medicaid Service Summary

Medicaid Service	Age	Must be Ordered By
Assertive Community Treatment Team	Adults	MD DO Licensed psychologist [that is, a Health Services Provider— Psychologist (HSP-P)] NP PA
Community Support—Adults	Adults	
Community Support—Children	Children	
Community Support Team—Adults	Adults	
Day Treatment—Child and Adolescent	Children and Adolescents	
Diagnostic/ Assessment	Children and Adults	
Intensive In-home Services	Children	
Mobile Crisis Management	Children and Adults	
Multisystemic Therapy	Children and Adults	
Partial Hospitalization	Children and Adults	
Professional Treatment Services in Facility-Based Crisis Programs	Adults	
Psychosocial Rehabilitation	Adults	
Substance Abuse Comprehensive Outpatient Treatment Program	Adults	
Substance Abuse Intensive Outpatient Service	Children and Adults	
Substance Abuse Medically Monitored Community Residential Treatment	Adults	
Substance Abuse Non-medical Community Residential Treatment	Adults	
Ambulatory Detoxification	Adults and Children	
Non-hospital Medical Detoxification	Adults	
Medically Supervised or ADATC Detoxification/ Crisis Stabilization	Adults	
Outpatient Opioid Treatment	Adults and Children	

5.3 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 Professional or Qualified Professional. Medically necessary services delivered by Paraprofessionals are delivered under the supervision and direction of the Licensed

Note: The service definitions for community support for adults and children have been revised effective January 1, 2009. Other service definitions are currently undergoing revision; utilization review statements were updated June 11, 2009. Please check the DMA policy index page (<http://www.ncdhhs.gov/dma/mp/>) frequently to see updates as they become available.

Multisystemic Therapy (MST): Medicaid Billable Service

Service Definition and Required Components

Multisystemic Therapy (MST) is a program designed for youth generally between the ages 7 through 17 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 three years of enrollment as a provider, the organization must have achieved national accreditation. The organization must be established as a legally recognized entity in the United States and qualified/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, detention centers and jails (state funds only), 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

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

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.

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Mobile Crisis Management (MH/DD/SA): Medicaid Billable Service

Service Definition and Required Components

Mobile Crisis Management involves all support, services and treatments necessary to provide integrated crisis response, crisis stabilization interventions, and crisis prevention activities. Mobile Crisis Management services are available at all times, 24/7/365. 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.

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 three years of enrollment as a provider, the organization must have achieved national accreditation. The organization must be established as a legally recognized entity in the United States and qualified/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 CCAS, 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 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 Community Support worker responds and stabilizes his/her crisis, the Community Support 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, federal Medicaid regulations will deny Medicaid payment for services delivered to inmates of public correctional institutions or for patients in facilities with more than 16 beds that are classified as Institutions of Mental Diseases.

Program Requirements

Mobile Crisis Management services 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

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

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.

If it is a Medicaid-covered service, utilization management will be done by the statewide vendor. If it is a non-covered Medicaid service or non-Medicaid client, then the utilization review will be done by the LME.

The maximum length of service is 24 hours per episode.

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.

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

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

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

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

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

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Diagnostic/Assessment (MH/DD/SA): Medicaid Billable Service

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 (e.g., SUDDS IV, ASI, SASSI) for specific substance abuse target populations (i.e., Work First, DWI, etc.) 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 and authorization of services under the purview of the LME.

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

Staffing Requirements

The Diagnostic/Assessment team must include at least two QPs, according to 10A NCAC 27G .0104, both of whom are licensed or certified clinicians; one of the team members must be a qualified practitioner whose professional licensure or certification authorizes the practitioner to diagnose mental illnesses and/or addictive disorders. One of which must be an MD, DO, Nurse Practitioner, Physician Assistant, or licensed psychologists. For substance abuse-focused Diagnostic/Assessment, the team must include a CCS or CCAS. 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 Medicaid recipients this service cannot be provided in an IMD (for adults) or in a public institution, (jail, detention center,)

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.

Utilization Management

A recipient may receive one Diagnostic/Assessment per year. An assessment equals one event. For individuals eligible for Enhanced Benefit services, referral by the LME for Diagnostic/Assessment is required. Additional events require prior authorization from the statewide vendor or LME.

If it is Medicaid-covered service, utilization management will be done by the state vendor or the DHHS-approved LME contracted with the Medicaid agency. If it is a non-covered Medicaid service or non-Medicaid client, then the utilization review will be done by the LME.

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

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:

A. Recipient has achieved initial Person Centered Plan goals and additional goals are indicated.

AND

B. Recipient is making satisfactory progress toward meeting goals.

AND

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.

OR

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

OR

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

Discharge Criteria

Service 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:

- A. The recipient has achieved goals; discharge to a lower level of care is indicated, or recipient has entered a Substance Abuse Intensive Out-Patient Program.
- B. The youth and families/caregivers have skills and resources needed to step down to a less intensive service.
- C. There is a significant reduction in the youth's problem behavior and/or increase in pro-social behaviors.
- D. The youth's or parent/guardian requests discharge (and is not imminently dangerous to self or others).
- E. An adequate continuing care plan has been established.
- F. The youth requires a higher level of care (i.e., inpatient hospitalization or PRTF).

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

Documentation Requirements

Minimum standard is a daily note for services provided that includes the recipient's name, Medicaid 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 of the staff providing the service.

Expected Outcomes

The individual's living arrangement has been stabilized, crisis needs have been resolved, linkage has been made with needed community service/resources; youth has gained living skills; parenting skills have been increased; need for out of home placements has been reduced/eliminated

Service Exclusions/Limitations

An individual can receive Intensive In-Home Services from only one Intensive In-Home provider organization at a time.

Intensive in-home services cannot be provided during the same authorization period with the following services except as specified below: Community Support, Multisystemic Therapy, Day Treatment, Hourly Respite, Individual, group or family therapy, SAIOP, or living in a Level II-IV child residential or substance abuse residential facility

Service Limitation: CS can be billed for a maximum of 8 units per month in accordance with the person centered plan for individuals who are receiving intensive in-home services for the purpose of facilitating transition to the service, admission to the service, meeting with the person as soon as possible upon admission, providing coordination during the provision of service, ensuring that the service provider works directly with the CS professional and discharge planning.

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

Note: The service definitions for community support for adults and children have been revised effective January 1, 2009. Other service definitions are currently undergoing revision; utilization review statements were updated June 11, 2009. Please check the DMA policy index page (<http://www.ncdhhs.gov/dma/mp/>) frequently to see updates as they become available.

Community Support—Children/Adolescents (MH/SA): Medicaid Billable Service

Service Definition and Required Components

Community Support services are community-based rehabilitative services and interventions necessary to treat children and adolescents 20 years old or younger (for State-funded services youth 3 through 17 years of age) to achieve their mental health and/or substance abuse recovery goals and to assist parents and other caregivers in helping children and adolescents build resiliency. These medically necessary services directly address the recipient's diagnostic and clinical needs, 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 a Person Centered Plan.

Community Support services, are community-based, rehabilitative in nature, and intended to meet the mental health and/or substance abuse needs of children and adolescents who have significant identified symptoms that seriously interfere with or impede their roles or functioning in family, school, or community. These services are designed to

- enhance the skills necessary to address the complex mental health and/or substance abuse symptoms of children and adolescents who have significant functional deficits due to these disorders, to promote symptom reduction and improve functioning in their daily environments;
- assist the child/adolescent and family in acquiring the necessary skills for reaching recovery from mental health and/or substance abuse disorders, for self management of symptoms and for addressing vocational, housing, and educational needs;
- link recipients to, and coordinate, necessary services to promote clinical stability and meet the mental health/substance abuse treatment, social, and other treatment support needs while supporting the emotional and functional growth and development of the child; and
- monitor and evaluate the effectiveness of delivery of all services and supports identified in the Person Centered Plan.

The rehabilitative service activities of Community Support consist of a variety of interventions that must directly relate to the recipient's diagnostic and clinical needs as reflected in a comprehensive clinical assessment and goals outlined in the Person Centered Plan.

These shall include the following, as clinically indicated:

- Facilitation of the Person Centered Planning process with the Child and Family Team which includes the child, parent or legal guardian, and others identified as important in the recipient's life (e.g., family, friends, providers);
- Identification of strengths that will aid the child and family in the child's recovery, as well as the identification of barriers that impede the development of skills necessary for functioning in the community that will be addressed in the Person Centered Plan;
- Initial development, implementation, and ongoing revision of Person Centered Plan;

- Monitoring the implementation of the Person Centered Plan, including involvement of other medical and non-medical providers, the child and the family, and other natural and community supports;
- Individual (1:1) interventions with the child or adolescent, unless a group intervention is deemed more efficacious;
- Therapeutic interventions that directly increase the acquisition of skills needed to accomplish the goals of the Person Centered Plan;
- Identification and self-management of symptoms;
- Identification and self-management of triggers and cues (early warning signs);
- Monitoring and evaluating the effectiveness of interventions as evidenced by symptom reduction and progress toward goals identified in the Person Centered Plan
- Direct preventive and therapeutic interventions, associated with the mental health or substance abuse diagnosis that will assist with skill building related to goals in the Person Centered Plan as related to the mental health or substance abuse diagnosis and symptoms;
- Direct interventions in escalating situations to prevent crisis (including identifying cues and triggers);
- Assistance for the youth and family in implementing preventive and therapeutic interventions outlined in the Person Centered Plan (including the crisis plan);
- Response to crisis 24/7/365 as indicated in the recipient's crisis plan and participation in debriefing activities to revise the crisis plan as needed;
- Relapse prevention and disease management strategies;
- Psychoeducation regarding the identification and self-management of prescribed medication regimen, with documented communication to prescribing practitioner(s);
- 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. Psychoeducation services and training furnished to family members and/or caregivers must be provided to, or directed exclusively toward the treatment of, the Medicaid eligible individual. Psychoeducation 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 for the express purpose of helping to assist with developing coping skills. These skills will support recovery and encourage problem solving strategies for managing issues posed by the recipient's condition. Psychoeducational activities are performed for the direct benefit of the Medicaid recipient and help the recipient develop increasingly sophisticated 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.
- Coordination and oversight of initial and ongoing assessment activities; and
- Ensuring linkage to the most clinically appropriate and effective services.

The Qualified Professional drives the delivery of this rehabilitation service. In partnership with the youth and his or her family, and the legally responsible person (if applicable), the Community Support Qualified Professional is responsible for convening the Child and Family Team, which is the vehicle for the person-centered planning process. The Community Support Qualified Professional has ongoing clinical responsibility for initiating, developing, implementing, and revising the Person Centered Plan.

