State-Funded Enhanced Mental Health and Substance Abuse Services

Date Published August 1, 2013

NC Division of Mental Health, Developmental Disabilities and Substance Abuse Services	State-Funded Enhanced Mental Health and Substance Abuse Services Date Published: August 1, 2013

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NOTE: Information in **Sections 1.0** through **7.0** in Policy 8A supersedes information found in the attachments.

1.0 Description of the Service

This document describes policies and procedures that state-funded providers shall follow to receive reimbursement for covered enhanced benefit behavioral health services provided to eligible individuals. It sets forth the basic requirements for qualified providers to bill state-funded mental health and substance abuse services through the Local Management Entity-Managed Care Organization (LME-MCO), including services for individuals with intellectual or developmental disabilities (I/DD), as appropriate. The state-funded services covered under this policy are found in Attachment D.

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,* Administrative Publication System Manuals, 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); and
e. *DMH/DD/SAS Integrated Payment and Reporting System Target Population (Client Eligibility Criteria)*

2.0 Individuals Eligible for State-Funded Services

Individuals who meet the target population client criteria set forth in the Integrated Payment and Reporting System Target Population Client Eligibility Criteria are eligible for state-funded services.

Individuals may be ineligible for a state-funded service due to coverage by other payors that would make them ineligible for the same or similar service funded by the state (e.g. individual is eligible for the same service covered by Medicaid, Health Choice or other third party payor).

3.0 When State-Funded Services Are Covered

3.1 General Criteria

Services related to this policy are covered when they are medically necessary and when:

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

b. the service can be safely furnished, and no equally effective and more conservative or less costly treatment is available statewide; and
c. the service is furnished in a manner not primarily intended for the convenience of the individual, the individual's caregiver, or the provider.

3.2 Specific Criteria

All state-funded services are based upon a finding of medical necessity, which is determined by generally accepted North Carolina community practice standards as verified by Local Management Entity-Managed Care Organization. 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 D, Service Definitions,** for service-specific medical necessity criteria. Service definitions are also located at: http://www.ncdhhs.gov/mhddsas/providers/servicedefs/index.htm.

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/.

- 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*

4.0 When State-Funded Services Are Not Covered

Services related to this policy are not covered when:

a. the individual does not meet the eligibility requirements listed in Integrated Payment and Reporting System Target Population (Client Eligibility Criteria);
b. the individual does not meet the medical necessity criteria listed in **Section 3.0;**
c. the service duplicates another provider's service; or
d. the 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 or before the first day of service for all state-funded services, with the following exceptions as identified in the service definitions found in **Attachment D**.

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

5.2 Prior Approval Requirements

The provider(s) shall submit to Local Management Entity-Managed Care Organization the following:

a. the prior approval request; and
b. all supporting documentation that demonstrates that the individual has met the specific criteria in **Subsection 3.2** of this policy, specific to the service being requested.

5.3 Utilization Management and Authorization of State-Funded Services

Utilization management of state-funded services is a part of the assurance of medical necessity for the service. Authorization, which is an aspect of utilization management, validates approval by the Local Management Entity-Managed Care Organization to provide a medically necessary service to eligible individuals.

Refer to the specific service definition for utilization management and authorization requirements.

Utilization management must be performed by the Local Management Entity-Managed Care Organization.

5.4 Service Orders

A comprehensive clinical assessment is one mechanism to demonstrate medical necessity for a service and to assess and identify an individual's needs. For state-funded services, a service order is recommended. Providers shall coordinate with the LME-MCO regarding their requirements for service orders.

5.5 State-Funded Service Summary

State-Funded Service	Age
Diagnostic Assessment	All Ages
Assertive Community Treatment Team	Age 18+
Community Support Team—Adults	Age 18+
Day Treatment - Child and Adolescent	Age 5 through 17
Intensive In-home Services	Age 3 through 17
Mobile Crisis Management	All ages
Multisystemic Therapy	Ages 7 through 17
Partial Hospitalization	All ages
Professional Treatment Services in Facility-Based Crisis Programs	Age 18+
Psychosocial Rehabilitation	Age 18+
Substance Abuse Comprehensive Outpatient Treatment Program	Age 18+
Substance Abuse Intensive Outpatient Service	All ages
Substance Abuse Medically Monitored Community Residential Treatment	Age 18+
Substance Abuse Halfway House	Age 18+
Substance Abuse Non-Medical Community Residential Treatment	Age 18+
Ambulatory Detoxification	Age 18+
Social Setting Detoxification	Age 18+
Non-Hospital Medical Detoxification	Age 18+
Medically Supervised or ADATC Detoxification Crisis Stabilization	Age 18+
Outpatient Opioid Treatment	Age 18+

5.6 Clinical or Professional Supervision

State-funded services are provided to individuals by agencies that are enrolled in a Local Management Entity-Managed Care Organization's provider network and that employ Licensed Professionals (LPs), Qualified Professionals (QPs), Associate Professionals (APs), and Paraprofessionals. Clinical or professional supervision must be provided according to the supervision and staffing requirements outlined in each service definition. Medically necessary services delivered by APs are delivered under the supervision and direction of the LP or QP. Medically necessary services delivered by Paraprofessionals are delivered under the supervision and direction of the LP, QP or, when the service definition does not specify a more stringent supervision requirement, an AP. Supervision

shall be provided at the frequency and for the duration indicated in the individualized supervision plan created for each AP and Paraprofessional upon hire. Each supervision plan must be reviewed annually.

The Licensed Professional or Qualified Professional personally works with individual's families, and team members to develop an individualized PCP. The LP or QP 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 QP status and spends as much time as necessary directly supervising the staff member providing the service to ensure that the goals outlined on each PCP are being implemented and that individuals are receiving services in a safe and efficient manner in accordance with accepted standards of practice.

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

5.7 Person Centered Plans

Most state-funded services covered by this policy require a PCP. Refer to the service definitions in **Attachment D,** 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 PCPs is the DMH/DD/SAS *Person-Centered Planning Instruction Manual*. The guidance offered throughout **Subsection 5.7** is derived from it.

5.7.1 Person-Centered Planning

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

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

Before most services may be billed, a written PCP for the delivery of medically necessary services must be in place. The PCP 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 PCP. Refer to **Attachment B** for effective PCP goal writing guidelines.

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

5.7.2 Person Centered Plan Reviews and Annual Rewriting

All PCPs must be updated as needed and must be rewritten at least annually.

At a minimum, the PCP must be reviewed by the responsible professional based upon the following:

a. Target date or expiration of each goal
    - Each goal on the PCP must be reviewed separately, based on the target date associated with it. Short-range goals in the PCP may never exceed 12 months from the Date of Plan.
b. Change in the 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.

For individuals who receive psychosocial rehabilitation services, the PCP shall be reviewed every six months.

5.8 Documentation Requirements

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

5.8.1 Responsibility for Documentation

The staff member who provides the service is responsible for accurately documenting the services billed to and reimbursed by the Local Management Entity-Managed Care Organization:

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

5.8.2 Contents of a Service Note

Service notes unless otherwise noted in the service definition, 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, Mobile Crisis Management)
c. **Type of contact** (face-to-face, phone call, collateral)
d. **Place of service,** when required by service definition
e. **Purpose** of the contact as it relates to the goal(s) in the PCP
f. **Description of the intervention** provided. Documentation of the intervention must accurately reflect treatment for the duration of time indicated. For case management–type services, a description of the case management activity fulfills this requirement.
g. **Duration** of service: Amount of time spent performing the intervention
h. **Assessment of the effectiveness** of the intervention and the individual's progress toward the individual's goal. For case management functions within an enhanced service in this policy, a description of the result or outcome of the case management activity fulfills this requirement.
i. **Signature** and credentials or job title of the staff member who provided the service, as described in **Subsection 5.8.1**
j. **Each service note page must** be identified with the individual's name, Medicaid identification number, and record number.

5.8.3 Other Service Documentation Requirements

Frequency, format, and any other service-specific documentation requirements can be found in the service definitions in **Attachment D** or the DMH/DD/SAS *Records Management and Documentation Manual*. Services that are billed to the Local Management Entity-Managed Care Organization must comply with the documentation requirements outlined in the DMH/DD/SAS *Records Management and Documentation Manual,* state reimbursement guidelines, and all service related documentation must relate to goals in the individual's PCP. Refer to **Attachment C** for additional documentation Best Practice guidelines.

6.0 Providers Eligible to Bill for State-Funded Services

To be eligible to bill for services under this policy, providers shall:

a. meet Local Management Entity-Managed Care Organization requirements for participation;
b. be currently enrolled in the LME-MCOs provider network; and
c. bill only for services that are within the scope of their clinical practice, as defined by the appropriate licensing entity.

6.1 Provider Qualifications

Qualified provider agencies must be credentialed by the LME-MCOs and enrolled in an LME-MCO's provider network for each service they wish to provide. The credentialing process includes a service-specific checklist and adherence to the following:

a. Rules for Mental Health, Developmental Disability, and Substance Abuse Facilities and Services
b. Confidentiality Rules
c. Client Rights Rules in Community MH/DD/SA Services
d. *Records Management and Documentation Manual*
e. DMH/DD/SAS Communication Bulletins
f. Implementation Updates to rules, revisions, and policy guidance
g. *Person-Centered Planning Instruction Manual*
h. Integrated Payment and Reporting System requirements

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

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

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

6.2 Staff Definitions

6.2.1 North Carolina General Statutes Requirements

6.2.1.1 Licensed Professionals Providing State-Funded Services Under This Policy

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

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

6.2.1.2 North Carolina Administrative Code Requirements

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

a. Qualified Professional - QP
b. Associate Professional - AP
c. Paraprofessional

7.0 Additional Requirements

7.1 Compliance

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

7.2 Audits and Compliance Reviews

Local Management Entities-Managed Care Organizations are responsible for the management and oversight of the public system of mental health, developmental disabilities and substance abuse services at the community level. An LME-MCO shall plan, develop, implement, and monitor services within a specified geographic area to ensure expected outcomes for consumers within available resources, per NC GS § 122C-115.4(a).

The area authority or county program shall monitor the provision of mental health, developmental disabilities, or substance abuse services for compliance with law, which monitoring and management shall not supersede or duplicate the regulatory authority or functions of agencies of the Department, per NC GS § 122C-111.

DMH/DD/SAS conducts annual monitoring of a sample of mental health and substance abuse services funded with SAPTBG and CMHBG dollars. The purpose of the monitoring is to ensure that these services are provided to individuals in accordance with federal regulations and requirements. The LME-MCO shall also conduct compliance reviews and monitor provider organizations under the authority of DMH/DD/SAS to ensure compliance with federal block grant regulations and requirements.

Attachment A: Claims-Related Information

Reimbursement requires compliance with all Integrated Payment and Reporting System (IPRS) guidelines, including obtaining appropriate referrals for individuals meeting IPRS Target Population eligibility criteria.

A. Claim Type

Professional (837P transaction).

B. Diagnosis Codes

Providers shall bill the ICD-9-CM diagnosis code(s) to the highest level of specificity that supports medical necessity.

A qualified provider who renders services to an individual eligible for state-funded services shall bill all other third-party payors, including Medicaid, NC Health Choice, and Medicare, before submitting a claim for IPRS reimbursement.

Claims submitted to IPRS have coding requirements that are specific to DMH/DD/SAS IPRS billing policy. Specifically, diagnosis coding is required on all claims to IPRS. IPRS recognizes only the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) codes. IPRS does not recognize any diagnosis codes in the Diagnostic and Statistical Manual of Mental Disorders, 4th Edition (DSM-IV).

To use the ICD-9-CM, identify the appropriate code in Volume 2 of the ICD-9-CM. Locate the identified code in Volume 1 of the ICD-9-CM. Use the instructions in Volume 1 to clarify and specify the best code with which to identify an individual's condition.

C. Billing Code(s)

Providers shall select the most specific billing code that accurately describes the service(s) provided.

Mobile Crisis Management

HCPCS Code	Description	Billing Unit
H2011	Crisis intervention service, per 15 minutes (Mobile Crisis Management)	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

Community Support Team—Adults

HCPCS Code	Description	Bill with Modifier	Billing Unit
H2015	Comprehensive Community Support services, per 15 minutes	HT – denotes individual	1 unit = 15 minutes

Assertive Community Treatment Team

HCPCS Code	Description	Billing Unit
H0040	Assertive Community Treatment program, per diem	1 unit = 1 event

Psychosocial Rehabilitation

HCPCS Code	Description	Billing Unit
H2017	Psychosocial Rehabilitation services, 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	Billing Unit
H0035	Mental Health Partial Hospitalization, treatment, less than 24 hours	1 unit = 1 event

Professional Treatment Services in Facility-Based Crisis Programs – Adult

HCPCS Code	Description	Billing Unit
S9484	Crisis Intervention mental health services, per hour (facility based crisis services)	1 unit = 1 hour

Substance Abuse Intensive Outpatient Program

HCPCS Code	Description	Billing Unit
H0015	Alcohol or drug services; Intensive Outpatient (treatment program that operates at least 3 hours per day and at least 3 days per week and is based on an individualized treatment plan), including assessment, counseling; crisis intervention, and activity therapies or education	1 unit = 1 event per day (3 hours minimum)

Substance Abuse Comprehensive Outpatient Treatment

HCPCS Code	Description	Billing Unit
H2035	Alcohol or other drug treatment program, per hour (Substance Abuse Comprehensive Outpatient Treatment)	1 unit =1 hour

Substance Abuse Non-Medical Community Residential Treatment—Adult

HCPCS Code	Description	Bill with Modifier	Billing Unit
H0012	Alcohol or drug services; subacute detoxification (residential addiction program outpatient) (substance abuse non-medical community)	HB	1 unit = 1 day not to exceed more than 30 days in a 12-month period

Substance Abuse Medically Monitored Community Residential Treatment

HCPCS Code	Description	Billing Unit
H0013	Alcohol or drug services; acute detoxification (residential addiction program outpatient) (Substance Abuse Medically Monitored Community)	1 unit = 1 day not to exceed more than 30 days in a 12-month period

Substance Abuse Halfway House

HCPCS Code	Description	Billing Unit
H2034	Alcohol or drug services; (Substance Abuse Halfway House)	1 unit = 1 day

Ambulatory Detoxification

HCPCS Code	Description	Billing Unit
H0014	Alcohol or drug services; Ambulatory Detoxification	1 unit = 15 minutes

Social Setting Detoxification

HCPCS Code	Description	Billing Unit
YP790	Alcohol or drug services; (Social Setting Detoxification)	1 unit = 1 day

Non-Hospital Medical Detoxification

HCPCS Code	Description	Billing Unit
H0010	Alcohol or drug services; subacute detoxification (residential addiction program inpatient) (Non-Hospital Medical Detoxification)	1 unit = 1 day not to exceed more than 30 days in a 12-month period

Medically Supervised Detoxification Crisis Stabilization

HCPCS Code	Description	Billing Unit
H2036	Alcohol or other drug treatment program, per diem (Medically Supervised Detox or Crisis Stabilization)	1 unit = 1 day not to exceed more than 30 days in a 12-month period

Opioid Treatment

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

D. Modifiers

Providers shall follow applicable modifier guidelines. Refer to **Section C** above.

E. Billing Units

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

F. Place of Service

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

G. Reimbursement

Providers shall bill their usual and customary charges based on DMH/DD/SAS reimbursement policy.

Attachment B: Goal Writing

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

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

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

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

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

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

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

a. **Words open to many interpretations (TRY *NOT* TO USE THESE WORDS) are:**
   - to know
   - to understand
   - to really understand
   - to appreciate
   - to fully appreciate
   - to grasp the significance of
   - to enjoy
   - to believe
   - to have faith in
   - to internalize

b. **Words open to fewer interpretations (USE THESE *TYPES* OF WORDS) are:**
   - to write
   - to recite
   - to identify
   - to sort
   - to solve
   - to construct
   - to build
   - to compare
   - to contrast
   - to smile

c. **Here are some 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].***

Attachment C: Documentation—Best Practice Guidelines

Services that are billed for state funds must comply with IPRS reimbursement guidelines and relate to goals in the individual's PCP. All service-related documentation must meet the requirements outlined in the *Records Management and Documentation Manual* and the *Person-Centered Planning Instruction Manual*. To assist in assuring that these guidelines are met, documentation shall be:

a. **Accurate** — describing the facts as observed or reported;

b. **Timely** — recording significant information at the time of the event, to avoid inaccurate or incomplete information;

c. **Objective** — recording facts and avoiding drawing conclusions. Professional opinion must be phrased to clearly indicate that it is the view of the recorder;

d. **Specific, concise, and descriptive** — recording in detail rather than in general terms, being brief and meaningful without sacrificing essential facts, and thoroughly describing observation and other pertinent information;

e. **Consistent** — explaining any contradictions and giving the reasons for the contradictions;

f. **Comprehensive, logical, and reflective of thought processes** — recording significant information relative to an individual's condition and course of treatment or rehabilitation. Document pertinent findings, services rendered, changes in the individual's condition, and response to treatment or rehabilitation, as appropriate. Include justification for initial services as well as continued treatment or rehabilitation needs. Document reasons for any atypical treatment or rehabilitation utilized.

g. **Clear** — recording meaningful information, particularly for other staff involved in the care or treatment of the individual. **Write in non-technical terms** to the extent possible.

Attachment D: Service Definitions

Mobile Crisis Management (State-Funded)

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

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

Provider Requirements
Mobile Crisis Management services shall be delivered by a team of practitioners employed by mental health, substance abuse, or intellectual or developmental disability provider organizations that meet the requirements of 10A NCAC 27G and the provider qualification policies, procedures, and standards established by DMH/DD/SAS. These policies and procedures set forth the administrative, financial, clinical, quality improvement, and information services infrastructure necessary to provide services. Provider organizations shall demonstrate that they meet these standards by being credentialed by the LME-MCO. Additionally, the organization shall achieve national accreditation with at least one of the designated accrediting bodies within one year of enrollment as a provider with the LME-MCO. The organization shall be established as a legally recognized entity in the United States and qualified or registered to do business as a corporate entity in the State of North Carolina, capable of meeting all of the requirements of the LME-MCO credentialing process, DMH/DD/SAS Communication Bulletins, DMH/DD/SAS *Records Management and Documentation Manual*, and service implementation standards. The provider organization shall comply with all applicable federal and state requirements.

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

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

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

   AND

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

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

Service Type and Setting
Mobile Crisis Management is a direct and periodic service that is available at all times, 24 hours a day, seven days a week, 365 days a year. 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 individual's outpatient clinician stabilized his or her crisis, the outpatient billing code should be used, not crisis management. If a Community Support Team worker responds and stabilizes his or her crisis, the Community Support 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 individual 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:

- Teams providing this service shall provide at least 80% of their units face-to-face with individuals receiving 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 an individual'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.

Program Requirements
Mobile Crisis Management services should be delivered in the least restrictive environment and provided in or as close as possible to an individual's home.

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

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

For individuals 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 individuals who are already receiving services, Mobile Crisis Management should recommend revisions to existing crisis plan components in PCPs, 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-MCO, the crisis management provider shall contact the LME-MCO to determine if the individual is enrolled with a provider that should and can provide or be involved with the response. Mobile Crisis Management shall be used to divert individuals from inpatient psychiatric and detoxification services. These services are not used as "step down" services from inpatient hospitalization.

Utilization management shall be performed by the LME-MCO.

Entrance Criteria
The individual is eligible for this service when the following criteria are met:

A. the individual or family are experiencing an acute, immediate crisis as determined by a crisis rating scale specified by DMH/DD/SAS;

AND

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

OR

C. The individual or family members evidences impairment of judgment, impulse control, cognitive or perceptual disabilities.

OR

D. The individual is intoxicated or in withdrawal, 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 or who are at substantial risk of future crises.

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

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

Documentation Requirements
The minimum standard is a daily full service note that includes the individual's name, Medicaid identification number, record number, date of service, purpose of contact, describes the provider's interventions - including 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 are not sufficient to provide the necessary documentation. For individuals new to the public system, Mobile Crisis Management shall develop a crisis plan before discharge.

Service Exclusions
Services that may not be concurrently provided with Mobile Crisis Management include the following: Assertive Community Treatment Team, 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.

Diagnostic Assessment (State-Funded):

Service Definition and Required Components
A Diagnostic Assessment is an intensive clinical and functional face-to-face evaluation of an individual's mental health, intellectual or developmental disability, or substance abuse condition. The assessment results in the issuance of a Diagnostic Assessment report with a recommendation regarding whether the individual meets target population criteria and includes an order for Enhanced Benefit services that provides the basis for the development of the PCP. For substance abuse-focused Diagnostic Assessment, the designated diagnostic tool specified by DMH/DD/SAS (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.

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

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

This assessment will be signed and dated by the MD, DO, PA, NP, or 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-MCO for administrative review and authorization of services under the purview of the LME-MCO.

Provider Requirements
Diagnostic Assessments shall be conducted by practitioners employed by mental health, substance abuse, or intellectual or developmental disability provider organizations that meet the

requirements of 10A NCAC 27G and the provider qualification policies, procedures, and standards established by DMH/DD/SAS. These policies and procedures set forth the administrative, financial, clinical, quality improvement, and information services infrastructure necessary to provide services. Provider organizations shall demonstrate that they meet these standards by being credentialed by the LME-MCO. Additionally, the organization shall achieve national accreditation with at least one of the designated accrediting bodies within one year of enrollment as a provider with the LME-MCO. The organization shall be established as a legally recognized entity in the United States and qualified or registered to do business as a corporate entity in the State of North Carolina, capable of meeting all of the requirements of the LME-MCO credentialing process, DMH/DD/SAS Communication Bulletins, the DMH/DD/SAS *Records Management and Documentation Manual*, and service implementation standards. The provider organization shall comply with all applicable federal and state requirements.

Staffing Requirements

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

Service Type and Setting

A Diagnostic Assessment is a direct periodic service that may be provided in any location.

Program Requirements

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

Utilization Management

An individual may receive one Diagnostic Assessment per year. An assessment equals one event. For individuals eligible for Enhanced Benefit services, referral and utilization management by the LME-MCO for Diagnostic Assessment is required. Additional diagnostic assessments require prior authorization and utilization management from the LME-MCO.

Entrance Criteria

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

A. There is a known or suspected mental health, substance abuse, or intellectual or developmental disability diagnosis;

OR

B. Initial screening or triage information indicates a need for additional mental

health, substance abuse, intellectual, or developmental disabilities treatment or supports.

Continued Stay Criteria
Not applicable.

Discharge Criteria
Not applicable.

Expected Outcomes
A Diagnostic Assessment determines whether the individual is appropriate for and can benefit from mental health, intellectual disability, developmental disability, or substance abuse services based on the individual's diagnosis, presenting problems, and treatment and recovery goals. It also evaluates the individual's level of readiness and motivation to engage in treatment. Results from a Diagnostic Assessment include an interpretation of the assessment information, appropriate case formulation, an order for immediate needs and the development of PCP. For individuals with a substance abuse diagnosis, a Diagnostic Assessment recommends a level of placement using N.C. Modified AASAM criteria.

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

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

Intensive In-Home Services (State-Funded):

Service Definition and Required Components

The Intensive In-Home (IIH) service is a team approach designed to address the identified needs of children and adolescents who, due to serious and chronic symptoms of an emotional, behavioral, or substance use disorder, are unable to remain stable in the community without intensive interventions. This service may only be provided to individuals through age 17. This medically necessary service directly addresses the individual's mental health 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 PCP. This team provides a variety of clinical rehabilitative interventions available 24 hours per day, 7 days per week, 365 days per year.

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

- 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 individual.

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

This team service includes a variety of interventions that are available 24 hours per day, 7 days per week, 365 days per year. Services are delivered by the IIH staff who maintain contact and intervene as one organizational unit. IIH services are provided through a team approach; however, discrete interventions may be delivered by any one or more team members as clinically indicated. Not all team members are required to provide direct intervention to each individual on the caseload. The Team Leader must provide direct clinical interventions with each individual. 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 individual and his or her caregivers
- Psychoeducation imparts information about the individual's diagnosis, condition, and treatment to the individual, family, caregivers, or other persons involved with the individual's care
- Intensive case management, which includes the following:
  - assessment
  - planning
  - linkage and referral to paid and natural supports
  - monitoring and follow up
- Arrangements for psychological and psychiatric evaluations
- Crisis management

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

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

A comprehensive clinical assessment is one mechanism to demonstrate medical necessity for a service and to assess and identify an individual's needs. For state-funded services, a service order is recommended. Providers shall coordinate with the LME-MCO regarding their requirements for service orders.

Provider Requirements

IIH services shall be delivered by practitioners employed by mental health, substance abuse, or intellectual or developmental disability provider organizations that are currently certified as a Critical Access Behavioral Healthcare Agency (CABHA), and meet the requirements of 10A NCAC 27G and the provider qualification policies, procedures, and standards established by DHM/DD/SAS. These policies and procedures set forth the administrative, financial, clinical, quality improvement, and information services infrastructure necessary to provide services. Provider organizations shall demonstrate that they meet these standards by being credentialed by the LME-MCO. Additionally, the organization shall achieve national accreditation with at least one of the designated accrediting bodies within one year of enrollment as a provider with the LME-MCO. The organization shall be established as a legally recognized entity in the United States and qualified or registered to do business as a corporate entity in the State of North Carolina, capable of meeting all of the requirements of the LME-MCO credentialing process, DMH/DD/SAS Communication Bulletins, the DMH/DD/SAS *Records Management and Documentation Manual*, and service implementation standards. The provider organization shall comply with all applicable federal and state requirements.

The organization is responsible for obtaining prior authorization from the LME-MCO for medically necessary services identified in the PCP.

Staffing Requirements

All treatment shall be focused on, and for the benefit of, the eligible individual receiving 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). An associate level Licensed Professional actively seeking licensure may serve as the team leader conditional upon being fully licensed within 30 months from the effective date of this policy. For associate level licensed team leaders hired after the effective date of this policy, the 30-month timeline begins at date of hire.

AND

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

AND

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

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

All staff providing Intensive In-Home services to children and families must have a minimum of one (1) year of 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 individual served by the team
- Designating the appropriate team staff such that specialized clinical expertise is applied as clinically indicated for each individual
- Providing and coordinating the assessment and reassessment of the individual's clinical needs
- Providing clinical expertise and guidance to the IIH team members in the team's interventions with the individual

- 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.

The Licensed Professional or Qualified Professional has responsibility for the following:

- Coordinating and overseeing 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 PCP 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 individual or other family members with other licensed professionals and Child and Family Team members.
- Monitoring and documenting the status of the individual's progress and the effectiveness of the strategies and interventions outlined in the PCP

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

- Participating in the person-centered planning process
- Assisting with implementing a home-based behavioral support plan with the individual and his or her caregivers as indicated in the PCP
- Providing psychoeducation as indicated in the PCP
- Assisting the team leader in monitoring and evaluating the effectiveness of interventions, as evidenced by symptom reduction and progress toward goals identified in the PCP
- 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 QP or AP status according to 10A NCAC 27G .0104 and who have the knowledge, skills, and abilities required by the population and age to be served may deliver IIH services.

Family members or legally responsible persons of the individual receiving Intensive In-Home services may not provide these services for reimbursement.

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

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, or by June 30, 2011 for staff who were currently working as an IIH Team member as of January 1,2011, all IIH staff shall complete the following training requirements:

    IIH staff must complete 24 hours* of training (a minimum of 3 days) in one of the designated therapies, practices or models below specific to the population(s) to be served by each IIH Team. The designated therapies, practices or models are as follows:
    - 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)

        1. Practices or models must be treatment focused, not prevention focused.
        2. Each practice or model chosen must specifically address the treatment needs of the population to be served by each IIH.
        3. Cognitive Behavior Therapy training must be delivered by a licensed professional.
        4. Trauma-focused therapy and family therapy training must be delivered by a trainer who meets the qualifications of the developer of the specific therapy, practice or model and meets the training standard of the specific therapy, practice or model. If no specific trainer qualifications are specified by the model then the training must be delivered by a licensed professional.

    * Licensed Professionals (LP) who have documented evidence of post graduate training in the chosen qualifying practice (identified in the DMA Clinical Coverage Policy 8A March 20, 2006) dated no earlier than March 20, 2006 may count those training hours toward the 24-hour requirement. It is the responsibility of the LP to have clearly documented evidence of the hours and type of training received.

    Licensed (or associate level Licensed Professionals, under supervision) staff shall be trained in and provide the aspects of these practice(s) or model(s) that require licensure,

such as individual therapy or other therapeutic interventions falling within the scope of practice of Licensed Professionals. It is expected that Licensed (or associate level Licensed Professionals, under supervision) staff will practice within their scope of practice.

Non-licensed staff [QPs and APs] shall be trained in and provide only the aspects of these practice(s) or model(s) that do not require licensure and are within the scope of their education, training, and expertise. Non-licensed staff will practice under supervision according to the service definition. It is the responsibility of the Licensed (or associate level Licensed Professional, 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, or by March 31, 2011 for staff who were currently working as an IIH Team member as of January 1, 2011, shall complete the following training requirements:
    - 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 or Recovery training curriculum when available as an alternative to the full 12 hour training; if not, then the full 12 hour training must be completed.

AND

2. Within 90 days of hire to provide this service, or by June 30, 2011 for staff who were currently working as an IIH Team member as of January 1,2011, all IIH Team Leaders shall complete all supervisory level training required by the developer of the designated therapy,

practice or model. If no specific supervisory level training exists for the designated therapy, practice, or model, then all IIH Team Leaders must complete a minimum of 12 hours of clinical supervision training.

All Non-Supervisory IIH Staff (QPs and APs)

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

- 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 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 or Recovery training curriculum when available as an alternative to the full 12-hour training; if not, then the full 12-hour training must be completed.

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

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

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

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 individual. Additionally, the team provides interventions with the family and caregivers on behalf of and directed for the benefit of the individual as well as plans, links, and monitors services on behalf of the individual. 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.

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

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

Program Requirements

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 individual are required in the first month, and at least 6 face-to face contacts per individual 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 the individual's progress toward goals as identified in the PCP.

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

- Direct clinical interventions as identified in the PCP; and
- Case management interventions (face-to-face, telephone time, and collateral contacts).

Services are delivered face-to-face with the individual, 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 individual, 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 individual.

At any point while the individual is receiving IIH services, IIH staff shall link him or her to an alternative service when clinically indicated and functionally appropriate for the needs of the individual 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

An individual is eligible for this service when all of the following criteria are met:

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 intellectual or developmental disability.
B. Based on the current comprehensive clinical assessment, this service was indicated and outpatient treatment services were considered or previously attempted, but were found to be inappropriate or not effective.
C. The individual has current or past history of symptoms or behaviors indicating the need for a crisis intervention as evidenced by suicidal or homicidal ideation, physical aggression toward others, self-injurious behavior, serious risk taking behavior (running away, sexual aggression, sexually reactive behavior, or substance use).
D. The individual'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.
E. The individual is at imminent risk of out-of-home placement based on his or her current mental health or substance abuse clinical symptomatology, or is currently in an out-of-home placement and a return home is imminent.

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 PCP.

A comprehensive clinical assessment is one mechanism to demonstrate medical necessity for a service and to assess and identify an individual's needs. For state-funded services, a service order is recommended. Providers shall coordinate with the LME-MCO regarding their requirements for service orders.

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

Prior authorization by the LME-MCO is required. To request the initial authorization, submit the PCP with signatures, the required authorization request form, and any additional documentation required to the LME-MCO. In addition, submit a completed LME-MCO Consumer Admission and Discharge Form to the LME-MCO.

The LME-MCO 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 individual and his or her family, for the purpose of further developing the PCP.

Continued Service Criteria

The desired outcome or level of functioning has not been restored, improved, or sustained over the time frame outlined in the individual's PCP; or the individual 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 individual has achieved current PCP goals, and additional goals are indicated as evidenced by documented symptoms.
B. The individual is making satisfactory progress toward meeting goals and there is documentation that supports that continuation of this service will be effective in addressing the goals outlined in the PCP.

C. The individual is making some progress, but the specific interventions in the PCP need to be modified so that greater gains, which are consistent with the individual's premorbid level of functioning, are possible.
D. The individual fails to make progress, or demonstrates regression, in meeting goals through the interventions outlined in the PCP. The individual'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 individual has achieved goals and is no longer in need of IIH services.
B. The individual's level of functioning has improved with respect to the goals outlined in the PCP, inclusive of a transition plan to step down to a lower level of care.
C. The individual 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 individual or legally responsible person no longer wishes to receive IIH services.
E. The individual, based on presentation and failure to show improvement despite modifications in the PCP, requires a more appropriate best practice treatment modality based on North Carolina community practice standards (for example, National Institute of Drug Abuse, American Psychiatric Association).

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

NOTE: Any denial, reduction, suspension, or termination of service requires notification to the individual, legally responsible person, or both about the individual's appeal rights pursuant to G.S. 143B-147(a)(9) and Rules 10A NCAC 27I .0601-.0609.

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 individual's PCP.

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

- Decrease in the frequency or intensity of crisis episodes
- Reduction in symptomatology
- Engagement in the recovery process by the individual, and family or caregivers
- Improved functioning in the home, school and community settings
- Ability of the individual and family or caregiver to better identify and manage triggers, cues, and symptoms
- Sustained improvement in developmentally appropriate functioning in specified life domains
- Increased utilization of coping skills and social skills that mitigate life stresses resulting from the individual's diagnostic and clinical needs

- Reduction of symptoms and behaviors that interfere with the individual'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 individual and family or caregivers

Documentation Requirements
Refer to 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:

- Individual's name
- Medicaid identification number, if applicable
- 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 individual's specified goals as outlined in the PCP
- Signature and credentials of the staff member(s) providing the service

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

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

Utilization Management
Services are based upon a finding of medical necessity, shall be directly related to the individual's diagnostic and clinical needs, and are expected to achieve the specific rehabilitative goals specified in his or her PCP. Medical necessity is determined by North Carolina community practice standards as verified by the LME-MCO.

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 individual's physician, therapist, or other licensed practitioner. Typically, a medically necessary service shall be generally recognized as an accepted method of medical practice or treatment. Each

case is reviewed individually to determine if the requested service meets the criteria outlined in this policy.

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

Prior authorization by the LME-MCO is required.

The LME-MCO will evaluate the request to determine if medical necessity supports more or less intensive services.

The LME-MCO may cover up to 60 days for the initial authorization period based on the medical necessity documented in the individual's PCP, the authorization request form, and supporting documentation. Submit the reauthorization request before the initial authorization expires. The LME-MCO may cover up to 60 days for reauthorization based on the medical necessity documented in the required PCP, the authorization request form, and supporting documentation. If continued IIH services are needed at the end of the initial authorization period, submit the PCP and a new request for authorization reflecting the appropriate level of care and service to the LME-MCO. 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:

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

Service delivery to individuals other than the child or adolescent receiving the service may be covered only when the activity is directed exclusively toward the benefit of that child or adolescent.

IIH services may not be provided during the same authorization period as the following services: 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; Psychiatric Residential Treatment Facility (PRTF); or substance abuse residential services.

Multisystemic Therapy (MST) (State-Funded):

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 or violent behaviors, are at risk of out-of-home placement due to delinquency or; adjudicated youth returning from out-of-home placement or; chronic or violent juvenile offenders, 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 individuals and their families. Services include: an initial assessment to identify the focus of the MST intervention; individual therapeutic interventions with the child or adolescent and his or her 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 individual's behavior.

A comprehensive clinical assessment is one mechanism to demonstrate medical necessity for a service and to assess and identify an individual's needs. For state-funded services, a service order is recommended. Providers shall coordinate with the LME-MCO regarding their requirements for service orders.

Provider Requirements
MST services shall be delivered by a team of practitioners employed by mental health, substance abuse, or intellectual or developmental disability provider organizations that meet the

requirements of 10A NCAC 27G and the provider qualification policies, procedures, and standards established by DMH/DD/SAS. These policies and procedures set forth the administrative, financial, clinical, quality improvement, and information services infrastructure necessary to provide services. Provider organizations shall demonstrate that they meet these standards by being credentialed by the LME-MCO. Additionally, the organization shall achieve national accreditation with at least one of the designated accrediting bodies within one year of enrollment as a provider with the LME-MCO. The organization shall be established as a legally recognized entity in the United States and qualified or registered to do business as a corporate entity in the State of North Carolina, capable of meeting all of the requirements of the LME credentialing process, DMH/DD/SAS Communication Bulletins, the DMH/DD/SAS *Records Management and Documentation Manual*, and service implementation standards. The provider organization shall comply with all applicable federal and state requirements.

MST providers must have the ability to deliver services in various environments, such as homes, schools, homeless shelters, street locations, etc. Organizations that provide MST must provide "first responder" crisis response on a 24 hours a day, seven days a week, 365 days a year basis, to individuals 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 individuals receiving MST and their family on an ongoing basis. All staff on the MST team shall receive a minimum of 1 hour of group supervision and 1 hour of telephone consultation per week. MST team member–to–family ratio shall not exceed 1:5 for each member.

Service Type and Setting

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

Clinical Requirements

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 are billed in 15-minute increments.

Program services are primarily delivered face-to-face with the individual and/or his or her 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 individual 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 individuals receiving the service.

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

Utilization management must be performed by the LME-MCO.

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

Entrance Criteria
All of the following criteria must be met:

A. There is an Axis I or II diagnosis present, other than a sole diagnosis of an intellectual or developmental disability.
B. The individual should be between the ages of 7 through 17.
C. The individual displays willful behavioral misconduct (e.g., theft, property destruction, assault, truancy or substance use or abuse or juvenile sex offense), when in conjunction with other adjudicated delinquent behaviors
D. The individual 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.
E. The individual 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 individual's PCP or the individual 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. The individual continues to exhibit willful behavioral misconduct.

AND

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

OR

C. The individual is not making progress; the PCP must be modified to identify more effective interventions.

OR

D. The individual is regressing; the PCP must be modified to identify more effective interventions.

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

A. The individual has achieved 75% of the PCP goals; discharge to a lower level of care is indicated.
B. The individual is not making progress or is regressing, and all realistic treatment options within this modality have been exhausted.
C. The individual or family requests discharge and is not imminently dangerous to self or others.
D. The individual 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 individual, legally responsible person, or both about the individual's appeal rights in accordance with the Department's beneficiary notices procedure pursuant to G.S. 143B-147(a)(9) and Rules 10A NCAC 27I .0601-.0609.

Documentation Requirements
Minimum standard is a daily full service note that includes the individual's name, Medicaid 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 individual has improved in domains such as: adaptive, communication, psychosocial, problem solving and behavior, behavioral misconduct has been reduced or eliminated (e.g. theft, property destruction, assault, truancy or substance abuse or use, or juvenile sex offense, when in conjunction with other delinquent behaviors). The family has increased capacity to monitor and manage the individual's behavior and the need for out of home placement has been reduced or eliminated.

Service Exclusions and Limitations
An individual may receive MST services from only one MST provider organization at a time.

MST services may not be billed for individuals who are receiving Intensive In-Home Services, Day Treatment, Hourly Respite, individual, group or family therapy, SAIOP, child residential Level II–IV, or substance abuse residential services.

Community Support Team (CST) (State-Funded)

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

***NOTE:** State-funded services for adults begin at age 18.

This is an intensive community-based rehabilitation team service that provides direct treatment and restorative interventions as well as case management. CST is designed to

- reduce presenting psychiatric or substance abuse symptoms and promote symptom stability,
- restore the individual's community living and interpersonal skills,
- provide first responder intervention to deescalate the current crisis, and
- ensure linkage to community services and resources.

This team service includes a variety of interventions that are available 24 hours a day, 7 days a week, 365 days a year, and are delivered by the CST staff, who maintain contact and intervene as one organizational unit. CST services are provided through a team approach; however, discrete interventions may be delivered by any one or more team members as clinically indicated. Not all team members are required to provide direct intervention to each individual on the caseload. The Team Leader must provide direct clinical interventions with each individual. The team approach involves structured, face-to-face, scheduled therapeutic interventions to provide support and guidance in all areas of functioning in life domains: emotional, social, safety, housing, medical and health, educational, vocational, and legal.

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

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

- Individual therapy
- Behavioral interventions such as modeling, behavior modification, behavior rehearsal
- Substance abuse treatment interventions

- Development of relapse prevention and disease management strategies to support recovery
- Psychoeducation for the individual, families, caregivers, or other individuals involved with the individual about his or her diagnosis, symptoms, and treatment.
- Psychoeducation regarding the identification and self-management of the prescribed medication regimen, with documented communication to prescribing practitioner(s)
- Intensive case management
    - assessment
    - planning
    - linkage and referral to paid and natural supports
    - monitoring and follow up
- Arranging for psychological and psychiatric evaluations and
- Crisis management, including crisis planning and prevention

A comprehensive clinical assessment is one mechanism to demonstrate medical necessity for a service and to assess and identify an individual's needs. For state-funded services, a service order is recommended. Providers shall coordinate with the LME-MCO regarding their requirements for service orders.

Provider Requirements

CST services shall be delivered by practitioners employed by mental health, substance abuse, or intellectual or developmental disability provider organizations that are currently certified as a Critical Access Behavioral Healthcare Agency (CABHA), and meet the requirements of 10A NCAC 27G and the provider qualification policies, procedures, and standards established by DHM/DD/SAS. These policies and procedures set forth the administrative, financial, clinical, quality improvement, and information services infrastructure necessary to provide services. Provider organizations shall demonstrate that they meet these standards by being credentialed by the LME-MCO. Additionally, the organization shall achieve national accreditation with at least one of the designated accrediting bodies within one year of enrollment as a provider with the LME-MCO. The organization shall be established as a legally recognized entity in the United States and qualified or registered to do business as a corporate entity in the State of North Carolina, capable of meeting all of the requirements of the LME-MCO credentialing process, DMH/DD/SAS Communication Bulletins, the DMH/DD/SAS *Records Management and Documentation Manual*, and service implementation standards. The provider organization shall comply with all applicable federal and state requirements.

The organization is responsible for obtaining prior authorization from the LME-MCO for medically necessary services identified in the PCP.

Staffing Requirements

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

A. One full-time equivalent (FTE) team leader who is a Licensed Professional who has the knowledge, skills, and abilities required by the population and age to be served (may be filled by no more than two individuals). An associate level Licensed Professional actively seeking licensure may serve as the team leader conditional upon being fully licensed within 30 months from the effective date of this policy. For associate level Licensed

Professional team leaders hired after the effective date of this policy, the 30-month timeline begins at date of hire.

B. One FTE QP who has the knowledge, skills, and abilities required by the population and age to be served (may be filled by no more than two individuals).
C. One FTE who is a QP, AP, Paraprofessional, or Certified Peer Support Specialist, and who has the knowledge, skills, and abilities required by the population and age to be served (may be filled by no more than two individuals).

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

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

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

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

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

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

Community Support Team
Team Leader
• Provides individual therapy for individuals served by the team • Behavioral interventions such as modeling, behavior modification, behavior rehearsal • Designates the appropriate team staff so that specialized clinical expertise is applied as clinically indicated for each individual • Provides and coordinating the assessment and reassessment of the individual's clinical needs • Provides clinical expertise and guidance to the CST members in the team's interventions with the individual • Provides the clinical supervision of all members of the team for the provision of this service. An individual supervision plan is required for all CST members except the Team Leader • Determines team caseload by the level of acuity and the needs of the individual served • Facilitates weekly team meetings of the CST • Monitors and evaluates the services, interventions, and activities provided by the team

Team Leader or QP
• Provides psychoeducation as indicated in the PCP • Assists with crisis interventions • Assists the Team Leader with behavioral and substance abuse treatment interventions • Assists with the development of relapse prevention and disease management strategies • Coordinates and oversees the initial and ongoing assessment activities • Develops the initial PCP and its ongoing revisions and ensures its implementation • Consults with identified medical (for example, primary care and psychiatric) and non-medical providers, engages community and natural supports, and includes their input in the person-centered planning process • Ensures linkage to the most clinically appropriate and effective services including arranging for psychological and psychiatric evaluations • Monitors and documents the status of the individual's progress and the effectiveness of the strategies and interventions outlined in the PCP

(charts continue next page)

AP, QP, or Team Leader
• Provides psychoeducation as indicated in the PCP • Assists with crisis interventions • Assists the Team Leader with behavioral and substance abuse treatment interventions • Assists with the development of relapse prevention and disease management strategies • Participates in the initial development, implementation, and ongoing revision of the PCP • Communicates the individual's progress and the effectiveness of the strategies and interventions to the Team Leader as outlined in the PCP

Paraprofessional
• Provides psychoeducation as indicated in the PCP • Assists with crisis interventions • Assists the Team Leader with behavioral and substance abuse interventions • Assists with the development of relapse prevention and disease management strategies • Participates in the initial development, implementation, and ongoing revision of the PCP • Communicates the individual's progress and the effectiveness of the strategies and interventions to the Team Leader as outlined in the PCP

Certified Peer Support Specialist
• Serves as an active member of the CST, participates in team meetings, and provides input into the person-centered planning process • Guides and encourages individuals to take responsibility for and actively participate in their own recovery • Assists the individual with self-determination and decision-making • Models recovery values, attitudes, beliefs, and personal action to encourage wellness and resilience • Teaches and promotes self-advocacy to the individual • Supports and empowers the individual to exercise his or her legal rights within the community

All staff providing CST services shall have a minimum of 1 year of documented experience with the adult MH/SA population. (Exception: A Certified Peer Support Specialist is not required to demonstrate 1 year of documented experience in working with the adult MH/SA population, as his or her personal experience in MH/SA services fulfills that requirement.)

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

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

All CST Staff

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

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

AND

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

    CST staff must complete 24 hours* of training (a minimum of 3 days) in one of the designated therapies, practices or models below specific to the population(s) to be served by each CST Team. The designated therapies, practices or models are as follows:

    The designated therapies, practices or models are as follows:

    - Cognitive Behavior Therapy or
    - Trauma-Focused Therapy (For Example: Seeking Safety, TARGET, TREM, Prolonged Exposure Therapy for PTSD) or
    - Illness Management and Recovery (SAMHSA Toolkit http://mentalhealth.samhsa.gov/cmhs/CommunitySupport/toolkits/illness/default.asp).

        1. Practices or models must be treatment-focused models, not prevention or education focused models.
        2. Each practice or model chosen must specifically address the treatment needs of the population to be served by each CST.
        3. Cognitive Behavior Therapy training must be delivered by a licensed professional.
        4. Trauma-focused therapy and Illness Management and Recovery training must be delivered by a trainer who meets the qualifications of the developer of the specific therapy, practice or model and meets the training standard of the specific therapy, practice or model. If no specific trainer qualifications are specified by the model, then the training must be delivered by a licensed professional.

    * Licensed Professionals (LP) who have documented evidence of post graduate training in the chosen qualifying practice (identified in the DMA Clinical Coverage Policy 8A, March 20,2006) dated no earlier than March 20, 2006 may count those

training hours toward the 24-hour requirement. It is the responsibility of the LP to have clearly documented evidence of the hours and type of training received.

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

Non-licensed staff [QPs, APs, Peer Support Specialists, and Paraprofessionals] shall be trained in and provide only the aspects of these practice(s) or model(s) that do not require licensure and are within the scope of their education, training, and expertise. Non-licensed staff will practice under supervision according to the service definition. It is the responsibility of the Licensed (or associate level Licensed Professional, 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 chosen modality (Cognitive Behavioral Therapy, Trauma Focused Therapy, and Illness Management and Recovery (SAMHSA Toolkit)) is required. If no requirements have been designated by the developers of that modality, a minimum of 10 hours of continuing education in components of the selected modality must be completed annually.

CST Team Leaders

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

1. In addition to the training required for all CST staff, CST Team Leaders, within **90 days** of hire to provide this service, **or** by **March 31, 2011** for staff who were currently working as a CST Team member as of January 1, 2011, shall complete the following training requirements:
    - 13 hours of Introductory Motivational Interviewing (MI) training by a MINT Trainer** (mandatory 2-day training).
    - 12 hours of Person Centered Thinking (PCT) training from a Learning Community for Person Centered Practices certified PCT trainer.
        - All new hires to CST must complete the full 12-hour training.
        - Staff who previously worked in CST 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 CST within the same agency and had six (6) hours of PCT training under the old requirement may complete the additional six (6) hour PCT or Recovery training curriculum when available as an alternative to the full 12-hour training; if not, then the full 12 hour training must be completed.

AND

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

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

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

- 13 hours of Introductory Motivational Interviewing* (MI) training (mandatory 2-day training)
- 12 hours of Person Centered Thinking (PCT) training from a Learning Community for Person Centered Practices certified PCT trainer.
  - All new hires to CST must complete the full 12-hour training.
  - Staff who previously worked in CST 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 CST within the same agency and had six (6) hours of PCT training under the old requirement may complete the additional six (6) hour PCT or Recovery training curriculum when available as an alternative to the full 12-hour training; if not, then the full 12-hour training must be completed.

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

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

Time Frame	Training Required	Who	Total Minimum Hours Required
Within **30 days** of hire to provide service	▪ 3 hours CST service definition required components ▪ 3 hours of crisis response	▪ All Staff	6 hours
	▪ 3 hours of PCP Instructional Elements	▪ CST Team Leaders ▪ QPs responsible for PCP	3 hours
Within **90 days** of hire to provide this service, **or** by **March 31, 2011**, for staff members of existing providers	▪ 13 hours of Introductory Motivational Interviewing* (MI) (mandatory 2-day training) ▪ 12 hours of Person Centered Thinking	▪ CST Team Leaders	25 hours
Within **90 days** of hire to provide this service, **or** by **June 30, 2011**, for staff members of existing providers	▪ 13 hours of Introductory Motivational Interviewing* (MI) (mandatory 2-day training) ▪ 12 hours of Person Centered Thinking	▪ All Non-Supervisory CST Team Staff	25 hours
	▪ To ensure the core fundamental elements of training specific to the modality** selected by the agency for the provision of services are implemented a minimum of 24 hours of the selected modality must be completed.	▪ All CST Staff	24 hours
	▪ All supervisory level training required by the developer of the designated therapy, practice or model with a minimum of 12 hours must be completed.	▪ CST Team Leaders	12 hours
Annually	▪ Follow up training and ongoing continuing education required for fidelity to chosen modality** (If no requirements are designated by developers of that modality, a minimum of 10 hours of continuing education in components of the selected modality must be completed.).	▪ All CST Staff	10 hours**

* Motivational Interviewing training must be provided by a Motivational Interviewing Network of Trainers (MINT) trainer.

**Modalities must be ONE of the following: Cognitive Behavioral Therapy, Trauma Focused Therapy, and Illness Management and Recovery (SAMHSA Toolkit).

Total Hours of Training for the CST Staff:

- CST staff other than the Team Leader and QPs responsible for PCPs – **31 hours plus required hours for selected model**
- QPs responsible for the PCP – **34 hours plus required hours for selected model**
- Team Leader – **34 hours plus required hours for selected model and supervisory training requirement**

AND

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

Service Type and Setting

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

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

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

Program Requirements

The CST staff 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 the individual's progress toward goals as identified in the PCP.

The CST staff shall be able to provide multiple contacts a week—daily, if needed—based on the severity of the individual's mental health and substance abuse clinical and diagnostic needs, as indicated in the PCP. During an individual's first month of service, the CST staff shall provide at least eight (8) contacts. In subsequent months, CST services are provided at least once a week.

It is understood that CST is appropriate to serve people who are homeless, transient, and challenging to engage. Therefore, the expectation is that collateral contacts made in an attempt to locate and engage the individual to continue the individual's treatment be documented in the service record.

CST varies in intensity to meet the changing needs of individuals with mental illness and substance abuse disorders who have complex and extensive treatment needs, to support them in community settings, and to provide a sufficient level of service as an alternative to hospitalization. CST service delivery is monitored continuously and "titrated," meaning that

when an individual needs more or fewer services, the team provides services based on that level of need.

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

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

Units are billed in 15-minute increments.

Eligibility Criteria

The individual is eligible for this service when:

A. There is documented, significant impairment in at least two of the life domains (emotional, social, safety, housing, medical or health, educational, vocational, and legal). This impairment is related to the individual's diagnosis and impedes his or her use of the skills necessary for independent functioning in the community.

AND

B. 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 an intellectual or developmental disability.

AND

C. For individuals with a primary substance-related diagnosis, the American Society for Addiction Medicine Patient Placement Criteria (ASAM-PPC) are met.

AND

D. Four or more of the following conditions related to the diagnosis are present:
   1. High use of acute psychiatric hospitals or crisis or emergency services, including but not limited to mobile crisis management, in-clinic or crisis residential (2 or more admissions in a year), extended hospital stay (30 days within the past year), or psychiatric emergency services
   2. History of difficulty using traditional services (missing office appointments, difficulty maintaining medication schedules, etc.)
   3. Intermittently medication refractory (not achieving full response to medication or sustained reduction of symptoms) or difficulty maintaining compliance with taking medication
   4. Co-occurring diagnoses of substance abuse (ASAM—any level of care) and mental illness
   5. Legal issues (conditional release for non-violent offense; history of failures to show in court, etc.) related to the individual's Axis I or Axis II MH/SA diagnosis

6. Homelessness, or at high risk of homelessness, due to residential instability resulting from the individual's Axis I or Axis II MH/SA diagnosis
7. Clinical evidence of suicidal gestures, persistent ideation, or both in past 3 months
8. Ongoing inappropriate public behavior in the community within the last 3 months
9. Within the past 6 months, physical aggression, intense verbal aggression, or both toward self or others (due to symptoms associated with diagnosis) sufficient to create functional problems in the home, community, school, job, etc.
10. A less intense level of care has been tried and found to be ineffective for the clinical needs of the individual.

AND

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

Entrance Process

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

A comprehensive clinical assessment is one mechanism to demonstrate medical necessity for a service and to assess and identify an individual's needs. For state-funded services, a service order is recommended. Providers shall coordinate with the LME-MCO regarding their requirements for service orders.

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

Prior authorization by the LME-MCO is required for this service. To request the initial authorization, submit the PCP with signatures and the required authorization request form to the LME-MCO. In addition, submit a completed LME-MCO Consumer Admission and Discharge Form to the LME-MCO.

The initial authorization period may cover up to 60 days based on medical necessity.

Continued Service Criteria

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

AND

ANY of the following applies:

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

Discharge Criteria

ANY one of the following applies:

A. The individual's level of functioning has improved with respect to the goals outlined in the PCP, inclusive of a transition plan to step down to a lower level of care.
B. The individual has achieved positive life outcomes that support stable and ongoing recovery and is no longer in need of CST services.
C. The individual 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 individual or legally responsible person no longer wishes to receive CST services.
E. The individual, based on presentation and failure to show improvement, despite modifications in the PCP, requires a more appropriate best practice treatment modality based on North Carolina community practice standards (for example, National Institute of Drug Abuse, American Psychiatric Association).

Expected Clinical Outcomes

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

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

- Increased ability to function in the major life domains (emotional, social, safety, housing, medical or health, educational, vocational, and legal) as identified in the PCP
- Reduced symptomatology
- Decreased frequency or intensity of crisis episodes
- Increased ability to function as demonstrated by community participation (time spent working, going to school, or engaging in social activities)
- Increased ability to live as independently as possible, with natural and social supports

- Engagement in the recovery process
- Increased identification and self-management of triggers, cues, and symptoms
- Increased ability to function in the community and access financial entitlements, housing, work, and social opportunities
- Increased coping skills and social skills that mitigate life stresses resulting from the beneficiary's diagnostic and clinical needs
- Increased ability to use strategies and supportive interventions to maintain a stable living arrangement
- Decreased criminal justice involvement related to the beneficiary's Axis I or Axis II MH/SA diagnosis

Documentation Requirements
Refer to 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 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:

- Individual's name
- Service record number
- Medicaid identification number
- Service provided (for example, CST)
- 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 interventions
- Description of the effectiveness of the interventions in meeting the beneficiary's specified goals as outlined in the PCP
- Signature and credentials of the staff member(s) providing the service (for paraprofessionals, position is required in lieu of credentials with staff signature)

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

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

Utilization Management
Services are based upon a finding of medical necessity, shall be directly related to the individual's diagnostic and clinical needs, and are expected to achieve the specific rehabilitative goals specified in his or her PCP.

Medically necessary services are authorized in the most cost-efficient mode, as long as the

treatment that is made available is similarly efficacious as services requested by the individual's physician, therapist, or other licensed practitioner. Typically, the medically necessary service shall be generally recognized as an accepted method of medical practice or treatment. Each case is reviewed individually to determine if the requested service meets the criteria outlined by this policy.

Prior authorization by the LME-MCO is required according to published policy.

The LME-MCO will evaluate the request to determine if medical necessity supports more or less intensive services.

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

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

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

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

Units are billed in 15-minute increments.

Service Exclusions and Limitations

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

The following are not billable under this service:

- 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 (this is factored in the rate)

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

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

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

For the purposes of helping an individual transition to and from a service (facilitating an admission to a service, discharge planning, or both) and ensuring that the service provider works directly with the CST QP, CST services may be provided by the QP and billed for a maximum of 8 units for the first and last 30-day periods for individuals who are authorized to receive the following service:

- Assertive Community Treatment Team.

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

- Substance Abuse Intensive Outpatient Program
- Substance Abuse Comprehensive Outpatient Treatment.

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

For the purposes of helping an individual transition to and from a service (facilitating an admission to a service, discharge planning, or both), providing coordination during the provision of a service, and ensuring that the service provider works directly with the CST QP, CST services may be provided by the QP and billed in accordance with the authorization for services during the same authorization period for the following services based on medical necessity:

- All detoxification services
- Professional Treatment Services in Facility-Based Crisis Programs
- Partial Hospitalization
- Substance Abuse Medically Monitored Community Residential Treatment
- Substance Abuse Non-Medically Monitored Community Residential Treatment.

Assertive Community Treatment (ACT) Team
State-Funded Billable Service

Service Definition and Required Components

An Assertive Community Treatment (ACT) team consists of a community-based group of medical, behavioral health, and rehabilitation professionals who use a team approach to work together to meet the needs of individuals with severe and persistent mental illness. Individuals who are appropriate for ACT do not benefit from receiving services across multiple, disconnected providers, and may become at greater risk of hospitalization, homelessness, substance use, victimization, and incarceration. ACT teams provide person-centered services addressing a breadth of individual's needs, helping him or her achieve their personal goals. Thus, a fundamental charge of ACT is to be the first-line (and generally sole provider) of all the services that individuals who receive ACT need. Being the single point of responsibility necessitates a higher frequency and intensity of community-based contacts, and a very low individual-to-staff ratio. Services are flexible; teams offer varying levels of care across all individuals, and appropriately adjust service levels given an individual's changing needs across time. For example, an individual advancing in recovery and preparing to transfer off of the team may be seen by the team less than once per week as part of his or her transition plan. Another may need to be seen more than once a day for several months to help improve his or her stability following a recent hospital discharge, medication change, or move to an independent living setting.

ACT teams assist individuals in advancing toward personal goals with a focus on enhancing community integration and regaining valued roles (e.g., worker, daughter, resident, spouse, tenant, friend). Because ACT teams often work with individuals who may passively or actively resist services, ACT teams are expected to thoughtfully carry out planned assertive engagement techniques which largely consist of rapport-building strategies, facilitating meeting basic needs, and motivational interviewing techniques. These techniques are used to identify and focus on the individual's life goals and what he or she is motivated to change. Likewise, it is the team's responsibility to monitor the individual's mental status in a respectful manner that is congruent with the individual's level of need and functioning. The ACT team delivers all services according to a recovery-based philosophy of care, where the team promotes self-determination, respects the individual as expert in his or her own right, and engages peers in the process of promoting hope that the individual can recover from mental illness and regain meaningful roles and relationships in the community.

*The following chronological sections are identified with an asterisk within the following service definition and are the minimum requirements for ACT Teams:

A. Provider Requirements
B. Program Size
C. Staff Requirements
D. Staff Qualifications and Roles
E. Program Requirements
F. Service Frequency and Duration
G. Staff Training Requirements

***Provider Requirements**

The ACT team is administered by a provider organization that meets all of the following requirements:

A. meet the provider qualification policies, procedures, and standards established by the North Carolina Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS);
B. fulfill the requirements of 10A NCAC 27G;
C. demonstrate that they meet these standards by being certified by the Local Management Entities-Managed Care Organizations (LME-MCO); and
D. establishment as a legally constituted entity capable of meeting all of the requirements of the Provider Certification, LME-MCO Enrollment Agreement, DMH Communication Bulletins, and service implementation standards.

For State-Funded services, the ACT team provider organization is responsible for obtaining authorization from the LME-MCO for medically necessary services identified in the Person Centered Plan.

The ACT team 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; DMH Communication Bulletins; and other published instruction.

***Program Size**: Three ACT team sizes may be implemented: small, mid-size, and large:

a. Small teams serve a maximum of 50 individuals;
b. Mid-size teams serve 51 – 74 individuals; and
c. Large teams serve 75 - 120 individuals.

Teams in urban locations should implement mid-size to large teams. Teams in more rural locations will likely implement small or mid-size teams as large teams may be impractical in a sparsely populated area.

To ensure appropriate ACT team development, each new ACT team is recommended to titrate ACT intakes (e.g., 4–6 individuals per month) to gradually build up capacity to serve no more than 100–120 individuals (with a 1:9 ratio) and no more than 42–50 individuals (with a 1:8 ratio) for smaller teams.

ACT Program Fidelity Monitoring: Programs operating ACT teams will be evaluated according to a standardized fidelity measure to evaluate the extent to which defining elements of the program model are being implemented. The Tool for Measurement of ACT (TMACT; Monroe-DeVita, Moser, & Teague, 2011), or its successor as approved by DHHS, must be used to evaluate teams. The aim of these evaluations is not only to ensure that the model is being implemented as intended, but also to provide a mechanism for quality improvement feedback and guided consultation.

DHHS shall track adherence to the ACT model and determine annual ACT performance outcomes from Teams through their participation in the administration of the most current ACT fidelity assessment.

A tiered certification process for ACT teams will be used to guide technical assistance and consultation. These tiers define ranges for exceptional practice and provide opportunities for growth for marginal teams through strategic plans for improvement of practice.

In order to comply with the SFY2014 TMACT screening process, all teams will have an initial DACTS screening with a baseline score. Teams will be required to contact DMHDDSAS to be placed on the TMACT fidelity evaluation waitlist. TMACT fidelity evaluation certification ratings are outlined in Table 1 below. Along with the fidelity evaluation rating, teams must meet all the minimum requirements for an ACT team as outlined in this service definition.

Table 1. Tiered Certification Process for ACT Based on the Tool for Measurement of ACT (TMACT) Total Rating.

No Certification	TMACT Rating below 3.0
Basic Fidelity Level	TMACT Rating 3.0-3.6
Moderately High Fidelity Level	TMACT Rating 3.7-4.2
High Fidelity Level	TMACT Rating 4.3+

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A. **Basic Fidelity Level:** ACT teams scoring an overall TMACT fidelity of at least a 3.0 on average.

B. **Moderately High Fidelity Level:** ACT teams scoring an overall TMACT fidelity score of at least 3.7.

C. **High Fidelity Level:** ACT teams scoring a TMACT fidelity score of at least 4.3.

North Carolina Billing Guidance: ACT per diems may only be billed on days when the ACT Team has performed a face-to-face service with the individual or a family member. Only one per diem may be billed per individual per day. All other contacts, meetings, travel time, etc. is considered indirect costs and is accounted for in the buildup of the per diem rate.

For per diem rate to be generated, a 15 minute face-to-face contact that meets all requirements outlined below must occur. A 15 minute contact is defined as lasting at least 8 minutes.

Practitioners may not bill for services included in the ACT per diem and also bill for the that service outside of the per diem rate for individuals enrolled in ACT. Licensed direct care staff must provide services within the scope of practice for their license.

***Staffing Requirements**

An ACT team shall have sufficient staffing to meet the varying needs of individuals. As an all-inclusive treatment program, a variety of expertise should be represented on the team. To provide the appropriate level of coverage and services across all individuals, a low individual to staff ratio

must be maintained. Staffing requirements are outlined in Table 2 below, followed by a description of each team member's qualifications and roles within the team.

Table 2. Assertive Community Treatment Team Staffing Level Requirements

	Small Team (Up to 50 individuals[1])	**Mid-Size Team (Between 51 and 74 individuals[1])**	**Large Team (75 to 120 individuals[1])**
Staff to Individual Ratios Includes all team members, except psychiatrists and program assistants	1 team member per 8 or fewer individuals	1 team member per 9 or fewer individuals	1 team member per 9 or fewer individuals
Team Leader This position is to be occupied by only one person.	One full-time team leader.	One full-time team leader.	One full-time team leader.
Psychiatric Care Provider Prorating of FTE allowed given number of individuals actually served. No more than two psychiatric care providers may assume this role.	• At least 16 hours each week for 50 individuals, or equivalent if fewer individuals. • The psychiatrist works a minimum of eight hours each week, with the Psychiatric Nurse Practitioner (PNP) or Physician Assistant (PA) fulfilling the balance of the requirement given the	• Minimum of 16 hours of psychiatry time for 51 individuals, with an additional 2 hours for every 6 individuals added to the team (e.g., 20 hours for 63 individuals). • Half of the psychiatric care provider time must be fulfilled by a psychiatrist; a PNP, or PA may be employed to fulfill the balance of the requirement given the individual caseload size.	• At least 32 hours each week per 100 individuals, or equivalent (e.g., a team serving 75 individuals are expected to have a minimum of 24 hours of psychiatric care provider time or a team serving 120 individuals are expected to have a minimum of 40 hours of psychiatric care provider). • Half of the psychiatric

Table 2. Assertive Community Treatment Team Staffing Level Requirements

	individual caseload size.		care provider time must be fulfilled by a psychiatrist; a PNP, or PA may be employed to fulfill the balance of the requirement given the individual caseload size.
Nurses Prorating of FTE allowed given number of individuals actually served. No more than two individuals can share a1.0 FTE.	1.0 FTE Nurse who is an RN or APRN with a minimum of 1 year experience working with adults with serious mental illness and working knowledge of psychiatric medications.	• 2.0 FTE RNs or APRNs. • At least one RN with a minimum of 1 year experience working with adults with serious mental illness and working knowledge of psychiatric medications. • The remaining 1.0 nurse can be an RN or LPN.	• 3.0 FTE Nursing. • At least two Nurses are an RN or APRN, with at least one having a minimum of 1 year experience working with adults with serious mental illness and working knowledge of psychiatric medications. • The remaining 1.0 nurse can be an RN or LPN.
Substance Abuse Specialist No more than two individuals can share this position.	1.0 FTE with QP status and licensed or certified CCS, LCAS, LCAS-A, CSAC	1.0 FTE with QP status and licensed or certified CCS, LCAS, LCAS-A, CSAC	1.0 FTE with QP status and licensed or certified CCS, LCAS, LCAS-A, CSAC
Peer Specialist No more than two individuals can	1.0 FTE NC Certified Peer Support Specialist	1.0 FTE NC Certified Peer Support Specialist	1.0 FTE NC Certified Peer Support Specialist

Table 2. Assertive Community Treatment Team Staffing Level Requirements

share this position.			
Vocational Specialist This position is to be occupied by only one person.	One full-time AP or QP. Preference for someone who has at least one year experience providing employment services or has advanced education that involved field training in vocational services.	One full-time AP or QP. Preference for someone who has at least one year experience providing employment services or has advanced education that involved field training in vocational services.	One full-time AP or QP. Preference for someone who has at least one year experience providing employment services or has advanced education that involved field training in vocational services.
Dedicated Office-Based Program Assistant	1.0 FTE office-based program assistant solely dedicated to supporting the ACT team.	1.0 FTE office-based program assistant solely dedicated to supporting the ACT team.	1.0 FTE office-based program assistant solely dedicated to supporting the ACT team.
Additional Staff Any additional staffing should reflect the intended program size, number of individuals served, and needs of the team.[2]	At least 1 FTE ACT member with QP or AP status.	At least 2.0 FTE ACT team members, with at least one dedicated full-time staff with a Master's Level QP status. Remaining team members may be QP or AP status.	At least 3.0 FTE ACT team members, with at least one dedicated full-time staff with a Master's Level QP status. Remaining team members may be QP or AP status.

[1]Movement on to (admissions) and off of (discharges) the team may temporarily result in breaches of the maximum caseload. Therefore, teams will be expected to maintain an annual average not to exceed 50, 74, and 120 individuals, respectively.

[2]Areas of expertise and training may include, for example: supportive housing, psychiatric rehabilitation (e.g., assistance with ADLs, money management, benefits), empirically-supported therapy (e.g., trauma-focused care, CBT for psychosis), family liaison, and forensic and legal issues. If teams are targeting a specific clinical population, it is recommended they hire additional staff reflecting the expertise and training needed for the targeted clinical population (e.g., a second substance abuse counselor for teams serving primarily individuals with co-occurring substance use disorders).

***Staff Qualifications and Roles**

ACT Team services shall be provided by a team of individuals who have strong clinical skills, professional qualifications, experience, and competency to provide a full breadth of biopsychosocial rehabilitation services. While all staff should have some level of competency across disciplines, areas of staff expertise and specialization should be emphasized to fully benefit individuals receiving ACT services . Team members strive to offer evidence-based practices, which are clinical and rehabilitation services that have been demonstrated to be effective for adults with severe and persistent mental illness. Teams must have staff that is designated to provide housing/tenancy supports to individuals living independently in the community.

Team Leader: The ACT Team shall be staffed with one Team Leader. The Team Leader must be a licensed mental health professional holding any of the following licenses: Licensed Psychologist, Licensed Psychological Associate, Licensed Clinical Social Worker, Licensed Professional Counselor, Licensed Marriage and Family Therapist, Licensed Psychiatric Nurse Practitioner, Clinical Nurse Specialist certified as an advanced practice psychiatric clinical nurse specialist.

An associate level licensed professional may serve as the team leader conditional upon being fully licensed within 30 months from the effective date of this policy. For associate level licensed team leaders hired after the effective date of this policy, the 30-month timeline begins at date of hire.

The team leader must have three years of post-graduate clinical experience with SMI/SPMI.

The full-time Team Leader is responsible for:

A. overseeing the administrative operations of the team;
B. providing clinical oversight of services in conjunction with the Psychiatric Care Provider; as well as clinical supervision;
C. supervising team members to assure the delivery of best and ethical practices;
D. directly providing ACT services to an individual , where a therapeutic relationship is developed between the individual and the Team Leader. Example roles include:
    1. assuming an active role in screening referrals and assessing individuals at intake;
    2. acting as a lead clinician, therefore working closely with a select group of individuals receiving the service who can benefit from the Team Leader's clinical expertise;
    3. modeling behaviors through service provision for the purpose of clinical supervision;
    4. participating in person-centered planning meetings; and
    5. working with individual's natural supports.

The Team Leader is exclusively dedicated to the ACT team, with no responsibilities to other roles outside of the ACT team. Only one Qualified Professional shall assume the role as Team Leader. Qualifications are set forth in the above paragraph and in the Division of Medical Assistance Clinical Coverage Policy 8C; the Team Leader shall meet a Qualified Professional status according to 10A NCAC 27G .0104.

Psychiatric Care Provider: The Psychiatric Care Provider's minimal FTE is determined by the number of individuals receiving the service . Part-time Psychiatric Care Providers shall have designated hours to work on the team, with sufficient blocks of time on consistent days in order to carry out his or her clinical, supervisory, and administrative responsibilities. The role of psychiatric

care provider is to be filled by a psychiatrist(s), or shared by a psychiatrist and a nurse practitioner (NP) or a physician assistant (PA) under the supervision of the psychiatrist. No more than two psychiatric care providers may share this role.

ACT Team Psychiatrists must be board eligible or certified by the American Board of Psychiatry and Neurology and Licensed to practice in NC and meet the requirements as specified in NCAC 27G .0104.
ACT Team Nurse Practitioners must be currently licensed as a Nurse Practitioner in NC and meet the requirements as specified in 21 NCAC 36.0800 with at least three years full-time experience treating individuals with SMI/SPMI.

ACT Team Physician Assistants must be currently licensed as a PA in NC and must meet the requirements as specified in 21 NCAC 32S.0101-0220 with at least three years full-time experience treating individuals with SMI/SPMI.

Psychiatric Care Providers are full members of the team and shall perform the following activities in the community in support of both the individuals and the ACT team staff:

A. Typically sees an individual for the assessment and treatment of his or her symptoms and response to medication including side effects. Frequency will vary for each individual, with the majority seen within 4 to 6 weeks of last appointment, with many of the contacts being in the community. Less frequent visits should only occur when there are unusual circumstances present (for example, when the individual has been difficult to find);
B. ACT Team psychiatrist provides clinical supervision and oversight of the psychiatric services delivered by the NP or PA;
C. collaborates with the team leader in sharing overall clinical responsibility for monitoring an individual's treatment and clinical supervision to the team;
D. actively collaborates with nurses to develop and implement medication administration policies and procedures as well as oversee the medical care of individuals that include regular screenings for medical conditions and assessment of wellness and health management;
E. educates non-medical team members on psychiatric & non-psychiatric medications, their side effects, & health-related conditions; provides diagnostic and medication education to individuals, with medication decisions based on shared-decision making;
F. regularly participates in daily team meetings and treatment planning meetings; attends daily team meetings in proportion to time allocated on team;
G. provides brief therapy (formal or informal); and
H. provides psychiatric back-up to the program after-hours and weekends. (Note: may be on a rotating basis as long as other psychiatric care providers who share on-call have access to individual's current status and medical records/current medications).

Nurse: An ACT team shall be staffed with one to three RNs or APRNs, of whom at least one has a minimum of one year experience working with adults with serious mental illness and a working knowledge of psychiatric medications, regardless of team size (Refer to Table 2 for more specification on the number of nurses expected for the different size teams, as well as information on allowances for LPNs). Nursing staff are responsible for performing the following key roles, with LPNs responsible for tasks within their scope of practice and under the supervision of an ACT team RN:

A. manages the medication system in conjunction with the psychiatrist, administers and documents medication treatment;
B. screens and monitors the individual for medical problems and side effects;
C. engage in health promotion, prevention and education activities;

D. if the individual is in agreement, develop strategies to maximize taking medications as prescribed (e.g., reviewing home environment to find cues to remind individual to take medications; work with individual and psychiatric care provider to scale back the number of times medications are taking each day);
E. communicating and coordinating services with other medical providers; and
F. educating the team in monitoring psychiatric symptoms and medication side-effects.

Substance Abuse Specialist: The ACT team shall be staffed with a substance abuse specialist (refer to Table 2 for FTE requirements by team type) who shall meet Qualified Professional status according to 10A NCAC 27G .0104, and have a designation of CCS, LCAS, LCAS-A, or CSAC. The substance abuse specialist shall participate in training in Integrated Dual Disorder Treatment (Drake, Essock, Shaner, et al., (2001). The responsibilities of the substance abuse specialist are as follows:

A. conducts comprehensive substance abuse assessments considering the relationship between substance use and mental health;
B. assesses and tracks the individual's stages of change readiness and stages of treatment;
C. uses outreach and motivational interviewing techniques to work with individuals in earlier stages of change readiness;
D. facilitates access to 12-step groups and other community supports;
E. uses cognitive behavioral approaches and relapse prevention to work with individuals in later stages of change readiness;
F. ensures that the team's treatment approaches are consistent with individual's stages of change readiness;
G. facilitates the Person Centered Planning process for individuals assigned to him or her; and
H. serves as a consultant and educator to fellow ACT team members on the topic of integrated dual disorder treatment (IDDT).

Vocational Specialist: A team shall be staffed with a full-time vocational specialist (Refer to Table 2 for FTE requirements by team type). Preference is for someone who has at least 1 year experience providing employment services or has an advanced education that involved field training in vocational services. The Vocational Specialist is required to participate in training in the evidence-based Individual Placement and Support Model (Drake, McHugo, Becker, Anthony, Clark, 1996), and should provide vocational services in a way that is consistent with all IPS model principles. The responsibilities of the vocational specialist are as follows:

A. engages the individual on the topic of school or work, particularly competitive employment, educating them about their opportunities and the benefits of working and school;
B. completes a pre-vocational assessment that is focused on individual's strengths and preferences, and on-the-job assessments, where appropriate;
C. conducts job development, where the vocational specialist builds relationships with local businesses and educates them about the services that the vocational specialist provides, collects information about positions, and ideally determines potential for job carving options;
D. facilitates individualized job placement according to individual's preferences, with a focus on competitive employment;
E. collaborates with the NC IPS-SE Team for case consultation and other job development activities.
F. provides job coaching and ongoing supports, assisting the individual in learning the job skills, navigating the work place, managing work relationships with other employees and supervisor;

G. provides benefits counseling directly, as well as connects individuals to experts for more extensive benefits counseling as needed; this includes development of SSI/SSDI Work Incentives and NC Medicaid Buy-in: *Health Coverage For Workers With Disabilities*;
H. facilitates the Person Centered Planning process for individuals assigned to him or her; and
I. serves as a consultant and educator to fellow ACT team members on the topic of evidence-based supported employment, which is the Individual Placement and Support (IPS-SE) model.

Peer Specialist: Each ACT team has at least one NC Certified Peer Support Specialist (also refer to Table 2, Additional Staff). This professional's life experience with mental illness or substance abuse and behavioral health services provides expertise that professional training cannot replicate. The certified peer support specialist is a fully integrated team member who provides highly individualized services in the community and promotes the self-determination and shared decision-making abilities of individuals. The responsibilities of the Peer Support Specialist are as follows:

A. Provides coaching, mentoring, and consultation to the individual to promote recovery, self-advocacy, and self-direction;
B. promotes wellness management strategies, which includes delivering manualized interventions (e.g., Wellness Recovery Action Planning or Illness Management and Recovery);
C. assists individuals in developing psychiatric advance directives;
D. models recovery values, attitudes, beliefs, and personal action to encourage wellness and resilience
E. provides consultation to team members to assist in understanding of recovery and the role of the Peer Support Specialists, promoting a culture in which individuals' points of view and preferences are recognized, understood, respected, and integrated into treatment;
F. serves as an active member of the ACT team, equivalent to other team members, which includes facilitating the Person Centered Planning process for individuals assigned to him or her if a QP.
G. supports and empowers the individual to exercise his or her legal rights within the community

Additional Staff: The additional clinical staff may include licensed mental health professionals, QP, or an AP, as listed in Table 2 above. These individuals shall have the knowledge, skills, and abilities required by the population and age to be served to carry out rehabilitation and support functions. Staff who are a Qualified Professional are responsible for facilitating the Person Centered Planning process for individuals assigned to him or her. Activities of these additional staff may include a range of psychosocial rehabilitative interventions and case coordination tasks. Specialization is encouraged in such areas as: psychiatric rehabilitation; therapy; and additional supports in the areas of substance abuse counseling and vocational services, etc.

Program Assistant: The full-time office-based program administrative assistant position is assigned to solely work with the ACT team, providing a range of supports to the team, including:

A. organizing, coordinating, and monitoring all non-clinical operations of the ACT Team, including:
    1. managing medical records;
    2. operating and coordinating the management information system;
    3. maintaining accounting and budget records for individual and program expenditures; and

B. entering and tracking team performance and individual outcome data, as well as running reports on such data.
C. providing support to the team by receiving calls and responding to office walk-ins, triaging and coordinating communication between the team and individuals; and
D. actively participating in the daily team meeting, assisting with organizational record-keeping and scheduling activities.

Service Type and Setting
A fundamental feature of ACT is that services are taken to the individual in his or her natural environment, rather than having the individual come into an office or clinic setting to receive services. Three reasons for this fundamental feature of the ACT model include:

A. Individuals who are appropriate for ACT may not elect to or may be unable to consistently seek out care on his or her own accord;
B. Interventions will be more effective when delivered within the individual's natural environment, where learned skills are applicable within the immediate setting; and
C. Team members gather critical assessment data while in the field.

Examples of natural settings include: an individual's home, place of recreation or socialization, family home, place of work or school, or the street. Bringing services to individuals in their natural environments should be done in a respectful manner (e.g., team members shall not appear at the individual's place of work without receiving permission to do so beforehand).

Note: For ACT, the case management component may be billed when provided 30 days prior to discharge when an individual resides in a general hospital or a psychiatric inpatient setting.

***Program Requirements**
ACT teams shall provide the majority of services to individuals in the community. On average, 75% of face-to-face service contacts shall be provided in the community (non-office-based or non-facility-based settings). For the purpose of ACT program fidelity monitoring, of interest is the *median rate* of community-based services. To calculate the median, the number of face-to-face contacts in the community are divided by the total number of face-to-face contacts, for each individual in a given month. Individuals' community-based service percentages are rank-ordered low to high, and the middle individual is selected to represent all individuals.

A. Hours of Operation: ACT Teams are available to individuals 24 hours a day, 7 days a week, 365 days a year. ACT Teams should have an office open 12 hours per day, Monday through Friday, for walk-ins and calls. Planned services shall be available seven days per week.
B. Delivery of Planned Services: Typically, only one to three team members may be needed to cover the extended afternoon and early evening hours. Team members shall flex their hours appropriate to each individual's needs at that time (e.g., if a individual is in need of evening medication monitoring for a
limited time, the team makes arrangements to provide such monitoring; if an individual needs vocational supports in the evening, the team shall make arrangements to provide such supports).
C. Services are expected to be provided over the weekend, including medication monitoring, rehabilitation services, and all other applicable ACT team services.
D. Services shall be provided over holidays, with these services typically consisting of basic coverage for those individuals who may need more intensive crisis response stabilization or medication management.
E. Crisis Response: ACT team members shall provide "first responder" crisis response 24 hours a day, 7 days a week, 365 days a year to individuals experiencing a crisis.

1. Team members shall directly receive all crisis calls from individuals without routine triaging by a third party.
2. Team members who are on-call shall have access to necessary information, such as all individuals' crisis plans.
3. Many crisis calls will likely be handled on the phone directly with the individual or coordinating with other providers or natural supports (e.g., hospital staff, residential workers, housing provider, family members).
4. As needed, licensed team members shall be available to provide on-site assessment, de-escalation, and follow-up.
5. Psychiatric coverage shall be available 24 hours per day. It is also necessary to arrange for and provide psychiatric back-up for all hours that the psychiatric care provider is not regularly scheduled to work.

F. Daily Team Meeting: The daily team meeting is the central hub of communication for ACT team staff, sharing recent assessment information and planning for the day's activities. Daily team meetings (Monday-Friday) allow ACT staff to systematically update information, briefly discuss individual status over the past 24 hours, problem-solve emerging issues, and plan approaches to address and prevent crises. This critical organizational meeting is also used to plan the service contacts for the following 24-hour period or weekend according to the person-centered plans, ensuring that all individuals receive the best possible services with continuity. All team members shall prioritize this meeting, with full attendance on all or most days. There must be a reliable communication mechanism in place to relay important information to team members not present during that day or shift. The ACT team shall use its daily team meeting to accomplish the following:

1. Conduct a brief, but clinically relevant, review of significant events or change in status of all individuals in the past 24 hours and record status of all individuals.
    A. A Individual Log or CardEx is maintained that succinctly documents important clinical information (e.g., whether an individual was seen or attempted to be seen, by whom, notable comments about symptoms, functioning, medication, intervention, and response to intervention) and housing status and housing issues to serve as a snapshot of care, the Individual Log/CardEx should be organized by individual for each month.
    B. Develop a Daily Team Schedule for the day's contacts based on a central file of individuals' weekly or monthly schedules, which are derived from interventions specified within the person-centered plans. The Daily Team schedule is flexible.
2. Assistance with an individual's emerging needs and planned proactive contacts to prevent future crises are also worked into the schedule. A process must be in place to assure that planned activities are carried out or, if not, are rescheduled.
3. The Team Leader shall assume a leadership role within the daily team meeting, guiding the direction and pace of the discussion. If more extensive conversation and planning are needed in regard to a specific individual, the Team Leader directs relevant team members to convene to assess and plan following the team meeting. All team members share responsibility in conducting the roll call, maintaining the Log/CardEx, and creating the Daily Team Schedule.

ACT Services: The ACT team directly provides a full range of biopsychosocial and rehabilitation services to individuals. The interventions and activities, grouped by service domain, include, but are not limited to, those listed in Table 3 below.

Table 3. Interventions and Activities to be Directly Delivered by ACT Teams.

Assertive Engagement of individuals	• Use collaborative and motivational interventions that promote individuals' development of intrinsic motivation to receive services from the ACT team. • Use for a short time when collaborative approaches fail and risks are high, therapeutic limit-setting interventions that promote individuals' development of motivation to receive services from the ACT team.
Assessment and Service Planning:	• Identify or update primary psychiatric and co-occurring disorders, symptoms, and related functional problems, particularly as they relate to impediments to individuals' desired life roles, as a part of the Comprehensive Clinical Assessment as described in the Medicaid State Plan. • Assess transition readiness on an ongoing basis using standardized tools. • Update and revise, in partnership with the individual, an individualized, comprehensive, culturally sensitive, goal-oriented Person-Centered Plan. • Identify individualized strengths, resources, preferences, needs, and goals, and include identified strengths in the treatment plan goals and action steps. • Create specific and clinically thoughtful interventions to be delivered by the team, which are then cross-walked to a individual weekly/monthly schedule used to guide day-to-day team planning. • Identify risk factors for harm to self or others. • Monitor response to treatment, rehabilitation, and support services. • Develop person-centered, functional crisis plans.
Empirically Supported Interventions and Psychotherapy	• Provide cognitive-behavioral interventions targeting specific psychological and behavioral problems (e.g., anxiety, psychotic symptoms, emotional dysregulation, and trauma symptoms). • All psychotherapy services shall be provided by a trained, Licensed or Associate Licensed therapist; however basic cognitive-behavioral interventions may be carried out be non-licensed staff with appropriate training and supervision.
Family Life & Social	• Restore and strengthen the individual's unique social and family

Table 3. Interventions and Activities to be Directly Delivered by ACT Teams.

Relationships	relationships. • Provide psycho-educational services (e.g., provide accurate information on mental illness & treatment to families and facilitate communication skills and problem solving). • Coordinate with child welfare and family agencies. • Support in carrying out parent role. • Teach coping skills to families in order to support individual's recovery. • Enlist family support in recovery of the individual. • Facilitate the individual's natural supports through access to local support networks and trainings, such as NAMI's Family-to-Family. • Help individuals expand network of natural supports.
Health	• Educate to prevent health problems. • Provide and coordinate medical screening and follow up. • Schedule routine and acute medical and dental care visits, and assist individual in attending these visits. • Sex education and counseling. • Health and nutrition counseling.
Housing	• Assist individuals in obtaining safe, decent, and affordable housing that follows his or her preferences in level of independence and location, consistent with an evidenced based Supportive Housing model. • Locate housing options with a focus on integrated independent settings. • Apply for housing subsidies and housing programs. • Assist the individual in developing amicable relationships with local landlords. • Assist the individual in negotiating and understanding the terms of the lease and paying rent and utilities. • Provide tenancy support and advocacy for the individual's tenancy rights at the individual's home at least monthly. Examples of these interventions include: utility management, cleaning, and relationships with other tenants and the landlord.

Table 3. Interventions and Activities to be Directly Delivered by ACT Teams.

	• Assist with relocation • Teach skills in purchasing and repairing household items.
Integrated Dual Disorders Treatment for Substance Abuse	• Provide support that is non-confrontational and promotes harm reduction or abstinence, depending on the individual's stage of change readiness. • Assess stages of change readiness and related stage of treatment. • Provide outreach and engagement to those in a pre-contemplation or contemplation stage of change readiness. • Use motivational interviewing for those in a contemplation and preparation phase of change readiness. • Provide active substance abuse counseling and relapse prevention, using cognitive-behavioral interventions, for those in later stages of change readiness. • Educate on substance abuse & interaction with mental illness. • Provide individual & group modalities for dual disorders treatment. • All staff providing substance abuse treatment must be appropriately registered, certified, or licensed.
Medication Support	• Use a shared decision-making model in identifying medication needs and preferences. • Prescription, administration, and ordering of medication by appropriate medical staff. • Assist the individual in accessing medications. • Carefully monitor medication response and side effects. • Educate individuals about medications. • Help individuals develop ability to take medications with greater independence.
Money Management & Entitlements	• Assist individual in gathering documents and completing entitlement and other benefit applications. • Accompany individuals to entitlement offices. • Assist with re-determination of benefits.

Table 3. Interventions and Activities to be Directly Delivered by ACT Teams.

	• Provide financial crisis management. • Teach budgeting skills and asset development. • Teach skills in managing food stamps. • Assist with representative payeeship.
Psychiatric Rehabilitation and Assistance with Activities of Daily Living	• Provide skill-building, coaching, and access to necessary resources to help individuals with: - Personal care - Safety skills - Money management skills - Grocery shopping, cooking, and food safety/storage. - Purchasing and caring for clothing. - Household maintenance and cleaning skills. - Social skills - Using transportation and other community resources.
Vocational Services	• Encouraging and motivating individuals around work, especially competitive employment, and school as achievable goals. • Identifying and developing interests and skills. • Assisting with locating preferred jobs and going through the application process. • Providing ongoing supports, such as job coaching. • Developing and strengthening relationships with local employers and other vocational support agencies. • Educating employers about available vocational supports and working with individuals with disabilities, such as serious mental illness. • Surveying local employers to identify various work settings and job roles. • Exploring and proposing job carving options with employers. E.g., breaking down a job role into multiple job roles with a more limited list of tasks and responsibilities, and Full-Time Equivalent (FTE) requirements.

Table 3. Interventions and Activities to be Directly Delivered by ACT Teams.

	• Finding, enrolling, and supporting participation in school/training programs. • Providing benefits counseling and linkage to SSA work incentives.
Wellness Self-Management & Relapse Prevention	• Educating about mental illness, treatment, and recovery. • Teaching skills for coping with specific symptoms and stress management. • Facilitating the development of a personal crisis management plan, including suicide prevention or psychiatric advance directive. • Developing a relapse prevention plan, including identification/recognition of early warning signs and rapid intervention strategies. • Delivery of manualized wellness management interventions via group and individual work such as Wellness Recovery Action Plans (WRAP) or Illness/Wellness Management and Recovery (IMR/WMR).

Team Approach: To effectively meet the varying needs of individuals and mitigate the effects of staff turnover, ACT uses a team approach to delivering services. All ACT team members shall know all individuals, but not all team members necessarily work closely with all individuals. To achieve desired individual outcomes, interventions must be carried out with consistency and following empirically-supported practices, and within the context of strong therapeutic relationships. Each individual is assigned to work more closely with a select group of team members, determined by a variety of factors, including team members' expertise and skills, rapport, and other factors specific to the individual's preferences (e.g., male or female). In using an individualized treatment team approach, it is expected that the majority of individuals shall see at least 3 team members in a given month.

Meeting with multiple team members also helps increase the chances that individuals will receive the range of services needed for recovery; including Supported Employment, Illness Management/Recovery, and other vital services. It also means that when some staff are on vacation or otherwise away from work, there are team members who know the individual well and can respond promptly and effectively to service needs. It is highly recommended that ACT individuals meet with a select group of team members each month as a result of careful team member assignment given the interventions identified in the person-centered plan.[1] Individuals meeting with a high number of team members (e.g., 6 or more) in a month are less likely to develop necessary therapeutic relationships and receive consistent care (the exception here is when a individual requires a high level of team monitoring, the entire team often shares responsibility due to the resources required).

[1]A maximum number of team members is not specified, but the principles stated in this paragraph should be followed.

Assertive Engagement and Organizational Boundaries: Providers shall make a significant effort to engage individuals in services. Efforts to engage individuals are not limited to the initial treatment phase. Engagement is a fluid, on-going process that extends throughout a individual's relationship with the ACT team. Engagement strategies are individualized, well planned, and based on input from a variety of sources.

The input of family members, natural supports, and previous and subsequent treatment providers is essential in developing engagement strategies that can effectively reach the individual. Specifically, ACT Teams must:

A. Include the individual in the admission, initial assessment, and initial planning process as the primary stakeholder;
B. Include individual's identified family, natural supports, and others as identified by the individual;
C. Meet with the individual in his or her environment at times of the day/week that honors the individual's preferences; and
D. Meet individuals at home and in jails or prisons, streets, homeless shelters, or hospitals.

Retention of individuals is a high priority for ACT. ACT Teams shall ensure that a process is in place for identifying individuals in need of more or less assertive engagement. Interventions are monitored to determine the success of these techniques, and the need to adapt the techniques or approach accordingly.

***Service Frequency and Duration:** ACT individuals have varying needs and the ACT team is the sole provider of the services to address those needs. Therefore, a high level of service is required reflecting crisis response, maintenance, and rehabilitation and growth-oriented interventions.

ACT is a flexible service provided in an individualized manner. As such, service frequency and intensity will vary across individuals. However, when considering caseload averages, the team must see individuals at least 2 times per week and for at least 60 minutes per week. For the purpose of ACT program fidelity monitoring, of interest is the *median rate* of service frequency and the *median rate* of service intensity.

> For example, to calculate the median rate of service frequency the mean number of face-to-face contacts the team has with a given individual in a week is calculated by totaling the number of such contacts in a 4-week period and dividing by 4. The weekly averages (means) across all individuals are then rank-ordered low to high, and the middle individual is selected to represent all individuals.

It is expected that additional face-to-face and phone contacts are made with individuals, their natural supports, and other providers on their behalf (e.g., inpatient hospital staff, landlord, residential staff).

Staff Training and Supervision: ACT services shall be provided by a team of individuals who have strong clinical skills, professional qualifications, experience, and competency to provide the range of practices, outlined in Table 2. All ACT team members are expected to receive initial and ongoing training in core and evidence-based practices that support the implementation of ethical, person-centered, high-fidelity ACT practice, as defined in the required fidelity model.

All team members are also expected to receive ongoing clinical supervision from ACT team clinical leadership, with the ACT team leader as the primary clinical supervisor. Most team members should receive scheduled clinical supervision once a week, either in individual or group format; no staff should go without a supervision session in a given month in accordance with APSM.

Clinical Supervision is the provision of guidance, feedback, and training to team members to assure that quality services are provided to individuals (e.g., following evidence-based practices, negotiating ethical quandaries, managing transference and counter transference and maintaining and facilitating the supervisee's competence and capability to best serve individuals in an effective manner). Clinical supervision is a critical factor in determining the appropriate acquisition of evidence-based practices by supervised staff. Examples for how clinical supervision may be delivered within ACT include:

A. Meeting as a group (separately from the daily team meeting) or individually to discuss specific clinical cases;
B. Field mentoring (e.g., helping staff by going out in the field with them to teach, role model skills, and providing feedback on skills);
C. Reviewing and giving feedback on the specific tools (e.g., the quality of assessments, treatment plans, progress notes) to better capture and document clinical content;
D. Didactic teaching or individual and group cross-training; and
E. Formal in-office individual supervision (includes both impromptu and scheduled supervision).

***Staff Training Requirements:** Each ACT Team staff member shall successfully complete the DHHS Approved Training in high-fidelity ACT, Crisis Response, DHHS approved tenancy support training, brief Motivational Interviewing, and Person-Centered Thinking within the first 120 days of each team member's date of hire. Qualified Professional staff responsible for Person Centered Plan development shall also complete "PCP Instructional Elements" training within the same time frame.

For each year of employment, each ACT team member (excluding the program assistant) is to receive additional three hours of training in an area that is fitting with their area of expertise, which they then, in turn, cross-train** their fellow team members. This additional training may be in the form of locally provided training, online workshops, or regional/national conferences.

Broader topics of additional training include, for example:

A. Benefits counseling
B. Cognitive behavioral therapy for psychosis
C. Critical Time Intervention
D. Culturally and Linguistically Appropriate Services (CLAS)
E. DHHS Approved Individual Placement and Support- Supported Employment
F. Family Psychoeducation
G. Functional assessments and psychiatric rehabilitation
H. Integrated Dual Disorders Treatment
I. Limited English Proficiency (LEP), blind or visually impaired, and deaf and hard of hearing accommodations
J. Medication algorithms
K. NAMI Psychoeducational trainings
L. Psychiatric advanced directives
M. Recovery Oriented Systems of Care: policy and practice
N. SOAR (SSI/SSDI Outreach, Access and Recovery) Stepping Stones to Recovery

O. Permanent Supportive Housing, such as the SAMHSA evidenced based practices toolkit, Housing First: The Pathway's Model to End Homelessness for People with Mental Illness and Addiction, and other evidenced based models.
P. Trauma-informed care
Q. Wellness and integrated healthcare
R. Wellness management and recovery interventions (includes WRAP, IMR/WMR)
S. Supervising NC Certified Peer Support Specialists

**Cross-training example: The substance abuse specialist attends a 3 hour workshop related to motivational interviewing (MI). Within a month of attendance at the workshop, the substance abuse specialist provides a 20 minute cross-training to fellow team members following the daily team meeting on the fundamental principles of MI, using a recent example of an individual served by the team.

The team leader shall maintain documentation of both supervision and training activities, including cross-training activities.

Utilization Management

Services are based upon a finding of medical necessity, must be directly related to the individual's diagnostic and clinical needs, and are expected to achieve the specific rehabilitative goals detailed in the his or her PCP. Medical necessity is determined by North Carolina community practice standards, as verified by the LME-MCO which will evaluate the request to determine if medical necessity supports more or less intensive services.

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

Prior authorization by the LME-MCO is required.

Entrance Criteria
ACT teams shall document written admission criteria that reflect the following requirements, which must be met for an individual to be deemed eligible for ACT Team services:

A. Individuals (ages 18 and over) with severe and persistent mental illness; priority is given to people with schizophrenia, other psychotic disorders (e.g., schizoaffective disorder), and bipolar disorder because these illnesses more often cause long-term psychiatric disability. Individuals with other psychiatric illnesses are eligible dependent on the level of the long-term disability. Individuals with a primary diagnosis of a substance abuse disorder or intellectual/developmental disabilities are not the intended client group.

AND

B. The individual has significant functional impairment as demonstrated by at least one of the following conditions:

    1. Significant difficulty consistently performing the range of routine tasks required for basic adult functioning in the community (for example, caring for personal

business affairs; obtaining medical, legal, and housing services; recognizing and avoiding common dangers or hazards to self and possessions; meeting nutritional needs; attending to personal hygiene) or persistent or recurrent difficulty performing daily living tasks except with significant support or assistance from others such as friends, family, or relatives;

2. Significant difficulty maintaining consistent employment at a self-sustaining level or significant difficulty consistently carrying out the head-of-household responsibilities (such as meal preparation, household tasks, budgeting, or child-care tasks and responsibilities); or
3. Significant difficulty maintaining a safe living situation (for example, repeated evictions or loss of housing or utilities).

AND

C. The individual has one or more of the following problems, which are indicators of continuous high-service needs:
   1. High use of acute psychiatric hospital (2 or more admissions during the past 12 months) or psychiatric emergency services;
   2. Intractable (persistent or recurrent) severe psychiatric symptoms (affective, psychotic, suicidal, etc.);
   3. Coexisting mental health and substance abuse disorders of significant duration (more than 6 months);
   4. High risk or recent history of criminal justice involvement (such as arrest, incarceration, probation);
   5. Significant difficulty meeting basic survival needs, residing in substandard housing, homelessness, or imminent risk of homelessness;
   6. Residing in an inpatient or supervised community residence, but clinically assessed to be able to live in a more independent living situation if intensive services are provided; or requiring a residential or institutional placement if more intensive services are not available; or
   7. Difficulty effectively using traditional office-based outpatient services.

AND

D. There are no indications that available alternative interventions would be equally or more effective based on North Carolina community practice standards and within the LME-MCO service array.

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

A signed service order must be completed by a physician, licensed psychologist, physician assistant, or nurse practitioner according to his or her scope of practice. 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 the LME-MCO for the service. The service order must be based on a comprehensive clinical assessment of the individual's needs.

The provider shall obtain prior authorization required on the first day of this service. In order to request the initial authorization, the Person Centered Plan with signatures and the required authorization request form must be submitted to the LME-MCO. In addition, a completed Consumer Admission and Discharge Form must be submitted to the LME-MCO.

Prior authorization is required on the first day of this service. Services may cover up to 180 days for the initial authorization period based on medical necessity.

Continued Stay Criteria
The desired outcome or level of functioning has not been restored, improved, or sustained over the time frame outlined in the individual's Person Centered Plan; or the individual continues to be at risk for relapse based on current clinical assessment, history, or the tenuous nature of the functional gains;
AND

One of the following applies:

A. The individual has achieved current Person Centered Plan goals and additional goals are indicated as evidenced by documented symptoms;
B. The individual 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 individual 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 his or her premorbid or potential level of functioning, are possible; or
D. The individual fails to make progress or demonstrates regression in meeting goals through the interventions outlined in the Person Centered Plan. (In this case, the individual's diagnosis should be reassessed to identify any unrecognized co-occurring disorders, and treatment recommendations should be revised based on the findings).

If the individual is functioning effectively with this service and discharge would otherwise be indicated, the ACT team services 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 either of the following:

A. The individual has a documented history of regression in the absence of ACT team services, or attempts to titrate ACT Team services downward have resulted in regression; or
B. There is an epidemiologically sound expectation that symptoms will persist and that ongoing outreach treatment interventions are needed to sustain functional gains.

Transition or Discharge Criteria
Must meet at least one of the following:

A. The individual and team determine that ACT services are no longer needed based on the attainment of goals as identified in the person-centered plan and a less intensive level of support is appropriate;
B. The individual moves out of the catchment area and the ACT has facilitated the referral to either a new ACT provider or other appropriate mental health service in the new place of residence and has assisted the individual in the transition process;
C. The individual and, if appropriate, the guardian, choose to withdraw from services and documented attempts by the program to reengage the individual with the service have not been successful; or
D. The individual has not demonstrated significant improvement following reassessment and several adjustments to the treatment plan over at least three months and alternative

treatment or providers have been identified that are deemed necessary and are expected to result in greater improvement; or

E. The individual's behavior has worsened, such that continued treatment will not result in sustainable change; or more intensive levels of care, or a different level of agency support is indicated.

Documentation of discharge or transition to lower levels of care must include all of the following:

A. The reasons for discharge or transition as stated by both the individual and the ACT Team;
B. The individual's biopsychosocial status at discharge or transition;
C. A written final evaluation summary of the individual's progress toward the goals set forth in the PCP;
D. A plan for follow-up treatment, developed in conjunction with the individual; and
E. The signatures of the individual, the team leader, and the psychiatrist.

A completed LME-MCO Consumer Admission and Discharge Form must be submitted to the LME-MCO.

NOTE: Any denial, reduction, suspension, or termination of service requires notification to the individual, legally responsible person, or both about the individual's appeal rights pursuant to G.S. 143B-147(a)(9) and Rules 10A NCAC 27I .0601-.0609.

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 (for example, counseling, case management, crisis response) for each date of service, written and signed by the person(s) who provided the service, that includes all of the following:

A. Individual's name;
B. Medicaid identification number;
C. Service provided (for example, ACT Team);
D. Date of service;
E. Place of service;
F. Type of contact (face-to-face, telephone call, collateral);
G. Purpose of the contact;
H. Description of the provider's interventions;
I. Amount of time spent performing the interventions;
J. Description of the effectiveness of the interventions in meeting the individual's specified goals as outlined in the Person Centered Plan (PCP); and
K. Signature and credentials of the staff member(s) providing the service (for paraprofessionals, position is required in lieu of credentials with staff signature).

Expected Outcomes

Given the provision of High-Fidelity ACT Team services, it is expected that individuals will reduce the amount of time spent in institutional settings and become more integrated within their own community. Individual's goals are personal and, therefore, expected outcomes will vary. However, indications of the ACT team's success would include, for example, an increased proportion of individuals who:

A. are living in integrated, independent, safe and affordable housing;
B. are employed in competitive work settings fitting with their preferences;
C. have developed meaningful relationships with natural supports;
D. have established a medical home and a behavioral health home;
E. along with their natural supports, report higher satisfaction with services;
F. remain engaged in services;
G. demonstrate increased skill in managing their own illnesses; and
H. rely less on crisis services.

To provide a standardized mechanism for ACT teams to track individual outcomes, which can then guide their own performance initiatives; teams will be required to regularly submit data through the ACT Monitoring Application:

Expected clinical outcomes should include some of the following:

A. Individual satisfaction;
B. Increased adherence to treatment/service plan;
C. Improved clinical outcomes;
D. Vocational/educational gains;
E. Increased length of stay in community residence;
F. Increased use of natural supports;
G. Reduced utilization of inpatient level of support;
H. Improved physical health; and
I. Increased use of wellness self-management and recovery tools.

Service Exclusions and Limitations

An individual may receive ACT Team services from only one ACT Team provider organization during any active authorization period for this service.

A. Services that may be provided concurrently with ACT:
    1. Opioid Treatment;
    2. Detoxification Services;
    3. Facility Based Crisis;
    4. Substance Abuse Residential Treatment; or
    5. Adult mental health residential programs (for example, supervised living low or moderate; or group living low, moderate, or high).
B. Services that may not be provided concurrently with ACT*:
    1. Individual, Group and Family Outpatient;
    2. Outpatient Medication Management;
    3. Outpatient Psychiatric Services;
    4. Mobile Crisis Management;
    5. Psychosocial Rehabilitation;
    6. Community Support Team;
    7. Partial Hospitalization;
    8. Tenancy Support (provided outside the ACT Team);
    9. Nursing home facility; or
    10. State-Funded Supported Employment.

The following activities may not be billed or considered the activity for which the ACT per diem is billed:

A. Time spent doing, attending or participating in recreational activities unless tied to specific planned social

B. Services provided to teach academic subjects or as a substitute for educational personnel such as, but not limited to, a teacher, teacher's aide or an academic tutor.
C. Habilitative services for the adult to acquire, retain and improve the self-help, socialization and adaptive skills necessary to reside successfully in community settings.
D. Child care services or services provided as a substitute for the parent or other individuals responsible for providing care and supervision.
E. Respite care.
F. Transportation for the individual or family. Services provided in the car are considered transportation.
G. Services provided to individuals under age 18.
H. Covered services that have not been rendered.
I. Services provided before the MCO (including the Prepaid Inpatient Health Plan) has approved authorization.
J. Services not identified on the adult's authorized treatment plan.
K. Services provided without prior authorization by the MCO.
L. Services provided to children, spouse, parents or siblings of the eligible adult under treatment or others in the eligible adult's life to address problems not directly related to the eligible adult's issues and not listed on the eligible adult's treatment plan.
M. Any art, movement, dance or drama therapies.
N. Anything not included in the approved ACT service definition.
O. Clinical and administrative supervision of staff (this is factored in the rate).

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

**ACT is a comprehensive service; it is assumed that an individual's informed choice over needed services has been made when an individual has agreed to be served by an ACT Team. The exception is the clinical need for a specialized acute inpatient or outpatient therapy (i.e., therapy for eating disorders, personality disorders) which the Licensed Professionals may not be trained to provide.

ACT team services may be billed for up to 30 days in accordance with the Person Centered Plan for individuals who are transitioning to or from Community Support Team, Partial Hospitalization, Substance Abuse Intensive Outpatient Program (SAIOP), Substance Abuse Comprehensive Outpatient Treatment (SACOT), Inpatient Hospitalization – refer to concurrent services above.

To make timely and seamless transitions to and from ACT Team services, individuals receiving Community Support Team services may continue to receive the case management component of these services for the first and last 30 days of the transition to and from ACT Team services in accordance with the Person Centered Plan. All Community Support Team transition activities are performed by the Qualified Professional.

Individuals receiving ACT services shall have immediate access to vocational services from the ACT team. Vocational Specialists on ACT teams shall be the main provider of employment services for ACT individuals and with the support and assistance from all ACT team members (e.g., all team members may provide ongoing support to individuals who are employed). ACT vocational specialists shall collaborate and consult with IPS-SE Program staff to enhance job development opportunities and business networking opportunities as appropriate. Referrals to the Division of Vocational Rehabilitation Services (DVRS) should only be made to access additional resources or supports that fall outside the scope of the ACT team's responsibility or resources (i.e., continuing education, self-employment/small business plans).

Psychosocial Rehabilitation (State-Funded):

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

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

There should be a supportive, therapeutic relationship between the providers, the individual receiving services, and family which addresses or implements interventions outlined in the PCP in ANY of the following skills development, educational, and pre-vocational activities:

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

A comprehensive clinical assessment is one mechanism to demonstrate medical necessity for a service and to assess and identify an individual's needs. For state-funded services, a service order is recommended. Providers shall coordinate with the LME-MCO regarding their requirements for service orders.

Provider Requirements
Psychosocial Rehabilitation services shall be delivered by a team of practitioners employed by mental health, substance abuse, or intellectual or developmental disability provider organizations that meet the requirements of 10A NCAC 27G and the provider qualification policies, procedures, and standards established by DMH/DD/SAS. These policies and

procedures set forth the administrative, financial, clinical, quality improvement, and information services infrastructure necessary to provide services. Provider organizations shall demonstrate that they meet these standards by being credentialed by the LME-MCO. Additionally, the organization shall achieve national accreditation with at least one of the designated accrediting bodies within one year of enrollment as a provider with the LME-MCO. The organization shall be established as a legally recognized entity in the United States and qualified or registered to do business as a corporate entity in the State of North Carolina, capable of meeting all of the requirements of the LME-MCO credentialing process, DMH/DD/SAS Communication Bulletins, the DMH/DD/SAS *Records Management and Documentation Manual*, and service implementation standards. The provider organization shall comply with all applicable federal and state requirements.

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

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

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

If the PSR provider organization also provides Supported Employment or Transitional Employment, these services are to be costed and reported separately.

Only the time during which the individual receives PSR services may be billed to the LME-MCO.

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

Utilization management must be performed by the LME-MCO.

Entrance Criteria
The individual is eligible for this service when ALL of the following apply:

A. There is an Axis I or II diagnosis present;
B. Level of Care Criteria;
C. The beneficiary has impaired role functioning that adversely affects at least two of the following:
    a. employment,
    b. management of financial affairs,
    c. ability to procure needed public support services,
    d. appropriateness of social behavior, or
    e. activities of daily living; and
D. The individual's level of functioning may indicate a need for psychosocial rehabilitation if the individual has unmet needs related to recovery and regaining the skills and experience needed to maintain personal care, meal preparation, housing, or to access social, vocational and recreational opportunities in the community.

Continued Stay Criteria
The desired outcome or level of functioning has not been restored, improved, or sustained over the time frame outlined in the individual's Person Centered Plan or the individual 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. The individual has achieved initial rehabilitation goals in the Person Centered Plan goals, and continued services are needed in order to achieve additional goals.
B. The individual is making satisfactory progress toward meeting rehabilitation goals.
C. The individual is making some progress, but the specific interventions need to be modified so that greater gains, which are consistent with his or her rehabilitation goals, are possible or can be achieved.
D. The individual is not making progress; the rehabilitation goals must be modified to identify more effective interventions.
E. The individual is regressing; the Person Centered Plan must be modified to identify more effective interventions.

Discharge Criteria
The individual's s level of functioning has improved with respect to the rehabilitation 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 applies:

A. The individual has achieved rehabilitation goals, discharge to a lower level of care is indicated.
B. The individual is not making progress, or is regressing and all realistic treatment options with this modality have been exhausted.
C. The individual requires a more intensive level of care or service.

NOTE: Any denial, reduction, suspension, or termination of service requires notification to the individual, legally responsible person, or both about the individual's appeal rights pursuant to G.S. 143B-147(a)(9) and Rules 10A NCAC 27I .0601-.0609.

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

Documentation Requirements
Minimum standard is a full weekly service note.

Service Exclusions
PSR may not be provided during the same authorization period with the following services: Partial hospitalization and ACTT.

Child and Adolescent Day Treatment (State-Funded):

Service Definition and Required Components

Day Treatment is a structured treatment service in a licensed facility for children or adolescents and their families that builds on strengths and addresses identified needs. This medically necessary service directly addresses the individual's diagnostic and clinical needs, which are evidenced by the presence of a diagnosable mental, behavioral, 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 PCP.

This service is designed to serve children who, as a result of their mental health 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 individual'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-Managed Care Organization, 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-MCO, provider) understand and support the primary purpose of the day treatment service definition which is to serve children who, as a result of their mental health or substance 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 individual's capacity to function in an educational setting, or to be maintained in community based services. It is available for children 5 through 17 years of age. Day Treatment must address the age, behavior, and developmental functioning of each individual to ensure safety, health, and appropriate treatment interventions within the program milieu.

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

The selected clinical model(s) or EBP(s) must address the clinical needs of each beneficiary, and those needs shall be identified in the comprehensive clinical assessment and documented

in the PCP. All criteria (program, staffing, clinical and other) for the Day Treatment service definition and all criteria for the chosen clinical model(s) or EBP(s) must be followed. Where there is any incongruence between the service definition and the clinical model(s) or EBP(s), the more stringent requirements must be met.

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

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

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

- 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 PCP, 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 or behaviors;
- Development or 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
- Psycho-education, and training of family, unpaid caregivers, or others who have a legitimate role in addressing the needs identified in the PCP.

NOTE: Psycho-education services and training furnished to family members or caregivers must be provided to, or directed exclusively toward the treatment of, the eligible beneficiary. Psycho-education imparts information to children, families, caregivers, or other individuals involved with the beneficiary's care about the individual'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 individual's condition. Psycho-educational activities are performed for the direct benefit of the

individual and help the individual develop increasingly developmentally appropriate coping skills for handling problems resulting from their condition. The goal of psycho-education is to reduce symptoms, improve functioning, and meet the goals outlined in the PCP.

In partnership with the individual, the individual's family, the legally responsible person (as applicable), and other service providers, a Child and Adolescent Day Treatment QP is responsible for convening the Child and Family Team, which is the vehicle for the person-centered planning process. The Child and Family Team comprises those persons relevant to the individual'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 individual. The Day Treatment provider works with other behavioral health service providers, as well as with identified medical (including primary care and psychiatric) and non-medical providers (for example, the county department of social services, school, the Department of Juvenile Justice and Delinquency Prevention), engages community and natural supports, and includes their input in the person-centered planning process. A Day Treatment QP is responsible for developing, implementing, and monitoring the PCP, which shall include a crisis plan. The Day Treatment provider is also responsible for documenting the status of the individual's progress and the effectiveness of the strategies and interventions outlined in the PCP.

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

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

- Assessing the individual'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 PCP
- Linking the individual 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.

A comprehensive clinical assessment is one mechanism to demonstrate medical necessity for a service and to assess and identify an individual's needs. For state-funded services, a service order is recommended. Providers shall coordinate with the LME-MCO regarding their requirements for service orders.

Provider Requirements

Day Treatment services shall be delivered by practitioners employed by mental health, substance abuse, or intellectual or developmental disability provider organizations that are currently certified as a Critical Access Behavioral Healthcare Agency (CABHA), and meet the requirements of 10A NCAC 27G and the provider qualification policies, procedures, and standards established by DHM/DD/SAS. These policies and procedures set forth the

administrative, financial, clinical, quality improvement, and information services infrastructure necessary to provide services. Provider organizations shall demonstrate that they meet these standards by being credentialed by the LME-MCO. Additionally, the organization shall achieve national accreditation with at least one of the designated accrediting bodies within one year of enrollment as a provider with the LME-MCO. The organization shall be established as a legally recognized entity in the United States and qualified or registered to do business as a corporate entity in the State of North Carolina, capable of meeting all of the requirements of the LME-MCO credentialing process, DMH/DD/SAS Communication Bulletins, the DMH/DD/SAS *Records Management and Documentation Manual*, and service implementation standards. The provider organization shall comply with all applicable federal and state requirements.

The organization is responsible for obtaining authorization from the LME-MCO for medically necessary services identified in the PCP.

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:

1. One (1) full time program director who meets the requirements specified for a QP (preferably Master's level or a Licensed Professional) and has a minimum of two years experience in child and adolescent mental health or substance abuse treatment services who must be actively involved in program development, implementation, and service delivery. This individual may serve as one of the QPs in the Day Treatment Program staffing ratio.
2. A minimum of one (1) FTE QP, per six children, who has the knowledge, skills, and abilities required by the population and age to be served, who must be actively involved in service delivery (for example, a program with four individuals needs one FTE QP, a program with seven individuals needs two FTE QPs), and a program with 19 individuals needs 4 FTE QPs).
3. A minimum of one (1) additional FTE (QP, AP, or Paraprofessional) for every 18 enrolled individuals beginning with the 18th enrolled individual (for example, a program with 17 individuals does not need the additional FTE; a program with 21 individuals needs one additional FTE; and a program with 36 individuals needs two additional FTEs).
4. A minimum of a .5 of a full time dedicated Licensed Professional for every 18 enrolled individuals. This individual must be actively involved in service delivery. An associate level Licensed Professional who fills this position must be fully licensed within 30 months from the effective date of this policy. For associate level Licensed Professionals hired after the effective date of this policy, the 30-month timeline begins at date of hire. For substance abuse focused programs, the Licensed Professional must be an LCAS (For example, a program with 10 individuals needs one .5 LP; a program with 19 individuals needs one full time LP).

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

A minimum ratio of one QP to every six (6) children is required to be present, with a minimum of two (2) staff present with children at all times. The exception is when only one individual who is receiving the service 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 individuals receiving this service.

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

Staff Training

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

- 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 calendar days** of hire to provide this service, **or** by **June 30, 2011** for staff who were currently working as a Day Treatment staff member as of January 1, 2011 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 or Recovery training curriculum if not, then the full 12 hour training must be completed.

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

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

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

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

Total Hours of Training for the Day Treatment Staff (as of 4/1/10):

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

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

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

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

Day Treatment shall be provided in a licensed facility separate from the individual'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 individual receiving this service.

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

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

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

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

Eligibility Criteria

Children five through 17 are eligible for this service when all of the following criteria are met:

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 an intellectual or developmental disability.
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.
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 individual exhibits behavior resulting in significant school disruption or significant social withdrawal.
D. The individual is experiencing mental health or substance abuse symptoms (not solely those related to his or her diagnosis of an intellectual or developmental disability) related to his or her diagnosis that severely impair functional ability in an educational setting which may include vocational education.
E. There is no evidence to support that alternative interventions would be equally or more effective, based on North Carolina community practice standards (Best Practice Guidelines of the American Academy of Child and Adolescent Psychiatry, American Psychiatric Association, American Society of Addiction Medicine).

Entrance Process

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

A comprehensive clinical assessment is one mechanism to demonstrate medical necessity for a service and to assess and identify an individual's needs. For state-funded services, a service order is recommended. Providers shall coordinate with the LME-MCO regarding their requirements for service orders.

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

Prior authorization by the LME-MCO is required. To request the initial authorization, the Day

Treatment provider must submit the PCP with signatures and the required authorization request form to the LME-MCO.

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

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

Continued Service Criteria
The desired outcome or level of functioning has not been restored, improved, or sustained over the time frame outlined in the individual's PCP; or the individual 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 individual has achieved current PCP goals, and additional goals are indicated as evidenced by documented symptoms.
B. The individual is making satisfactory progress toward meeting goals, and there is documentation that supports that continuation of this service will be effective in addressing the goals outlined in the PCP.
C. The individual is making some progress, but the specific interventions in the PCP need to be modified so that greater gains, which are consistent with his or her pre-morbid level of functioning, are possible.
D. The individual fails to make progress, or demonstrates regression, in meeting goals through the interventions outlined in the PCP. The individual'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 individual has achieved goals and is no longer in need of Day Treatment services.
B. The individual's level of functioning has improved with respect to the goals outlined in the PCP, inclusive of a plan to transition to a lower level of care or appropriate educational setting.
C. The individual 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 individual or legally responsible person no longer wishes to receive Day Treatment services.

E. The individual, based on presentation and failure to show improvement despite modifications in the PCP, requires a more appropriate best practice treatment modality based on North Carolina community practice standards (for example, National Institute of Drug Abuse, American Psychiatric Association).

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

NOTE: Any denial, reduction, suspension, or termination of service requires notification to the individual, legally responsible person, or both about the individual's appeal rights pursuant to G.S. 143B-147(a)(9) and Rules 10A NCAC 27I .0601-.0609.

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 individual's PCP. 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, or developmentally appropriate coping skills;
- Development or 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 or psychiatric symptoms that interfere with the beneficiary'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 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:

- Individual's name
- Service record number
- Medicaid 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 beneficiary's specified goals as outlined in the PCP
- Signature and credentials of the staff member(s) providing the service (for paraprofessionals, position is required in lieu of credentials with staff signature).

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

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

Utilization Management

Services are based upon a finding of medical necessity, must be directly related to the individual's diagnostic and clinical needs, and are expected to achieve the specific rehabilitative goals specified in his or her PCP. Medical necessity is determined by the LME-MCO.

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 individual's physician, therapist, or other licensed practitioner. Typically, a medically necessary service must be generally recognized as an accepted method of medical practice or treatment. Each case is reviewed individually to determine if the requested service meets the criteria outlined under this policy.

Prior authorization by the LME-MCO is required. The LME-MCO will evaluate the request to determine if medical necessity supports more or less intensive services.

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

If continued Day Treatment services are needed at the end of the initial authorization period, the Day Treatment provider must submit the PCP and a new request for authorization reflecting the appropriate level of care and service to the LME-MCO. This should occur before the authorization expires.

Services are billed in one-hour increments.

Service Exclusions and Limitations
The individual 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 individual may be covered only when the activity is directed exclusively toward the benefit of that individual.

Day Treatment services may not be provided during the same authorization period as the following services:
- Intensive In-Home Services;
- 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);
- Substance abuse residential services; or
- Inpatient hospitalization.

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

Partial Hospitalization (State-Funded):

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

Therapeutic Relationship and Interventions
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 individual'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 an individual remaining in the community and 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 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 or the individual's diagnostic conditions. This may include training in community living, and specific coping skills, and medication management. This assistance allows individuals to develop their strengths and establish peer and community relationships.

Service Type
This is day or night service that shall be provided a minimum of four hours per day, five days per week, and 12 months a year (exclusive of transportation time), excluding legal or governing body designated holidays. Service standards and licensure requirements are outlined in10A NCAC 27G .5000. Utilization management must be performed by the LME-MCO.

Resiliency or Environmental Intervention
This service assists the individual 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.

Utilization Management
Prior authorization by the LME-MCO is required. The amount, duration, and frequency of the service must be included in an individual's Person-Centered Plan. Initial authorization shall not exceed seven calendar days. Reauthorization shall not exceed seven calendar days. All utilization review activity shall be documented in the Provider's Service Plan.

Utilization management must be performed by the LME-MCO.

Medical Necessity
ALL of the following must apply:

A. Must have Axis I or II diagnosis
B. Level of Care Criteria, Level C NC SNAP
C. The individual is experiencing difficulties in at least one of the following areas:
    1. Functional impairment;
    2. Crisis intervention, diversion, or aftercare needs; or
    3. Is at risk for placement outside the natural home setting
D. The individual's level of functioning has not been restored or improved and may indicate a need for clinical interventions in a natural setting if any one of the following applies:
    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, 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 the individual's 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 Orders
A comprehensive clinical assessment is one mechanism to demonstrate medical necessity for a service and to assess and identify an individual's needs. For state-funded services, a service order is recommended. Providers shall coordinate with the LME-MCO regarding their requirements for service orders.

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

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

Discharge Criteria
The individual'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 applies:

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

NOTE: Any denial, reduction, suspension, or termination of service requires notification to the individual, legally responsible person, or both about the individual's appeal rights pursuant to G.S. 143B-147(a)(9) and Rules 10A NCAC 27I .0601-.0609.

Service Maintenance Criteria
If the individual 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 of the following:

A. Past history of regression in the absence of PH is documented in the individual's 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.

NOTE: Any denial, reduction, suspension, or termination of service requires notification to the individual, legally responsible person, or both about the individual's appeal rights pursuant to G.S. 143B-147(a)(9) and Rules 10A NCAC 27I .0601-.0609.

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.

Professional Treatment Services in Facility-Based Crisis Program (State-Funded):

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

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

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

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

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

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

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

Medical Necessity
The individual is eligible for this service when all of the following apply:

A. There is an Axis I or II diagnosis present or the beneficiary has a condition that may be defined as a intellectual or developmental disability as defined in GS 122C-3 (12a)
B. Level of Care Criteria, Level D NC-SNAP (NC Supports or Needs Assessment Profile) or ASAM (American Society of Addiction Medicine)
C. The individual is experiencing difficulties in at least one of the following areas:
    a. Functional impairment,
    b. Crisis intervention, diversion, or after-care needs, or
    c. Is at risk for placement outside of the natural home setting.
D. The individual's level of functioning has not been restored or improved and may indicate a need for clinical interventions in a natural setting if any one of the following applies:
    a. Unable to remain in family or community setting due to symptoms associated with diagnosis, therefore being at risk for out of home placement, hospitalization, or institutionalization.
    b. Intensive, verbal and limited physical aggression due to symptoms associated with diagnosis, which are sufficient to create functional problems in a community setting.
    c. At risk of exclusion from services, placement or significant community support systems as a result of functional behavioral problems associated with diagnosis.

Service Orders
A comprehensive clinical assessment is one mechanism to demonstrate medical necessity for a service and to assess and identify an individual's needs. For state-funded services, a service order is recommended. Providers shall coordinate with the LME-MCO regarding their requirements for service orders.

Continuation or Utilization Review
The desired outcome or level of functioning has not been restored, improved or sustained over the time frame outlined in the individual's service plan or the individual 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. The individual has achieved initial service plan goals and additional goals are indicated.
B. The individual is making satisfactory progress toward meeting goals.
C. The individual is making some progress, but the service plan (specific interventions) need to be modified so that greater gains, which are consistent with his or her premorbid level of functioning, are possible or can be achieved.
D. The individual is not making progress; the service plan must be modified to identify more effective interventions.
E. The individual is regressing; the service plan must be modified to identify more effective interventions.

AND

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

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

Discharge Criteria

The individual'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 applies:

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

NOTE: Any denial, reduction, suspension, or termination of service requires notification to the individual, legally responsible person, or both about the individual's appeal rights pursuant to G.S. 143B-147(a)(9) and Rules 10A NCAC 27I .0601-.0609.

Service Maintenance Criteria

If the individual is functioning effectively with this service and discharge would otherwise be indicated, Facility-Based Crisis services 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 of the following:

A. Past history of regression in the absence of facility based crisis service is documented in the service record
B. In the event there are epidemiologically sound expectations that symptoms will persist and that ongoing treatment interventions are needed to sustain functional gains, the nature of the individual's DSM-IV diagnosis necessitates a disability management approach.

NOTE: Any denial, reduction, suspension, or termination of service requires notification to the individual, legally responsible person, or both about the individual's appeal rights pursuant to G.S. 143B-147(a)(9) and Rules 10A NCAC 27I .0601-.0609.

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

Documentation Requirements
Minimum documentation is a daily service note per shift.

Substance Abuse Services

State-Funded Services
Diagnostic Assessment
See Diagnostic Assessment (MH/DD/SA) service.

Mobile Crisis Management
See Mobile Crisis Management (MH/DD/SA) service.

Community Support Team—Adult
See Community Support Team—Adult (MH/SA).

Intensive In-Home Services
See Intensive In-Home Services (MH/SA) service.

Multisystemic Therapy (MST)
See Multisystemic Therapy (MH/SA) service.

Partial Hospitalization
See Partial Hospitalization (MH/SA) service.

Professional Treatment Services in Facility-Based Crisis Program
See Professional Treatment Services in Facility-Based Crisis Program (MH/DD/SA) service.

Substance Abuse Intensive Outpatient Program (State-Funded):

Level II.1 Intensive Outpatient Services ASAM Patient Placement Criteria

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 adult and adolescents individuals 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 individual 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 individuals with physical disabilities; or individuals with co-occurring disorders of mental illness and substance abuse or dependence; or an intellectual or developmental disability and substance abuse or dependence.

SAIOP may be designed for homogenous groups of individuals e.g., pregnant women, and women and their children; 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 beneficiary's need for services. SAIOP services also informs the individual about benefits, community resources, and services; assists the individual in accessing benefits and services; arranges for the individual to receive benefits and services; and monitors the provision of services. Individuals receiving this service 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 individual's residence. The program is provided over a period of several weeks or months.

A comprehensive clinical assessment is one mechanism to demonstrate medical necessity for a service and to assess and identify an individual's needs. For state-funded services, a service

order is recommended. Providers shall coordinate with the LME-MCO regarding their requirements for service orders.

Provider Requirements
SAIOP must be delivered by practitioners employed by substance abuse provider organizations that meet the requirements of 10A NCAC 27G and the provider qualification policies, procedures, and standards established by DMH/DD/SAS. These policies and procedures set forth the administrative, financial, clinical, quality improvement, and information services infrastructure necessary to provide services. Provider organizations shall demonstrate that they meet these standards by being credentialed by the LME-MCO. Additionally, the organization shall achieve national accreditation with at least one of the designated accrediting bodies within one year of enrollment as a provider with the LME-MCO. The organization shall be established as a legally recognized entity in the United States and qualified or registered to do business as a corporate entity in the State of North Carolina, capable of meeting all of the requirements of the LME-MCO credentialing process, DMH/DD/SAS Communication Bulletins, the DMH/DD/SAS *Records Management and Documentation Manual*, and service implementation standards. The provider organization shall comply with all applicable federal and state requirements.

Organizations that provide SAIOP must provide “first responder” crisis response on a 24 hours a day seven days a week 365 days a year basis to individuals who are receiving this service.

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

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

Program Requirements
See Service Definition and Required Components.

Utilization Management
Authorization by the LME-MCO is required. The amount, duration, and frequency of SAIOP service must be included in an individual's authorized PCP. Services may not be delivered less frequently than the structured program set forth in the service description above. Individuals may be seen for the initial 30 calendar days of treatment without a prior authorization. Services provided after this initial 30-day "pass-through" period require authorization from the LME-MCO.

This pass-through is available only once per calendar year. Reauthorization shall not exceed 60 calendar days. Under exceptional circumstances, one additional reauthorization up to 2 weeks may be approved. This service is billed with a minimum of three hours per day as an event.

Entrance Criteria
The individual is eligible for this service when ALL of the following criteria are met:

A. There is an Axis I substance abuse disorder present;
B. The individual meets ASAM Level II.1 criteria.

Continued Stay Criteria
The desired outcome or level of functioning has not been restored, improved, or sustained over the time frame outlined in the individual's PCP or the individual 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. The individual has achieved positive life outcomes that support stable and ongoing recovery, and additional goals are indicated.
B. The individual is making satisfactory progress toward meeting goals.
C. The individual is making some progress, but the PCP (specific interventions) needs to be modified so that greater gains, which are consistent with the individual's premorbid level of functioning, are possible or can be achieved.
D. The individual is not making progress; the PCP must be modified to identify more effective interventions
E. The individual is regressing; the PCP must be modified to identify more effective interventions.

Expected Outcomes
The expected outcome of SAIOP is abstinence. Secondary outcomes include: sustained improvement in health and psychosocial functioning, reduction in any psychiatric symptoms (if present), reduction in public health 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 individual'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 and credentials of the staff providing the service. A documented discharge plan will be discussed with the individual and included in the record.

Discharge Criteria

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

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

Service Exclusions and Limitations

SAIOP may not be billed during the same authorization as SA Comprehensive Outpatient Treatment, all detoxification services levels, Non-Medical Community Residential Treatment or Medically Monitored Community Residential Treatment.

Substance Abuse Comprehensive Outpatient Treatment Program (State-Funded):

Level II.5 Partial Hospitalization ASAM Patient Placement Criteria

Service Definition and Required Components

SA Comprehensive Outpatient Treatment (SACOT) Program means a periodic service that is a time-limited, multi-faceted approach treatment service for adults who require structure and support to achieve and sustain recovery. SACOT Program is a service emphasizing reduction in use and abuse of substances or continued abstinence, the negative consequences of substance abuse, development of social support network and necessary lifestyle changes, educational skills, vocational skills leading to work activity by reducing substance abuse as a barrier to employment, social and interpersonal skills, improved family functioning, the understanding of addictive disease, and the continued commitment to a recovery and maintenance program. These services are provided during day and evening hours to enable individuals to maintain residence in their community, continue to work or go to school, and to be a part of their family life. The following types of services are included in the SACOT Program:

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 individuals with physical disabilities; or individuals with co-occurring disorders of mental illness and substance abuse or dependence; or an intellectual or developmental disability and substance abuse or dependence.

SACOT programs may be designed for homogenous groups of individuals e.g., individuals being detoxed on an outpatient basis; individuals with chronic relapse issues; pregnant women, and women and their children; individuals with co-occurring MH/SA disorders; individuals with HIV; or individuals with similar cognitive levels of functioning. SACOT includes case management to arrange, link or integrate multiple services as well as assessment and reassessment of the individual's need for services. SACOT services also inform the individual about benefits, community resources, and services; assists the individual in accessing benefits and services; arranges for the individual to receive benefits and services; and monitors the provision of services. Individuals receiving SACOT may be residents of their own home, a substitute home, or a group care setting; however, the SACOT Program must be provided in a setting separate from the individual's residence.

A comprehensive clinical assessment is one mechanism to demonstrate medical necessity for a service and to assess and identify an individual's needs. For state-funded services, a service order is recommended. Providers shall coordinate with the LME-MCO regarding their requirements for service orders.

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

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

Provider Requirements

SACOT Programs shall be delivered by a team of practitioners employed by substance abuse provider organizations that meet the requirements of 10A NCAC 27G and the provider qualification policies, procedures, and standards established by DMH/DD/SAS. These policies and procedures set forth the administrative, financial, clinical, quality improvement, and information services infrastructure necessary to provide services. Provider organizations shall demonstrate that they meet these standards by being credentialed by the LME-MCO. Additionally, the organization shall achieve national accreditation with at least one of the designated accrediting bodies within one year of enrollment as a provider with the LME-MCO. The organization shall be established as a legally recognized entity in the United States and qualified or registered to do business as a corporate entity in the State of North Carolina, capable of meeting all of the requirements of the LME-MCO credentialing process, DMH/DD/SAS Communication Bulletins, the DMH/DD/SAS *Records Management and Documentation Manual*, and service implementation standards. The provider organization shall comply with all applicable federal and state requirements.

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

Staffing Requirements

Persons who meet the requirements specified for CCS, LCAS, LCAS - associate level, and CSAC under Article 5C may deliver SACOT Program. The program must be under the clinical supervision of a LCAS or CCS who is on site a minimum of 90% of the hours the service is in operation. Clinical services may also be provided by staff who meet the requirements specified for QP or AP status for Substance Abuse according to 10A NCAC 27G .0104, under the supervision of a CCS. The maximum face-to-face staff-to-individual ratio is not more than 10

adults to one QP based on an average daily attendance. Paraprofessional level providers who meet the requirements for Paraprofessional status according to 10A NCAC 27G .0104 and who have the knowledge, skills, and abilities required by the population and age to be served may deliver SACOT Program, under the supervision of an LCAS, CSAC or CCS. Paraprofessional level providers may not provide services in lieu of on-site service provision to individuals receiving this service by a qualified CCS, LCAS, LCAS - associate level, or CSAC.

Consultation Services
Individuals receiving the service must have ready access to psychiatric assessment and treatment services when warranted by the presence of symptoms indicating a co-occurring non-substance related Axis I or Axis II disorder (e.g. major depression, schizophrenia, borderline personality disorder). These services shall be delivered by a psychiatrists who meet requirements as specified in NCAC 27G .0104. The providers shall be familiar with the SACOT Program treatment plan for each individual seen in consultation, shall have access to SACOT Program treatment records for the individual, and shall be able to consult by phone or in person with the CCS, LCAS or CSAC providing SACOT Program services.

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

Program Requirements
See Service Definition and Required Components.

Utilization Management
Authorization by the LME-MCO is required. The amount, duration, and frequency of the services must be included in an individual's authorized PCP. Services may not be recommended to occur less frequently than the structured program's requirements set forth in the service description above. Individuals receiving Substance Abuse Comprehensive Outpatient Treatment (SACOT) services may be seen for the initial 60 calendar days of treatment without a prior authorization. Services provided after this initial 60-calendar-day "pass-through" period require authorization from the LME-MCO. This pass-through is available only once per calendar year. Reauthorization shall not exceed 60 days. All utilization review activity shall be documented in the Provider's Service Plan.

This service is billed with a minimum of four hours per day billed in hourly increments.

Utilization management must be performed by the LME-MCO.

Entrance Criteria
The individual is eligible for this service when:

A. There is an Axis I diagnosis of a substance abuse disorder.

AND

B. The individual meets ASAM Level II.5 criteria.

Continued Stay Criteria
The desired outcome or level of functioning has not been restored, improved, or sustained over the time frame outlined in the individual's PCP or the individual 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:

1. The individual has achieved initial PCP goals and continued service at this level is needed to meet additional goals.
2. The individual is making satisfactory progress toward meeting goals.
3. The individual is making some progress, but the PCP (specific interventions) needs to be modified so that greater gains, which are consistent with the individual's premorbid level of functioning, are possible or can be achieved.
4. The individual is not making progress; the PCP must be modified to identify more effective interventions.
5. Individual is regressing; the PCP must be modified to identify more effective interventions.

AND

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

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

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

Expected Outcomes
The expected outcome is abstinence. Secondary outcomes include: sustained improvement in health and psychosocial functioning, reduction in any psychiatric symptoms (if present), reduction in public health or safety concerns, and a reduction in the risk of relapse as evidenced by improvement in empirically-supported modifiable relapse risk factors. For individuals with co-occurring MH/SA disorders, improved functioning is the expected outcome.

Documentation Requirements
Minimum standard is a daily full service note for each day of SACOT that includes the individual'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 and credentials of the staff providing the service. A documented discharge plan will be discussed with the individual and included in the record

Service Exclusions and Limitations

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

Substance Abuse Non-Medical Community Residential Treatment (State-Funded):

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

Level III.5 Clinically Managed High-Intensity Residential Treatment

Service Definition and Required Components
SA Non-Medical Community Residential Treatment (SANMCRT) is a 24-hour residential recovery program professionally supervised residential facility that provides trained staff who work intensively with adults with substance abuse disorders who provide or have the potential to provide primary care for their minor children. This is a rehabilitation facility, without twenty-four hour per day medical nursing or monitoring, where a planned program of professionally directed evaluation, care and treatment for the restoration of functioning for individuals with an addiction disorder.

These programs shall include assessment, referral, individual and group therapy, family therapy, recovery skills training, disease management, symptom monitoring, monitoring medications and self-management of symptoms, aftercare, follow-up and access to preventive and primary health care including psychiatric care. The facility may utilize services from another facility providing psychiatric or medical services. Services shall promote development of a social network supportive of recovery, enhance the understanding of addiction, promote successful involvement in regular productive activity (such as school or work), enhance personal responsibility and promote successful reintegration into community living. Services shall be designed to provide a safe and healthy environment for individuals receiving this service and their children.

Program staff will arrange, link or integrate multiple services as well as assessment and reassessment of the individual's need for services. Program staff will inform the individual about benefits, community resources, and services; assist the individual in accessing benefits and services; arrange for the individual to receive benefits and services; and monitor the provision of services.

For programs providing services to individuals with their children in residence or pregnant women: Each adult shall also receive in accordance with their Person-Centered Plan: training in therapeutic parenting skills, basic independent living skills, child supervision, one-on-one interventions with the community to develop interpersonal and community coping skills, including adaptation to school and work environments and therapeutic mentoring. In addition, their children shall receive services in accordance with 10A NCAC 27G .4100.

A comprehensive clinical assessment is one mechanism to demonstrate medical necessity for a service and to assess and identify an individual's needs. For state-funded services, a service

order is recommended. Providers shall coordinate with the LME-MCO regarding their requirements for service orders.

Provider Requirements
SANMCRT shall be delivered by a team of practitioners employed by substance abuse provider organizations that meet the requirements of 10A NCAC 27G and the provider qualification policies, procedures, and standards established by DMH/DD/SAS. These policies and procedures set forth the administrative, financial, clinical, quality improvement, and information services infrastructure necessary to provide services. Provider organizations shall demonstrate that they meet these standards by being credentialed by the LME-MCO. Additionally, the organization shall achieve national accreditation with at least one of the designated accrediting bodies within one year of enrollment as a provider with the LME-MCO. The organization shall be established as a legally recognized entity in the United States and qualified or registered to do business as a corporate entity in the State of North Carolina, capable of meeting all of the requirements of the LME-MCO credentialing process, DMH/DD/SAS Communication Bulletins, the DMH/DD/SAS *Records Management and Documentation Manual*, and service implementation standards. The provider organization shall comply with all applicable federal and state requirements.

Organizations that provide SANMCRT must provide “first responder” crisis response on a 24 hours a day, seven days a week, 365 days a year basis to individuals receiving this service.

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

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

Program Requirements
See Service Definition and Required Components and 10A NCAC 27G .4100 for residential recovery programs.

Utilization Management
Authorization by the LME-MCO is required. Service must be included in the individual's PCP. Initial authorization shall not exceed 10 days. Reauthorization shall not exceed 10 days. All utilization review activity shall be documented in the Provider's Service Plan.

Utilization management must be performed the LME-MCO.

Entrance Criteria
The individual is eligible for this service when ALL of the following criteria are met:

A. There is an Axis I diagnosis of a substance abuse disorder.
B. The individual meets ASAM Level III.5 criteria.

Continued Stay Criteria
The desired outcome or level of functioning has not been restored, improved, or sustained over the time frame outlined in the individual's PCP or the individual 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. The individual has achieved initial Person Centered Plan goals and requires this service in order to meet additional goals.
B. The individual is making satisfactory progress toward meeting goals.
C. The individual is making some progress, but the PCP (specific interventions) needs to be modified so that greater gains, which are consistent with the individual's pre-morbid level of functioning, are possible or can be achieved.
D. The individual is not making progress; the PCP must be modified to identify more effective interventions.
E. The individual is regressing; the PCP must be modified to identify more effective interventions.

AND

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

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

1. The individual has achieved positive life outcomes that support stable and ongoing recovery (and parenting skills, if applicable).
2. The individual is not making progress, or is regressing and all realistic treatment options have been exhausted indicating a need for more intensive services.
3. The individual or family no longer wishes to receive SANMCRT services.

Expected Outcomes
The expected outcome is abstinence. Secondary outcomes include: sustained improvement in health and psychosocial functioning, reduction in any psychiatric symptoms (if present), reduction in public health or safety concerns, and a reduction in the risk of relapse as evidenced by improvement in empirically-supported modifiable relapse risk factors. Additionally, for Residential Recovery Programs, improved parenting is an expected outcome.

Documentation Requirements
Minimum standard is a full daily note that includes the individual'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 and credentials of the staff providing the service. Residential Recovery Programs for women and children shall also provide documentation of all services provided to the children in the program. Goals for parent-child interaction shall be established and progress towards meeting these goals shall be documented in the parent's service record. A documented discharge plan discussed with the individual is included in the record.

Service Exclusions and Limitations
Substance Abuse Non-Medical Community Residential Treatment may not be billed the same day as any other MH/SA services except group living moderate. This is a short-term service that may only be billed for 30 days in a 12-month period.

Substance Abuse Medically Monitored Community Residential Treatment (State-Funded):

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

Level III.7 Medically Monitored Intensive Inpatient Treatment

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

A comprehensive clinical assessment is one mechanism to demonstrate medical necessity for a service and to assess and identify an individual's needs. For state-funded services, a service order is recommended. Providers shall coordinate with the LME-MCO regarding their requirements for service orders.

Provider Requirements
SAMMCRT shall be delivered by a team of practitioners employed by substance abuse provider organizations that meet the requirements of 10A NCAC 27G and the provider qualification policies, procedures, and standards established by DMH/DD/SAS. These policies and procedures set forth the administrative, financial, clinical, quality improvement, and information services infrastructure necessary to provide services. Provider organizations shall demonstrate that they meet these standards by being credentialed by the LME-MCO. Additionally, the organization shall achieve national accreditation with at least one of the designated accrediting bodies within one year of enrollment as a provider with the LME-MCO. The organization shall be established as a legally recognized entity in the United States and qualified or registered to do business as a corporate entity in the State of North Carolina, capable of meeting all of the requirements of the LME-MCO credentialing process, DMH/DD/SAS Communication Bulletins, the DMH/DD/SAS *Records Management and Documentation Manual*, and service implementation standards. The provider organization shall comply with all applicable federal and state requirements.

Organizations that provide SAMMCRT must provide "first responder" crisis response on a 24 hours a day, seven days a week, 365 days a year basis to the individuals who are receiving this service.

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

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

Program Requirements
See Service Definition and Required Components.

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

Entrance Criteria
The individual is eligible for this service when ALL of the following criteria are met:

A. There is an Axis I diagnosis of a substance abuse disorder.
B. The individual meets ASAM Level III.7 criteria.

Continued Stay Criteria
The desired outcome or level of functioning has not been restored, improved, or sustained over the time frame outlined in the individual's PCP or the individual continues to be at risk for

relapse based on history or the tenuous nature of the functional gains or ANY of the following applies:

A. The individual has achieved positive life outcomes that support stable and ongoing recovery and services need to be continued to meet additional goals.
B. The individual is making satisfactory progress toward meeting goals.
C. The individual is making some progress, but the PCP (specific interventions) needs to be modified so that greater gains, which are consistent with the individual's premorbid level of functioning, are possible or can be achieved.
D. The individual is not making progress; the PCP must be modified to identify more effective interventions.
E. The individual is regressing; the PCP must be modified to identify more effective interventions.

Discharge Criteria

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

- The individual has achieved positive life outcomes that support stable and ongoing recovery.
- The individual is not making progress, or is regressing and all realistic treatment options have been exhausted indicating a need for more intensive services.
- The individual no longer wishes to receive SAMMCRT services. (Note that although an individual may no longer wish to receive SAMMCRT services, the beneficiary must still be provided with discharge recommendations that are intended to help the beneficiary meet expected outcomes).

Expected Outcomes

The expected outcome is abstinence. Secondary outcomes individuals include: sustained improvement in health and psychosocial functioning, reduction in any psychiatric symptoms (if present), reduction in public health or safety concerns, and a reduction in the risk of relapse as evidenced by improvement in empirically-supported modifiable relapse risk factors.

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

Documentation Requirements

Minimum standard is a daily full service note that includes the individual'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 and credentials of the staff providing the service. A discharge plan shall be discussed with the individual and included in the record.

Service Exclusions and Limitations

This service may not be billed the same day as any other MH/SA service except CST or ACT.

Substance Abuse Halfway House (State-Funded):

Level III.1 Clinically Managed Low-Intensity Residential Treatment

Service Definition and Required Components
Clinically managed low intensity residential services are provided in a 24-hour facility where the primary purpose of these services is the rehabilitation of individuals who have a substance abuse disorder and who require supervision when in the residence. Individuals receiving this service attend work, school, and SA treatment services. 10A NCAC 27G .5600 sets forth required service components.

Rehabilitative services components offered within this level of care must include ALL of the following:

1. Disease management
2. Vocational, educational, or employment training.
3. Support services for early recovery and relapse prevention
4. Linkage with the self-help and other community resources for support (e.g. 12-step meetings, faith-based programs, etc.)

A comprehensive clinical assessment is one mechanism to demonstrate medical necessity for a service and to assess and identify an individual's needs. For state-funded services, a service order is recommended. Providers shall coordinate with the LME-MCO regarding their requirements for service orders.

Provider Requirements
Substance Abuse Halfway House shall be delivered by a team of practitioners employed by substance abuse provider organizations that meet the requirements of 10A NCAC 27G and the provider qualification policies, procedures, and standards established by DMH/DD/SAS. These policies and procedures set forth the administrative, financial, clinical, quality improvement, and information services infrastructure necessary to provide services. Provider organizations shall demonstrate that they meet these standards by being credentialed by the LME-MCO. The organization shall be established as a legally recognized entity in the United States and qualified or registered to do business as a corporate entity in the State of North Carolina, capable of meeting all of the requirements of the LME-MCO credentialing process, DMH/DD/SAS Communication Bulletins, the DMH/DD/SAS *Records Management and Documentation Manual*, and service implementation standards. The provider organization shall comply with all applicable federal and state requirements.

Staffing Requirements
Staff requirements are specified in licensure rule 10A NCAC 27G .5600.

Service Type and Setting
Facility is licensed under 10A NCAC 27G .5600.

Program Requirements
See Service Definition and Required Components and licensure requirements.

Utilization Management
Authorization by the LME-MCO is required. The amount and duration of this service must be included in an authorized beneficiary's PCP. Initial authorization for services will not exceed 180 days.

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

A. There is an Axis I substance abuse disorder present.
B. The individual meets ASAM Level III.1 or III.3 criteria.

Continued Stay Criteria
The desired outcome or level of functioning has not been restored, improved, or sustained over the time frame outlined in the individual's PCP or the individual 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. The individual has achieved initial PCP goals and additional goals are indicated.
B. The individual is making satisfactory progress toward meeting goals.
C. The individual is making some progress, but the PCP (specific interventions) needs to be modified so that greater gains, which are consistent with the individual's premorbid level of functioning, are possible or can be achieved.
D. The individual is not making progress; the Person Centered Plan must be modified to identify more effective interventions.
E. The individual is regressing; the PCP must be modified to identify more effective interventions.

AND
Utilization review must be conducted every 90 days and is so documented in the PCP and the service record.

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

1. The individual has achieved positive life outcomes that support stable and ongoing recovery.
2. The individual is not making progress, or is regressing and all realistic treatment options have been exhausted indicating a need for more intensive services.

3. The individual or family no longer wishes to receive Halfway House services.

Expected Outcomes
The expected outcome of Halfway House is abstinence. Secondary outcomes include: sustained improvement in health and psychosocial functioning, reduction in any psychiatric symptoms (if present), reduction in public health 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 Halfway House that includes the individual'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 and credentials of the staff providing the service. A documented discharge plan discussed with the individual is included in the record.

Service Exclusions and Limitations
Substance Abuse Halfway House may not be billed the same day as any other Residential Treatment or Inpatient Hospital service.

Detoxification Services

Ambulatory Detoxification (State-Funded):

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

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 individual's level of clinical severity and to achieve safe and comfortable withdrawal from mood-altering drugs (including alcohol) and to effectively facilitate the individual's transition into ongoing treatment and recovery.

A comprehensive clinical assessment is one mechanism to demonstrate medical necessity for a service and to assess and identify an individual's needs. For state-funded services, a service order is recommended. Providers shall coordinate with the LME-MCO regarding their requirements for service orders.

Provider Requirements
Ambulatory Detoxification Without Extended On-Site Monitoring shall be delivered by a team of practitioners employed by substance abuse provider organizations that meet the requirements of 10A NCAC 27G and the provider qualification policies, procedures, and standards established by DMH/DD/SAS. These policies and procedures set forth the administrative, financial, clinical, quality improvement, and information services infrastructure necessary to provide services. Provider organizations shall demonstrate that they meet these standards by being credentialed by the LME-MCO. Additionally, the organization shall achieve national accreditation with at least one of the designated accrediting bodies within one year of enrollment as a provider with the LME-MCO. The organization shall be established as a legally recognized entity in the United States and qualified or registered to do business as a corporate entity in the State of North Carolina, capable of meeting all of the requirements of the LME-MCO credentialing process, DMH/DD/SAS Communication Bulletins, the DMH/DD/SAS *Records Management and Documentation Manual*, and service implementation standards. The provider organization shall comply with all applicable federal and state requirements.

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 an individual'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 an LCAS or CCS.

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

Entrance Criteria
All of the following criteria must be met:
- There is an Axis I diagnosis of a substance abuse disorder present.
- The individual meets ASAM Level I-D criteria.

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

Utilization management must be performed by the LME-MCO.

Continued Stay and Discharge Criteria
The individual continues in Ambulatory Detoxification Without Extended On-Site Monitoring until ANY of the following criteria is met:
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 individual'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 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 individual is also documented prior to discharge.

Service Exclusions

Ambulatory Detoxification may not be billed the same day as any other service except for SA Comprehensive Outpatient Treatment.

Social Setting Detoxification (State-Funded):

Level III.2-D Clinically Managed Residential Detoxification

Service Definition and Required Components
Clinically Managed Residential Detoxification is an organized service that is delivered by appropriately trained staff, who provide 24-hour supervision, observation and support for individuals who are intoxicated or experiencing withdrawal symptoms sufficiently severe to require 24-hour structure and support. The service is characterized by its emphasis on peer and social support. Established clinical protocols are followed by staff to identify individuals who are in need of medical services beyond the capacity of the facility and to transfer such individuals to the appropriate levels of care.

A comprehensive clinical assessment is one mechanism to demonstrate medical necessity for a service and to assess and identify an individual's needs. For state-funded services, a service order is recommended. Providers shall coordinate with the LME-MCO regarding their requirements for service orders.

Provider Requirements
Social Setting Detoxification shall be delivered by a team of practitioners employed by substance abuse provider organizations that meet the requirements of 10A NCAC 27G and the provider qualification policies, procedures, and standards established by DMH/DD/SAS. These policies and procedures set forth the administrative, financial, clinical, quality improvement, and information services infrastructure necessary to provide services. Provider organizations shall demonstrate that they meet these standards by being credentialed by the LME-MCO. Additionally, the organization shall achieve national accreditation with at least one of the designated accrediting bodies within one year of enrollment as a provider with the LME-MCO. The organization shall be established as a legally recognized entity in the United States and qualified or registered to do business as a corporate entity in the State of North Carolina, capable of meeting all of the requirements of the LME-MCO credentialing process, DMH/DD/SAS Communication Bulletins, the DMH/DD/SAS *Records Management and Documentation Manual*, and service implementation standards. The provider organization shall comply with all applicable federal and state requirements.

Staffing Requirements
Persons who meet the requirements specified for a CCS, LCAS, LCAS - associate level, and CSAC under Article 5C may deliver Social Setting Detoxification. The program must be under the clinical supervision of a CCS or LCAS who is available 24 hours a day by telephone. All clinicians who assess and treat individuals receiving these services are able to obtain and interpret information regarding the needs of the individual including the signs and symptoms of alcohol and other drug intoxication and withdrawal as well as the appropriate treatment and

monitoring of those conditions and how to facilitate entry into ongoing care. Back-up physician services are available by telephone 24 hours a day. Services must be provided by staff who meet the requirements specified for QP or AP status in Substance Abuse according to 10A NCAC 27G .0104, under the supervision of an LCAS or CCS. Paraprofessional level providers who meet the requirements for Paraprofessional status according to 10A NCAC 27G .0104 and Certified Peer Support Specialist and who have the knowledge, skills, and abilities required by the population and age to be served may deliver Social Setting Detoxification, under the supervision of a LCAS or CCS. Paraprofessional level providers may not provide services in lieu of on-site service provision to individuals by a QP, CCS, LCAS, LCAS - associate level, or CSAC.

Service Type and Setting
Social Setting Detoxification is provided in a facility licensed under 10A NCAC 27G .3200.

Entrance Criteria
All of the following criteria must be met:
- There is an Axis I diagnosis of a substance abuse disorder present.
- The individual meets ASAM Level III.2-D criteria.

Utilization Management
Authorization by the LME-MCO is required. This service must be included in an individual's PCP. Initial authorization is limited to seven days.

Continued Stay and Discharge Criteria
The individual continues in Social Setting Detoxification until:
1. Withdrawal signs and symptoms are sufficiently resolved that he or she can be safely managed at a less intensive level of care; 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 of this service is abstinence and reduction in any psychiatric symptoms (if present).

Documentation Requirements
Minimum standard is a shift note for every 8 hours of service provided that includes the individual'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. In addition, 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. A documented discharge plan discussed with the individual is included in the record.

Service Exclusions
This service may not be billed the same day as any other MH/SA service except CST, and ACTT.

Non-Hospital Medical Detoxification (State-Funded):

Level III.7-D Medically Monitored Inpatient Detoxification

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

A comprehensive clinical assessment is one mechanism to demonstrate medical necessity for a service and to assess and identify an individual's needs. For state-funded services, a service order is recommended. Providers shall coordinate with the LME-MCO regarding their requirements for service orders.

Provider Requirements
Non-Hospital Medically Monitored Detoxification shall be delivered by practitioners employed by substance abuse provider organizations that meet the requirements of 10A NCAC 27G and the provider qualification policies, procedures, and standards established by DMH/DD/SAS. These policies and procedures set forth the administrative, financial, clinical, quality improvement, and information services infrastructure necessary to provide services. Provider organizations shall demonstrate that they meet these standards by being credentialed by the LME-MCO. Additionally, the organization shall achieve national accreditation with at least one of the designated accrediting bodies within one year of enrollment as a provider with the LME-MCO. The organization shall be established as a legally recognized entity in the United States and qualified or registered to do business as a corporate entity in the State of North Carolina, capable of meeting all of the requirements of the LME-MCO credentialing process, DMH/DD/SAS Communication Bulletins, the DMH/DD/SAS *Records Management and Documentation Manual*, and service implementation standards. The provider organization shall comply with all applicable federal and state requirements.

Staffing Requirements
Non-Hospital Medically Monitored Detoxification is staffed by physicians, who are available 24 hours a day by telephone and who conducts an assessment within 24 hours of admission. A registered nurse is available to conduct a nursing assessment on admission and oversee the monitoring of an individual's progress and medication administration. The level of nursing care is appropriate to the severity of the individual's needs, based on the clinical protocols of the program. Appropriately licensed and credentialed staff are available to administer medications in accordance with physician orders. Persons who meet the requirements specified for CCS, LCAS, LCAS - associate level, and CSAC under Article 5C may deliver a planned regimen of

24-hour evaluation, care and treatment services for individuals engaged in Non-Hospital Medically Monitored Detoxification. The planned regimen of 24-hour evaluation, care and treatment services must be under the clinical supervision of a CCS or LCAS who is available by phone 24 hours a day. The planned regimen of 24-hour evaluation, care and treatment services for individuals engaged in Non-Hospital Medically Monitored Detoxification must be provided by staff who meet the requirements specified for QP or AP status in Substance Abuse according to 10A NCAC 27G .0104, under the supervision of a LCAS or CCS. Paraprofessional level providers who meet the requirements for Paraprofessional status according to 10A NCAC 27G .0104 and who have the knowledge, skills, and abilities required by the population and age to be served may deliver the planned regimen of 24-hour evaluation, care and treatment services for individuals engaged in Medically Monitored Detoxification, under the supervision of a LCAS or CCS. Paraprofessional level providers may not provide services in lieu of on-site service provision to individuals by a QP, CCS, LCAS, LCAS - associate level, or CSAC.

Service Type and Setting
Non-Hospital Medical Detoxification is provided in a facility licensed under 10A NCAC 27G .3100.

Entrance Criteria
ALL of the following criteria must be met:

A. There is an Axis I diagnosis of a substance abuse disorder present.
B. The individual meets ASAM Level III.7-D criteria.

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

Utilization management must be performed by the LME-MCO.

Continued Stay and Discharge Criteria
The individual continues in Medically Monitored Detoxification until ANY of the following criteria is met:

- Withdrawal signs and symptoms are sufficiently resolved that he or she can be safely managed at a less intensive level of care; and
- Signs or symptoms of withdrawal have failed to respond to treatment and have intensified such that transfer to a more intensive level of detoxification service is indicated.

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

Documentation Requirements
Minimum standard is a full daily note that includes number, date of service, purpose of the 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 (includes tabulation of vital signs) are used as needed. A discharge plan, which has been discussed with the individual, is also included in the record.

Service Exclusions
This service may not be billed the same day as any other MH/SA service except CST and ACTT. This is a short-term service that may not be billed for more than 30 days in a short-term period.

Medically Supervised or ADATC Detoxification Crisis Stabilization (State-Funded):

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

Level III.9-D Medically Supervised Detoxification Crisis Stabilization

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

A comprehensive clinical assessment is one mechanism to demonstrate medical necessity for a service and to assess and identify an individual's needs. For state-funded services, a service order is recommended. Providers shall coordinate with the LME-MCO regarding their requirements for service orders.

Provider Requirements
Medically Supervised or ADATC Detoxification Crisis Stabilization shall be delivered by practitioners employed by substance abuse provider organizations that meet the requirements of 10A NCAC 27G and the provider qualification policies, procedures, and standards established by DMH/DD/SAS. These policies and procedures set forth the administrative, financial, clinical, quality improvement, and information services infrastructure necessary to provide services. Provider organizations shall demonstrate that they meet these standards by being credentialed by the LME-MCO. Additionally, the organization shall achieve national accreditation with at least one of the designated accrediting bodies within one year of enrollment as a provider with the LME-MCO. The organization shall be established as a legally recognized entity in the United States and qualified or registered to do business as a corporate entity in the State of North Carolina, capable of meeting all of the requirements of the LME-MCO credentialing process, DMH/DD/SAS Communication Bulletins, the DMH/DD/SAS *Records Management and Documentation Manual*, and service implementation standards. The provider organization shall comply with all applicable federal and state requirements.

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

Service Type and Setting
(Licensure TBD)

Entrance Criteria
ALL of the following criteria must be met:

A. There is an Axis I diagnosis of a substance abuse disorder present.
B. The individual meets ASAM Level III.9-D criteria.

Utilization Management
Authorization by the LME-MCO is required after the first eight hours of admission. This service must be included in an individual's PCP. Initial authorization is limited to five days.

Utilization management must be performed by the LME-MCO.

Continued Stay and Discharge Criteria
The individual continues in Medically Supervised or ADATC Detoxification Crisis Stabilization until ANY of the following criteria is met:

1. Withdrawal signs and symptoms are sufficiently resolved that he or she can be safely managed at a less intensive level of care;

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;
3. The addition of other clinical services is indicated.

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

Documentation Requirements
Minimum standard is a daily full service note that includes the individual's name, Medicaid identification number, date of service, purpose of the 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. In addition, detoxification rating scale tables [e.g., Clinical Institute Withdrawal Assessment-Alcohol, Revised (CIWA-AR)] and flow sheets (includes tabulation of vital signs) are used as needed. A discharge plan, which has been discussed with the individual, is also included in the record.

Service Exclusions
This service may not be billed the same day as any other MH/SA service except CST and ACTT. This is a short-term service that may not be billed for more than 30 days in a 12-month period.

Outpatient Opioid Treatment (State-Funded):

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:
   1. treatment,

OR

   2. maintenance.

B. Only direct face-to-face time with beneficiary to be reported.
C. Staff travel time to be reported separately.
D. Preparation and documentation time NOT reported.

Payment Unit
One daily unit.

Therapeutic Relationship and Intervention
Administration of methadone or other FDA approved drugs, as clinically indicated, may be billed under this service code to provide maintenance or detoxification services for individuals with an opioid addiction diagnosis.

Structure of Daily Living
Not applicable.

Cognitive and Behavioral Skill Acquisition
Not applicable.

Service Type
This is a periodic service.

Resiliency and Environment Intervention
Not applicable.

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

Medical Necessity
The individual is eligible for this service when all of the following criteria are met:

A. An Axis I or II diagnosis is present;
B. ASAM (American Society for Addiction Medicine) for Opioid Maintenance Therapy (OMT) Level of Service is met; and
C. Service is a part of an aftercare planning process (time limited step down or transitioning) and is required to avoid returning to a higher, more restrictive level of service.

Service Order Requirement
A comprehensive clinical assessment is one mechanism to demonstrate medical necessity for a service and to assess and identify an individual's needs. For state-funded services, a service order is recommended. Providers shall coordinate with the LME-MCO regarding their requirements for service orders.

A physician's order is required for medication to be administered.

Continuation and Utilization Review Criteria
The desired outcome or level of functioning has not been restored, improved or sustained over the time frame outlined in the individual's service plan or the individual continues to be at risk for relapse based on history or the tenuous nature of the functional gains;
OR
The individual meets any of the specifications listed in the ASAM criteria for Dimension 5 Relapse, Continued Use or Continued Problem Potential for Opioid Maintenance Therapy.

Authorization by the LME-MCO is required. Initial authorization shall not exceed 60 days. Reauthorization shall not exceed 180 days. All utilization review activity shall be documented in the Provider's Service Plan.

Discharge Criteria
The individual'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 applies:

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

NOTE: Any denial, reduction, suspension, or termination of service requires notification to the individual, legally responsible person, or both about the individual's appeal rights pursuant to G.S. 143B-147(a)(9) and Rules 10A NCAC 27I .0601-.0609.

Service Maintenance Criteria
If the individual is functioning effectively with this service and discharge would otherwise be indicated, Opioid 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:

A. Past history of regression in the absence of Opioid Treatment is documented in the individual's record.
B. The presence of a DSM-IV (or its successor) diagnosis that would necessitate a disability management approach, in the event that there is epidemiological sound expectations that symptoms will persist and that on going treatment interventions are needed to sustain functional gains.

NOTE: Any denial, reduction, suspension, or termination of service requires notification to the individual, legally responsible person, or both about the individual's appeal rights pursuant to G.S. 143B-147(a)(9) and Rules 10A NCAC 27I .0601-.0609.

Provider Requirement and Supervision
This service may 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 individual receives the service less frequently than weekly.

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

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

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

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