NC Division of Mental Health, Developmental Disabilities, and Substance Use Services
Comprehensive Case Management for Adult Mental Health/Adult Substance Use

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1.0 Description of the Procedure, Product, or Service

Comprehensive Case Management (CCM) for Adult Mental Health/Adult Substance Use (AMH/ASU) is a 24/7/365 service for adults with either a mental health (MH), substance use (SU), or co-occurring MH/SU diagnosis that access behavioral health crisis services for psychiatric care and substance use disorder services. The point of service initiation is in response to accessing multiple crisis services over a three (3) month period as stated in the entrance criteria. Within 24 hours of the qualifying event, the BH Care Management Coordinator will make a referral to a CCM provider. The individual will receive their first CCM visit in the community to begin the hands-on case management services within 24 hours of receiving the referral. CCM will be provided for a maximum of 6 months in a calendar year.

CCM teams should be staffed with professionals that are highly skilled case managers who are well informed of the resources in their community and how to access them. CCM teams should have up-to-date and in-depth knowledge of primary care providers, specialty health care providers, community transportation resources, medication resources, mental health providers, substance use providers, food pantries and resources, housing services and supports and other community-based services. A CCM team should be able to complete in depth case management assessments and then put the plan to action to ensure individuals have been linked to services that support a decrease in behavioral health crisis services.

It is critical that the CCM team is integrated into the behavioral health crisis system, including but not limited to, Emergency Departments (EDs), inpatient community hospitals, Mobile Crisis Management (MCM) Teams, Facility Based Crisis (FBC), State Operated Healthcare Facilities, Alcohol and Drug Abuse Treatment Centers (ADATCS), and Behavioral Health Urgent Care (BHUC). A CCM team must have the flexibility to begin engagement with an individual within 48 hours of the qualifying event of either mental health or substance use crisis to begin rapport building and service engagement. The CCM team assumes responsibility for developing a Case Management Service Plan that focuses solely on the case management functions that will be provided to address the individual's service and support needs.

An effective CCM team should be well connected with a wide range of community resources and supports which enables them to quickly link individuals to critical services and supports to prevent or reduce future crisis service events. The case manager is required to coordinate and communicate with any service providers currently in place, including the individual's primary care physician, the individual's mental health and/or substance use service provider, and the individual's obstetrician and gynecologist (OBGYN), when applicable.

The intended outcomes of CCM for AMH/ASU are to decrease emergency room and other MH/SU crisis service utilization, decrease psychiatric hospitalization readmissions, decrease involuntary commitments, and increase linkage to community-based services for adults with MH/SU disorders and a history of recurrent crisis events.

Refer to **Subsection 2.0.**

1.1 Comprehensive Case Management for AMH/ASU (CCM for AMH/ASU)

Comprehensive Case Management (CCM for AMH/ASU) is a service designed to ensure individuals utilizing multiple mental health crisis and/or substance use disorder crisis services have access to intensive case management services that can prevent emergency department admissions and involuntary commitments when appropriate community supports could stabilize the individual, and ensure that individuals have intensive, time-limited case management supports that link to appropriate community-based levels of care and supports. CCM for AMH/ASU will assist individuals in gaining access to necessary care: referral for Comprehensive Clinical Assessment (CCA) or Diagnostic Assessment (DA), medical, behavioral, social, and other services appropriate to their needs. CCM for AMH/ASU is individualized, person-centered, comprehensive, strengths-based, recovery-oriented, and outcome-focused. The functions of case management include:

1. Referral and linkage for a CCA or DA
2. Case Management Assessment
3. Case Management Service Plan;
4. Referral and linkage;
5. Psychoeducation;
6. Monitoring and follow-up; and
7. Program Specific Information.

1.1.1 Comprehensive Clinical Assessment

A Comprehensive Clinical Assessment (CCA) is completed by a licensed clinician that meets the criteria included in 10A NCAC 27G. 0104 (12). The CCA demonstrates medical necessity and must be completed prior to the provision of this service and is billed separately. 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 qualify as a current CCA. Relevant diagnostic information must be obtained and documented in the individual's Case Management Service Plan.

If the individual has substance use disorder, the ASAM criteria (http://www.asam.org/quality-practice/guidelines-and-consensus-documents/the-asam-criteria) shall be included. Information from the CCA should be used to develop the CCM for AMH/SU Case Management Plan.

1.1.2 Case Management Assessment

A comprehensive and culturally appropriate case management assessment documents a beneficiary's service needs, strengths, resources, preferences, and goals to develop a Case Management Service Plan. The case manager gathers information regarding all aspects of the beneficiary, including medical, physical, and functional, psychosocial, behavioral, financial, social, cultural, environmental, legal, and vocational or educational areas. The case management assessment integrates all current assessments including the comprehensive clinical assessment and medical assessments, including assessments and information from the primary care physician, including an OBGYN. The case management assessment includes early identification of conditions and needs for prevention and amelioration. The case management assessment involves consultation with other natural and paid supports such as family members, medical and behavioral health

providers, and educators to form a complete assessment. The case management assessment includes periodic reassessment to determine whether a beneficiary's needs or preferences have changed.

1.1.3 Case Management Service Plans

According to 10A NCAC 27G .0205, the case management service plan shall be developed based on the assessment, and in partnership with the individual or legally responsible person or both, within 30 days of admission for individuals who are expected to receive services beyond 30 days. The case management service plan shall include at least the following elements, also according to 10A NCAC 27G .0205:

- Client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement;
- Strategies;
- Staff responsible;
- A schedule for review of the plan after three months in consultation with the individual or legally responsible person, or both, to review goals and strategies to promote effective treatment;
- Basis for evaluation or assessment of outcome achievement; and
- written consent or agreement by the client or responsible party, or a written statement by the provider stating why such consent could not be obtained.

Refer to the DMHDDSAS Records Management and Documentation Manual (http://www.ncdhhs.gov/mhddsas/providers/recordsmanagement/resources.htm) for specific information.

1.1.4 Referral and Linkage

Referral and linkage activities connect an individual with medical, behavioral, social, and other programs, services, and supports to prevent possible crisis service usage, crisis events or possible involuntary commitment, and decrease the potential for recurring crisis service intervention. Referral and linkage activities include:

a. Assist the individual in applying for eligible benefits (Medicaid, housing, food stamps, WIC etc.) Assist pregnant women in applying for Medicaid for Pregnant Women (Baby Love)
b. Coordinating the delivery of services to reduce fragmentation of care and maximize mutually agreed upon outcomes;
c. Facilitating access to and connecting the individual to services and supports identified in the Case Management Service Plan;
d. Making referrals to providers for needed services and scheduling appointments with the individual;
e. Assisting the individual as he or she transitions through levels of care;
f. Educating the individual on mental health and substance use crisis services available in the community, and how to access them;
g. Facilitating communication and collaboration among all service providers and the individual;
h. Assisting the individual in establishing and maintaining a primary care physician; and
i. Assisting the pregnant individual in establishing obstetrician and prenatal care as necessary.

1.1.5 Psychoeducation

a. Development of relapse prevention, disease management strategies to support recovery, and recovery resources;
b. Psychoeducation for the individual, families, caregivers, or other individuals/natural supports involved with the individual about his or her diagnosis, symptoms, and treatment;
c. Psychoeducation regarding symptom reduction and self-management of any prescribed medications and medical needs management;
d. Psychoeducation to assist in building a natural support system.

1.1.6 Monitoring and Follow-Up

Monitoring and follow up includes activities and contacts that are necessary to ensure that the Case Management Service Plan is effectively implemented and adequately addresses the needs of the individual. Monitoring activities may involve the individual, his or her supports, providers, and others involved in care delivery. Monitoring activities help determine whether:

a. services are being provided in accordance with the individual's Case Management Service Plan;
b. services in the Case Management Service Plan are adequate and effective;
c. there are changes in the needs or status of the individual; and
d. the individual is making progress toward his or her goals.

1.2 Program Specific Information

1. CCM Team Meeting

The CCM team meeting is the central hub of communication. This allows for the sharing of recent assessment information and planning for the day's activities. The CCM team shall meet at least twice a week to allow staff to systematically update information, briefly discuss the status of individuals receiving services, problem-solve emerging issues, and plan approaches to address and prevent crises. This critical clinical supervision and organizational meeting is also used to plan upcoming service contacts. There must be a reliable communication mechanism in place to relay important information to team members not present during that day or shift. This meeting can be facilitated using a HIPAA compliant web platform.

2. Service Duration and Intensity

Individuals receiving CCM have complex medical, withdrawal management, and psychiatric needs which lead to frequent use of crisis service. The CCM team serves as linkage to medical, psychiatric, and basic needs (housing, food, transportation, employment/income, legal, insurance, etc.). Therefore, individuals should be seen at a minimum of two (2) hours of intervention per week when CCM is initiated. Service frequency and intensity is only expected to decrease as individuals are linked to community-based services and natural supports identified in the Case Management Service Plan.

It is expected that additional in person and telephonic communications are made with individual's natural supports, and other providers on their behalf (e.g., inpatient hospital staff, landlord, and residential staff).

3. Expected Outcomes

An individual:

1. has been successfully linked to the clinically appropriate mental health and/or substance use services in the community;
2. has increased utilization of natural, community and recovery supports;
3. has experienced a decrease in or has not accessed mental health and/or substance use crisis services;
4. becomes increasingly independent in managing his or her own care (e.g., making treatment appointments, attending treatment, taking medications as prescribed, etc.)

2.1 2.0 Specific Criteria

2.1.1 Eligibility Criteria

An individual, 18 and over, is eligible for this service when:

a. The individual is seeking crisis services and supports for what presents as mental health and/or substance use crisis at least:

1. 3 inpatient, FBC or withdrawal management service stays in the last three months;

OR

2. 3 ED visits, MCM encounters or BHUC visits in the last three months;

OR

3. A combination of inpatient/FBC/withdrawal management service stays and ED, MCM or BHUC visits that totals three encounters in the past three months;

OR

4. is currently pregnant and reports using substances (including alcohol)

AND

b. Either of the following

1. There is a MH, SU, or co-occurring diagnosis (as defined by the Diagnostic and Statistical Manual of Mental Disorders, fifth edition (DSM-5), or any subsequent editions of this reference material, other than a sole diagnosis of an intellectual or developmental disability;

OR

2. There is a Substance Use diagnosis (as defined by the Diagnostic and Statistical Manual of Mental Disorders, fifth edition (DSM-5), or any subsequent editions of this reference material, other than a sole diagnosis of an intellectual or developmental disability, and the individual is pregnant;

AND

c. The individual requires coordination between two or more agencies, including medical or non-medical providers, or the individual has not been successfully linked with community-based services to address their mental health and/or substance use symptoms;

AND

d. The individual is unable to manage his or her symptoms (independently or with family/caregiver support), resulting in accessing multiple crisis services and supports

2.1.2 Continued Stay Criteria

The individual is eligible to continue receiving CCM services after the initial authorization period, provided that the individual is

Making progress towards the initial goals of the case management Service Plan;

OR

Additional goals are indicated;

OR

The individual has not indicated significant improvement following reassessment.

2.1.3 Discharge Criteria

The individual has received CCM services for six months;

OR

The individual has successfully been linked with long-term community-based recovery supports;

OR

The individual no longer wishes to receive CCM support and has refused CCM services after reasonable attempts have been made to engage him/her in services

OR

The individual is clearly in need of a higher level of care and has been connected to the service

OR

The individual has been unavailable for 60 days or more.

OR

The individual or their legally responsible guardian no longer wishes to receive case management services.

5.0 Requirements for and Limitations on Coverage

5.1.1 Specific

Service authorization is required within 14 days of service initiation.

Reimbursement for CCM is limited to 10 units per day.

Services, based upon a finding of medical necessity, shall be directly related to the individual's diagnostic, clinical, and case management needs, and are expected to achieve the goals specified in the individual's Case Management Plan.

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.

CCM is a short-term service. Individuals will receive up to 60 consecutive days

for the authorization period. CCM is not intended to last longer than six months.

5.2 Limitations or Requirements

5.2.1 Service Limitations

Individuals that are receiving the following services are not eligible for CCM:

- Assertive Community Treatment
- Community Support Team
- Critical Time Intervention
- Substance Abuse Intensive Outpatient Program
- Substance Abuse Comprehensive Outpatient Treatment
- Substance Abuse Non-Medical Community Residential Treatment
- Group living low, moderate, or high
- Supervised living low and moderate
- Family living low and moderate
- Partial Hospitalization
- Psychosocial Rehabilitation
- Transition Management Services

If the individual is linked with a current service provider, the CCM team should support the individual in linking with their current service provider to determine if there are unmet needs that are not being addressed contributing to the high utilization of crisis services.

Provider(s) shall report the appropriate code(s) used which determines the billing unit(s). Units are billed in 15-minute increments. LME-MCOs and provider agencies shall monitor utilization of service by conducting record reviews and internal audits of units of service billed. LME-MCOs shall assess their network providers' adherence to service guidelines to assure quality services for individuals. The case management functions shall be any of the four: (assessment, service planning, linking, monitoring). The amount of weekly case management activity shall be determined by the level of acuity and the needs of the individual based on the comprehensive clinical assessment and the Case Management Service Plan. Weekly in person case management activities are expected to decrease over the length of the service as the individual is linked to community-based services and natural supports. It is the expectation that the level of case management activity including face-to-face contacts shall be commensurate with the complexity of MH/SU needs of the individual. Telehealth can be utilized if an in-person visit is unavailable at that time.

Individuals receiving services under a Standard Plan or NC Medicaid Direct are not eligible to receive this service.

5.2.2 Service Orders

A signed service order must be completed by the Licensed Team Lead. 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 by the 30th day. The service order must be based on an assessment of the individual's needs.

Service orders are valid for one year from the Date of Plan entered on the Case Management Service Plan.

5.2.3 Documentation Requirements

The service record documents the nature and course of an individual's progress in treatment. Providers must ensure that their documentation is consistent with the requirements contained in this policy and the *DMH/DD/SAS Records Management and Documentation Manual*.

5.3.3.1 Responsibility for Documentation

The case manager who provides the service is responsible for accurately documenting the services billed. The case manager must sign the written entry. The signature must include credentials.

5.3.3.2 Contents of a Service Note

Refer to *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 a full service note for each date of service, written and signed by the individual(s) who provided the service that includes the following:

a. Individual's name
b. Individual's identification or CNDS number
c. Service Record Number
d. Service provided
e. Date of service
f. Place of service
g. Type of contact (face-to-face, telephone call, collateral)
h. Purpose of the contact
i. Description of the case management activity (-ies)
j. Amount of time spent performing the intervention
k. Description of the results or outcome of the case management activity (-ies), any progress noted, and next steps, when applicable
l. Signature and credentials of the staff member(s) providing the service

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

5.4 Provider Qualifications and Occupational Licensing Entity Regulations

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

a. meet the provider qualification policies, procedures, and standards established by the Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS); and
b. fulfill the requirements of 10A NCAC 27G.

These policies and procedures set forth the administrative, financial, clinical, quality improvement, and information services infrastructure necessary to provide services. The organization shall be established as a legally constituted entity capable of meeting all

requirements of the Provider Endorsement, Enrollment Agreement, Communication Bulletins, and service implementation standards.

5.4.1 Qualifications for Case Managers

Case managers must meet the Qualified Professional requirements outlined in 10A NCAC 27G .0104 STAFF DEFINITIONS.

Staffing Requirements

CCM must be provided by a team of, three full-time equivalent positions (3 FTEs)

- 1.0FTE CCM Licensed Team Lead,
- 1.0 FTE CCM Case Manager, and
- 1.0 FTE Certified Peer Support Specialist.

Staffing ratio cannot exceed 1:20 individuals for the CCM Case Manager and Certified Peer Support Specialist (CPSS), and a caseload size of 1:10 for the Team Lead.

	Staff FTE (minimum and maximum), minimum FTE to the CCM team	**Staff Licensing/Training/Certification Requirements**
CCM Licensed Team Lead This position is to be occupied by only one person	• One full-time, dedicated, licensed team leader	• Licensed Psychologist, Licensed Psychological Associate, Licensed Clinical Social Worker/Associate, Licensed Clinical Mental Health Counselor/Associate, Licensed Clinical Addictions Specialist/Associate, or Licensed Marriage and Family Therapist/Associate
CCM Case Manager	• Must be a minimum 1.0 FTE dedicated to the CCM team	• Must meet the NC Qualified Professional (QP) requirements • At least two years of experience with the population to be served
CCM Peer Support Specialist	• Must be a minimum 1.0 FTE. Position can be split between not more than 2 CPSS	• Must have completed all requirements to obtain the NC CPSS credential prior to employment on the CCM team. • At least two years of experience with the population to be served

The CCM Licensed Team Lead must be 1.0 FTE dedicated to the CCM team, have at least two years of experience with the population to be served. They are responsible for providing clinical oversight to the team, providing supervision to the team, facilitating the CCM Team Meetings, facilitating any meetings with community partners, as well as completing the case management assessment.

The CCM Case Manager will facilitate the development of a case management service plan that addresses unmet needs and social determinants of health, provide community-based case management that refer and link individuals to services and resources identified in the case management service plan, follow up with community providers to ensure the individual has been linked to and is receiving support.

The CCM Certified Peer Support Specialist shall focus on the following peer delivered interventions: Coaching, mentoring, and consultation to the individual to promote recovery, self-advocacy, and self-direction; promoting wellness management strategies, which includes delivering manualized interventions (e.g., Wellness Recovery Action Planning or Illness Management and Recovery); assisting individuals in developing psychiatric advance directives; modeling recovery values, attitudes, beliefs, and personal action to encourage wellness and resilience; providing consultation to team members to assist in an understanding of recovery and the role of the Peer Support Specialist, promoting a culture in which the individual's points of view and preferences are recognized, understood, respected, and integrated into treatment; serving as an active member of the CCM team, equivalent to other team members, and supporting and empowering the individual to exercise his or her legal rights within the community.

The CCM team shall work collaboratively with the individual and family (if applicable with valid consent), individually or collectively, to serve them by:

- Identifying needs and/or concerns
- Informing
- Empowering
- Advocating
- Networking/Collaborating

5.5 Staff Training and Supervision Requirements

All staff providing CCM services shall complete a minimum of 32 hours of training as indicated below. New staff must complete these trainings within the first 30 days of the staff member's date of hire.

a. Comprehensive Case Management Service Definition Required Components Training (3hours)
b. Crisis Response (3 hours)*
c. Motivational Interviewing (13 hours)*
d. ASAM Criteria (13 hours)**

*Staff who have documentation of having received this required training shall be deemed to have met this requirement
**Licensed professionals who have completed the required ASAM Criteria training for CCA & DA shall be deemed to have met this requirement.

For each year of employment, each CCM team member shall receive an additional three hours of training in an area that is fitting with their area of expertise. This additional training may be in the form of locally provided training, online workshops and regional or national conferences. Broader topics of additional training may include:

- Family Psychoeducation
- Recovery Oriented Approaches
- Recovery Planning
- Benefits Counseling
- DHHS approved Individual Placement and Support/Supported Employment
- Psychiatric Rehabilitation
- Limited English Proficiency (LEP), blind or visually impaired, deaf, and hard of hearing accommodations

- NAMI psychoeducational trainings
- Psychiatric Advanced Directives
- SOAR (SSI/SSDI outreach, access, and recovery)
- Stepping Stones to Recovery
- Permanent Supportive Housing, such as the SAMHSA evidenced based practices toolkit, Housing First: Pathways Model to End Homelessness for People with Mental Illness and Addiction, and other evidenced based models
- Trauma Informed Care
- Wellness and Integrated Health Care
- Critical Time Intervention
- Wellness Management and Recovery Interventions (includes WRAP, IMR/WMR)
- Supervising NC Certified Peer Support Specialists
- DHHS Approved Tenancy Support Pregnancy & SUD
- Motivational Interviewing

6.0 Additional Requirements

6.1 Compliance

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

a. All applicable agreements, federal, state, and local laws and regulations including the Health Insurance Portability and Accountability Act (HIPAA) and record retention
requirements; and all DMHDDSAS's clinical service definition policies, guidelines, policies, provider manuals, implementation updates, and DHHS, DHHS division(s) or fiscal contractor(s).

Attachment A: Claims-Related Information for CCM

Provider(s) shall comply with the, *NC Tracks Provider Claims and Billing Assistance Guide*, communication bulletins, fee schedules, and any other relevant documents for specific coverage and reimbursement for state funds:

A. Claim Type

Professional (CMS-1500/837P transaction)

B. International Classification of Diseases, Tenth Revision, Clinical Modification (ICD- 10-CM) Codes

Provider(s) shall report the ICD-10-CM diagnosis code(s) to the highest level of specificity that supports medical necessity. Provider(s) shall use the current ICD-10-CM edition and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for code description as it is no longer documented in the policy.

C. Code(s)

Provider(s) shall select the most specific billing code that accurately and completely describes the procedure, product or service provided. Provider(s) shall use the Current Procedural Terminology (CPT), Health Care Procedure Coding System (HCPCS), ICD-10-CM procedure codes, and UB-04 Data Specifications Manual (for a complete listing of valid revenue codes) and any subsequent editions in effect at the time of service.

Provider(s) shall refer to the applicable edition for the code description.

HCPCS Code(s)	Billing Unit
YM130	1 unit = 15 minutes

Unlisted Procedure or Service
CPT: The provider(s) shall refer to and comply with the Instructions for Use of the CPT Codebook, Unlisted Procedure or Service, and Special Report as documented in the current CPT in effect at the time of service.

HCPCS: The provider(s) shall refer to and comply with the Instructions for Use of H codes, National Level II codes, Unlisted Procedure or Service and Special Report as documented in the current H Code edition in effect at the time of service.

D. Modifiers

Provider(s) shall follow applicable modifier guidelines.

E. Billing Units

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

F. Place of Service

CCM providers must deliver services face-to-face in various environments, including homes, school, courts, homeless shelters, and other community settings.