NC Division of Mental Health, Developmental Disabilities, and Substance Abuse Services
Comprehensive Case Management for AMH/ASU

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1.0 Description of the Procedure, Product, or Service

Comprehensive Case Management (CCM) for AMH/ASU is 24/7/365 service for adults with either a MH, SU, or co-occurring MH/SU diagnoses that access hospital emergency departments for psychiatric care. The point of service initiation and only source of referrals is a hospital emergency department (ED.) Within 24 hours of service initiation in the hospital ED, the individual will receive their first follow-up CCM visit in the community to begin the hands-on case management services.

CCM teams should be staffed with professionals that are not only highly skilled case managers, but also well informed of the resources in their community and how to access them. They 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. 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 hospital ED use.

It is critical that the CCM team is integrated into the hospital ED, and that both hospital ED staff and CCM staff clearly understand the roles and responsibilities. A CCM team must have the flexibility to begin engagement when an individual is triaged as an admission to the hospital ED for either mental health or substance use crisis to begin rapport building and service engagement while hospital ED staff is determining the individual's disposition. Once a discharge disposition has been made by hospital ED staff, the CCM staff assumes responsibility for developing a Person Centered Plan that focuses solely on the case management functions that will be provided to address the individual's service and support needs. If an admission disposition is made and the individual remains at the same hospital, the CCM team will continue engagement efforts and coordination of discharge services with unit staff. If the individual is transferred to another hospital, the CCM team shall make efforts to continue follow up to ensure that CCM services are offered prior to and after discharge.

Likewise, 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 hospital ED visits for mental health and/or substance use crisis. The on-going case management supports for no more than 6 months after service initiation should regularly assess any missing services, support individuals in selecting providers and agencies to receive services from, and once selected, link the individual to the selected provider agency/service.

The intended outcomes of CCM for AMH/ASU is to decrease the amount of time individuals spend in hospital EDs when seeking crisis supports for their MH/SU, to decrease and/or eliminate recurring hospital ED visits for MH/SU follow-up care, and to link beneficiaries to the clinically indicated community based services to avoid possible unnecessary involuntary commitments. This service can also be accessed by women who are pregnant that have either a serious emotional disturbance, mental illness, or a substance use related disorder.

Refer to **Subsection 2.0.**

The case manager is required to coordinate and communicate with any service providers currently in place, including Community Care of North Carolina (CCNC) (if Medicaid), the beneficiary's primary care physician, the beneficiary's mental health and/or substance use service provider, and the Medicaid beneficiary's obstetrician and gynecologist (OBGYN), when applicable. CCNC and the primary care physician shall be responsible for coordination of the beneficiary's overall health care.

Note: The age at which a beneficiary is considered an adult is determined by the funding source. State-funded services for adults begin at age 18; Medicaid-funded services for adults begin at age 21, unless the beneficiary is eligible through EPSDT.

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

Comprehensive case management (CCM for AMH/ASU) is a service delivered in community hospitals designed to ensure beneficiaries seeking mental health and/or substance abuse services in hospital emergency room departments have immediate access to intensive case management services that can prevent unnecessary involuntary commitments when appropriate community supports could stabilize the individual, decrease the amount of time beneficiaries spend in hospital emergency rooms, and ensure that beneficiaries have intensive, time-limited case management supports to ensure they are linked to appropriate community based levels of care. CCM for AMH/ASU will assist beneficiaries in gaining access to necessary care: medical, behavioral, social, and other services appropriate to their needs. CCM for AMH/ASU is individualized, person-centered, empowering, comprehensive, strengths-based, and outcome-focused. The functions of case management include:

a. Comprehensive Clinical Assessment for MH/SU;
b. Case Management Planning;
c. Referral and linkage; and
d. Monitoring and follow-up.

1.1.1 Comprehensive Clinical Assessment

A Comprehensive Clinical Assessment (CCA) shall be completed once an individual has been referred to the CCM for AMH/ASU service by hospital ED staff. The CCA must be completed by a Licensed Professional, or Associate Level Licensed Professional, who has the appropriate credentials. A comprehensive and culturally appropriate clinical assessment must contain the following components:

- A thorough description of the presenting problems, including source of distress, precipitating events that led to seeking hospital ED services, and associated problems or symptoms;
- A chronological general health and behavioral history (including both mental health and substance use);
- Current medications (for both physical and psychiatric treatment);
- A review of biological, psychological, familial, social, developmental, and environmental dimensions to identify strengths, needs, and risks in each area;
- Evidence of beneficiary and legally responsible person's (if applicable) participation in the assessment;

- Analysis and interpretation of the assessment information with an appropriate case formulation;
- Diagnoses from the DSM-5 [or any subsequent editions], including mental health, substance use disorders, and/or intellectual/developmental disabilities, as well as physical health conditions and functional impairment; and
- Recommendations for additional assessments, services, support, or treatment based on the results of the CCA.

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. It should include any admission and/or triage information obtained by hospital ED staff prior to referral to the CCM for AMH/ASU team, as well as natural supports that should be involved in the treatment process.

1.1.2 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 beneficiary with the disability to assume an informed and in-command role for life planning and for treatment, service and support options. The beneficiary 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 beneficiaries 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 other identified by the beneficiary (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 any service can be billed to Medicaid or NCHC, a written PCP for the delivery of medically necessary service must be in place. The PCP must be completed at the time the beneficiary 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.

At the point of service initiation, the CCM Case Manager will complete the Action Plan page of the PCP only, and focus on the immediate case management needs the individual is experiencing that led to seeking hospital ED services. If an individual is linked with a service provider that has a completed PCP on file, this page should be added to the PCP, and the CCM team should focus on ensuring the individual is fully linked to their current service providers.

If the individual doesn't have current service providers, the CCM team will complete a full PCP within five days of service initiation that clearly outlines the case management needs and services the individual will be linked to.

Refer to the DMHDDSAS Person-Centered Planning Instruction Manual, (http://www.ncdhhs.gov/mhddsas/statspublications/Manuals/pcp-instructionmanual2-3-10.pdf) and the DMHDDSAS Records Management and Documentation Manual (http://www.ncdhhs.gov/mhddsas/providers/recordsmanagement/resources.htm) for specific information.

1.1.3 Referral and Linkage

Referral and linkage activities connect a beneficiary with medical, behavioral, social and other programs, services, and supports to prevent possible involuntary commitment, reduce time spent in hospital ED, and decrease the potential for recurring ED admissions and drug-related ED visits. Referral and linkage activities include:

a. Coordinating the delivery of services to reduce fragmentation of care and maximize mutually agreed upon outcome;
b. Facilitating access to and connecting the beneficiary to services and supports identified in the Case Management Plan;
c. Making referrals to providers for needed services and scheduling appointments with the beneficiary;
d. Assisting the beneficiary as he or she transitions through levels of care;
e. Educating the beneficiary on mental health and substance use crisis services available in the community, and how to access them;
f. Facilitating communication and collaboration among all service providers and the beneficiary;
g. Assisting the beneficiary in establishing and maintaining a medical home with a CCNC physician or other primary care physician; and
h. Assisting the pregnant Medicaid beneficiary in establishing obstetrician and prenatal care as necessary.

1.1.4 Monitoring and Follow-Up

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

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

Additionally, the beneficiary shall work with the Certified Peer Support Specialist to develop either a Wellness Recovery Action Plan (WRAP) or Psychiatric Advanced Directive (PAD.)

1.1.5 Expected Outcomes

1. The beneficiary:
    1. has been successfully linked to the clinically appropriate mental health and/or substance use services in the community;
    2. is linked to natural supports as available;
    3. accesses community based mental health and/or substance use crisis supports when clinically indicated, including but not limited to: Mobile Crisis Management, Facility Based Crisis, Behavioral Health Urgent Care, or Peer Operated Respite;
    4. has experienced a decrease in or has not accessed mental health and/or substance use crisis supports through the hospital ED;

5. becomes increasingly independent in managing his or her own care (e.g., making treatment appointments, attending treatment, taking medications as prescribed, etc.) as appropriate.

b. The CCM team:

1. successfully links 80% of individuals to the clinically appropriate mental health and/or substance use services as evidenced by a reduction in individuals seeking MH/SU crisis services multiple times at hospital EDs

2. In addition to the above listed outcomes, a pregnant beneficiary:
    1. has started the application process for Medicaid for Pregnant Women (if they are currently uninsured)
    2. is linked to a CCNC primary care physician or obstetrician and gynecologist (OBGYN);
    3. is receiving appropriate and timely medical assessment or intervention including OBGYN care and other prenatal care as necessary; and
    4. becomes increasingly independent in managing her own care (e.g., making treatment appointments, attending treatment or prenatal appointments, taking medications as prescribed, etc.).

2.0 Eligibility Requirements

2.1 Provisions

2.1.1 General

(*The term "General" found throughout this policy applies to all Medicaid and NCHC policies*)

a. An eligible beneficiary shall be enrolled in either:
    1. the NC Medicaid Program *(Medicaid is NC Medicaid program, unless context clearly indicates otherwise*); or
    2. the NC Health Choice (*NCHC is NC Health Choice program, unless context clearly indicates otherwise)* Program on the date of service and shall meet the criteria in **Section 3.0 of this policy**.

b. Provider(s) shall verify each Medicaid or NCHC beneficiary's eligibility each time a service is rendered.

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

d. Following is only one of the eligibility and other requirements for participation in the NCHC Program under GS 108A-70.21(a): Children must be between the ages of 6 through 18.

2.1.2 Specific

(***The term "Specific" found throughout this policy only applies to this policy***)

a. <u>Medicaid</u>
None Apply.

b. <u>NCHC</u>
None Apply.

2.2 Special Provisions

2.2.1 EPSDT Special Provision: Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age

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

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

problem] identified through a screening examination (includes any evaluation by a physician or other licensed practitioner).

This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his or her health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

Medically necessary services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the beneficiary's physician, therapist, or other licensed practitioner; the determination process does not delay the delivery of the needed service; and the determination does not limit the beneficiary's right to a free choice of providers.

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

1. that is unsafe, ineffective, or experimental or investigational.
2. that is not medical in nature or not generally recognized as an accepted method of medical practice or treatment.

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

b. **EPSDT and Prior Approval Requirements**

1. If the service, product, or procedure requires prior approval, the fact that the beneficiary is under 21 years of age does **NOT** eliminate the requirement for prior approval.
2. **IMPORTANT ADDITIONAL INFORMATION** about EPSDT and prior approval is found in the *NCTracks Provider Claims and Billing Assistance Guide*, and on the EPSDT provider page. The Web addresses are specified below.

   NCTracks Provider Claims and Billing Assistance Guide: https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html

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

2.2.2 EPSDT does not apply to NCHC beneficiaries

2.2.3 Health Choice Special Provision for a Health Choice Beneficiary age 6 through 18 years of age

The Division of Medical Assistance (DMA) shall deny the claim for coverage for an NCHC beneficiary who does not meet the criteria within **Section 3.0** of this policy. Only services included under the NCHC State Plan and the DMA clinical coverage policies, service definitions, or billing codes are covered for an NCHC beneficiary.

2.3 Specific Criteria

2.3.1 Comprehensive Clinical Assessment

The provider shall complete a comprehensive clinical assessment that documents medical necessity prior to provision of this service. If a substantially equivalent assessment is available, it may be used as part of the current comprehensive clinical assessment if it:

a. reflects the current level of functioning; and
b. contains all the required elements as outlined in community practice standards and all applicable federal and state requirements,.

2.3.2 Eligibility Criteria

A beneficiary is eligible for this service when:

a. The beneficiary presents at a hospital ED seeing crisis services and supports for what presents as mental health and/or substance use crisis at least four times in the last six months;

AND

b. There is a MH/SU 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

c. There is a MH/SU 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 beneficiary is pregnant;

AND

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

AND

e. The beneficiary is unable to manage his or her symptoms or maintain abstinence, (independently or with family/caregiver support), resulting in intervention through the hospital ED for crisis services and supports.

2.3.3 Continued Service Criteria

The beneficiary is making measurable progress toward meeting the goals that require case management functions and there is documentation that supports that continuation of this service will be effective in assisting the beneficiary in meeting those goals identified in the Case Management Plan.

AND

Eligibility criteria listed above continue to be met with the exception that:

a. The beneficiary requires coordination between **one** (or more) agency (-ies), including medical or non-medical providers

AND

b. The beneficiary is unable to manage his or her symptoms or maintain abstinence, [independently or with family or caregiver support], due to at least **one** basic need identified in the initial assessment for services continuing to be unmet;

OR

At least three unmet basic needs have been identified through additional assessments during the course of service.

2.3.4 Discharge Criteria

The beneficiary has received CCM for six months.

OR

The beneficiary has met the goals in the goals outlined in the Case Management plan that require case management functions.

OR

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

OR

The beneficiary no longer meets continued service criteria.

OR

The beneficiary or his legally responsible guardian no longer wishes to receive case management services.

3.0 When the Procedure, Product, or Service Is Covered

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.

3.1 General Criteria Covered

Medicaid and NCHC shall cover the procedure, product, or service related to this policy when medically necessary, and:

a. the procedure, product, or service is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the beneficiary's needs;
b. the procedure, product, or service can be safely furnished, and no equally effective and more conservative or less costly treatment is available statewide; and

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

3.2 Specific Criteria Covered

3.2.1 Specific criteria covered by both Medicaid and NCHC

Medicaid and NCHC shall cover MH/SA TCM when the beneficiary meets the following criteria:

a. There is a current diagnosis reflecting the need for treatment; and
b. All covered services are medically necessary for meeting specific preventive, diagnostic, therapeutic, and rehabilitative needs of the beneficiary as defined below:
    1. **Preventive** means to anticipate the development of a disease or condition and preclude its occurrence.
    2. **Diagnostic** means to examine specific symptoms and facts to understand or explain a condition.
    3. **Therapeutic** means to treat and cure disease or disorders; it may also serve to preserve health.
    4. **Rehabilitative** means to restore that which one has lost, to a normal or optimum state of health.

3.2.2 Medicaid Additional Criteria Covered

None Apply.

3.2.3 NCHC Additional Criteria Covered

None Apply.

4.0 When the Procedure, Product, or Service Is Not Covered

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for Medicaid Beneficiaries under 21 Years of Age.

4.1 General Criteria

Medicaid and NCHC shall not cover the procedure, product, or service related to this policy when:

a. the beneficiary does not meet the eligibility requirements listed in **Section 2.0;**
b. the beneficiary does not meet the criteria listed in **Section 3.0;**
c. the procedure, product, or service duplicates another provider's procedure, product, or service; or
d. the procedure, product, or service is experimental, investigational, or part of a clinical trial.

4.2 Specific Non-Covered Criteria

4.2.1 Specific Criteria Not Covered by both Medicaid and NCHC

The following are not covered under this service:

a. any treatment interventions (for example, habilitation or rehabilitation activities);
b. any social or recreational activities (or the supervision of these activities);
c. clinical and administrative supervision of staff, including team meetings;

d. writing assessment reports, PCPs, or service notes; or
e. service record reviews.

4.2.2 Medicaid Additional Criteria Not Covered

None Apply.

4.2.3 NCHC Additional Criteria Not Covered

a. NCGS § 108A-70.21(b) "Except as otherwise provided for eligibility, fees, deductibles, copayments, and other cost sharing charges, health benefits coverage provided to children eligible under the Program shall be equivalent to coverage provided for dependents under North Carolina Medicaid Program except for the following:
   1. No services for long-term care.
   2. No nonemergency medical transportation.
   3. No EPSDT.
   4. Dental services shall be provided on a restricted basis in accordance with criteria adopted by the Department to implement this subsection."

5.0 Requirements for and Limitations on Coverage

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for Medicaid Beneficiaries under 21 Years of Age.

5.1 Prior Approval

Medicaid and NCHC shall require prior approval for MH/SA TCM.

5.2 Prior Approval Requirements

5.2.1 General

Within a week of the first contact with the beneficiary, the provider(s) shall submit to the Department of Health and Human Services (DHHS) Utilization Review Contractor the following:
a. the service approval request; and
b. all health records and any other records that support the beneficiary has met the specific criteria in **Subsection 3.2** of this policy.

5.2.2 Specific

Service authorization is required within one week of service initiation.

Reimbursement for CCM is limited to 1 unit per calendar (Sunday-Saturday) week.

Service delivery to beneficiaries other than the beneficiary(s) may be covered only when the activity is directed exclusively toward the benefit of the beneficiary(s).

Services, based upon a finding of medical necessity, shall be directly related to the beneficiary's diagnostic, clinical, and case management needs, and are

expected to achieve the goals specified in the beneficiary's Case Management Plan.

Additionally, CCM teams are able to bill for transportation service to the first two initial appointments and/or contacts with services identified in the CCA as a contributing factor to seeking hospital ED services that are then part of the individuals' Person Centered Plan. Examples of initial appointments and/or contacts that can be covered when in both the CCA and the PCP can include, but are not limited to:

- Psychiatric care provider
- Outpatient therapy or treatment services (i.e. individual, group, SAIOP)
- Mutual Aid Groups (i.e. AA, NA, etc.)
- Transportation services (i.e.- obtaining bus passes)
- Benefits/entitlements (i.e. DSS, SSI, etc.)
- Primary care provider
- Housing services/providers

Transportation to appointments and/or contacts that are not identified in both the CCA and the PCP will not be covered.

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 beneficiary'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. Beneficiaries will receive up to 180 consecutive days for the authorization period. CCM is not intended to last longer than six months.

5.3 Limitations or Requirements

5.3.1 Service Limitations

CCM services can be initially be provided during the same authorization period as the following services with some limitations: Community Support Team, Assertive Community Treatment Team, Critical Time Intervention, Substance Abuse Intensive Outpatient Program, Substance Abuse Comprehensive Outpatient Treatment, or Substance Abuse Non-Medical Community Residential Treatment. If CCM is provided to a beneficiary receiving one of the above listed services, the CCM team should focus on assessing if the current level of care is meeting the beneficiary's needs, root causes for repeat hospital ED admissions, and supporting the individual in re-engaging with their current service provider. Individuals that are linked with an enhanced service that includes a case management function will not receive CCM for longer than 30 days.

If the individual is currently receiving mental health and/or substance use services that are not meeting the individual's clinical needs as evidenced by repeat hospital ED visits, the CCM team will work with the individual and the LME-MCO to identify higher levels of care that could better meet the

individual's needs. Once the appropriate level of care has been identified, the CCM team will actively link the individual to the new service as well as other identified case management needs.

If the individual is not satisfied with their current service provider, the CCM team should support the individual in linking with their LME-MCO to determine if there are other providers that the individual can transfer to.

This service is billed on a weekly case rate basis. In order to bill for case management services, there must be documentation in the service record to reflect at least 15 minutes of weekly activity within any of the four case management functions (assessment, beneficiary centered planning, linking, monitoring). At least one weekly case management activity needs to be face-to-face with the beneficiary. The amount of weekly case management activity shall be determined by the level of acuity and the needs of the beneficiary based on the comprehensive clinical assessment and PCP. It is the expectation that the level of case management activity including face-to-face contacts shall be commensurate with the complexity of MH/SA needs of the beneficiary.

5.3.2 Service Orders

A signed service order must be completed by the CCM 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 prior to or on the day that the service is initially provided in order to bill for the service. The service order must be based on an assessment of the beneficiary's needs.

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

5.3.3 Documentation Requirements

The service record documents the nature and course of a beneficiary'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. Beneficiary's name
b. Medicaid or NCHC identification 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 beneficiary 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 use disorder 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 of the requirements of the Provider Endorsement, Enrollment Agreement, Medicaid Bulletins, and service implementation standards.

5.4.1 Qualifications for Case Managers

Case managers must meet **one** of the following qualifications based on the target population being served:

a. currently licensed by the appropriate North Carolina licensure board as a licensed clinical addiction specialist, licensed clinical social worker, licensed marriage and family therapist, licensed professional counselor, psychiatrist, licensed psychologist or a licensed psychological associate;
b. a graduate of a college or university with a masters degree in a human service field with one year of full-time, post-graduate degree accumulated MH/DD/SAS experience with the population served or a substance use disorder professional who has one year of full-time, post-graduate degree accumulated supervised experience in alcoholism and drug abuse counseling;
c. a graduate of a college or university with a bachelor's degree in a human service field with two years of full-time, post-bachelor's degree accumulated MH/DD/SAS experience with the population served or a substance use disorder professional who has two years of full-time, post-graduate degree accumulated supervised experience in alcoholism and drug abuse counseling

or a registered nurse who is licensed to practice in the State of North Carolina by the North Carolina Board of Nursing who also has four years of full-time accumulated experience in MH/DD/SAS with the population served; or

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

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

a. The case manager-to-beneficiary ratio shall not exceed 1:20 for each case manager.
b. The caseload shall be determined by the level of acuity and the needs of the beneficiary based on the comprehensive clinical assessment and PCP.
c. The Licensed Team Lead shall not carry a caseload, but is able to complete Comprehensive Clinical Assessments as needed.

Staffing Requirements

CCM must be provided by a team of, at minimum, four full-time equivalent positions (4 FTEs)- a Licensed Team Lead, two (2.0 FTE) Licensed CCM Case Managers, five (5.0 FTE) Qualified Professional (QP) CCM Case Managers and 1.0 FTE Certified Peer Support Specialist. As the CCM team increases their census, they are expected to ensure that the staffing ratio doesn't exceed 1:20 beneficiaries for the CCM Case Manager.

The maximum number of staff a CCM team can have is: 1 full time, dedicated Licensed Team Lead, 2.0 FTE Licensed CCM Case Managers, 10.0 FTE QP CCM Case Managers, and 3.0 FTE Certified Peer Support Specialists.

	Staff FTE (minimum and maximum), minimum FTE to the CCM team	**Staff Licensing/Training/Certification Requirements**
Staff to Beneficiary Ratios Includes all team members, except the CCM Team Lead.	1 team member per 20 or fewer individuals	• Maximum capacity based on full staffing: 300
Team Leader This position is to be occupied by only one person.	One full-time, dedicated team leader.	• Licensed Psychologist, Licensed Psychological Associate, Licensed Clinical Social Worker, Licensed Professional Counselor, Licensed Clinical Addictions Specialist, or Licensed Marriage and Family Therapist. • Preference is given to a clinician who is

		dually licensed in both mental health and substance use.
Licensed CCM Case Manager	• Minimum- 2.0 FTE • Maximum- 2.0 FTE • Must be a minimum 0.5 FTE dedicated to the CCM team	• Licensed Psychologist, Licensed Psychological Associate, Licensed Clinical Social Worker, Licensed Professional Counselor, Licensed Clinical Addictions Specialist, or Licensed Marriage and Family Therapist. • At least 1.0 FTE of the 2.0 FTE must have either their LCAS or CCS.
QP CCM Case Manager	• Minimum- 5.0 FTE • Maximum- 10.0 FTE • Must be a minimum 0.5 FTE dedicated to the CCM team	• At least two years of experience with the knowledge, skills, and abilities required by the population to be served • At least 5.0 FTE of the QP CCM Case Managers should have their QSAPP
CCM Peer Support Specialist	• Minimum- 1.0 FTE • Maximum- 3.0 FTE • Must be a minimum 0.5 FTE dedicated to the CCM team	• Must have completed all requirements to obtain the NC CPSS credential prior to employment on the CCM team. • At least 0.5 FTE CCM CPSS should have lived experience managing a substance use disorder.

The Licensed Team Lead must be a full-time, dedicated, fully licensed mental health professional who has at least two years of experience with the knowledge, skills, and abilities required by the population to be served, and must hold any of the following licenses: Licensed Psychologist, Licensed Psychological Associate, Licensed Clinical Social Worker, Licensed Professional Counselor, Licensed Clinical Addictions Specialist, Certified Clinical Supervisor, or Licensed Marriage and Family Therapist. Preference should be given to a clinician that is dually licensed in both mental health and substance use. Their primary role is to provide oversight and project management functions to the CCM team, which includes managing staff scheduling to ensure that at least one staff is on-site at the hospital ED 24/7/365, and a licensed professional is accessible for phone consultation 24/7/365. They are the face of the CCM team to the identified hospital staff, and network with community stakeholders and resources, as well as the LME-MCO. They should actively collect quality improvement data points around performance and outcomes for their CCM team, and develop quality improvement plans to address any areas of growth. The Licensed Team Lead will provide clinical oversight and management to the CCM team, and also have some limited responsibility for completion of Comprehensive Clinical Assessments as well as being able to provide clinical consultation over the phone to staff providing 24/7/365 services on-site.

The Licensed CCM Case Managers must be at least .50 FTE dedicated to the CCM team, have at least two years of experience with the knowledge, skills, and abilities required by the population to be served, and must hold any of the following licenses: Licensed Psychologist, Licensed Psychological Associate, Licensed Clinical Social Worker, Licensed Professional Counselor, Licensed Clinical Addictions Specialist, Certified Clinical Supervisor, or Licensed Marriage and Family Therapist. At least 1.0 FTE of the

Licensed CCM Case Managers must be a Licensed Clinical Additions Specialist or Certified Clinical Supervisor. They are responsible for completing CCA's on individuals after service initiation, as well as providing clinical consultation over the phone to staff providing 24/7/365 services on-site. They will also have limited responsibilities in providing direct case management services as they are able, and can be scheduled to cover on-site hospital ED coverage weekdays.

The QP CCM Case Managers must be at least .50 FTE dedicated to the CCM team, and have at least two years of experience with the knowledge, skills, and abilities required by the population to be served. The QP CCM Case Managers will provide the after-hours and weekend on-site hospital ED services. No more than 1 QP CCM Case Manager shall cover after-hours or weekend hours. At least 5 of the QP CCM Case Managers should have their QSAPP.

The Certified Peer Support Specialists must be at least .50 FTE dedicated to the CCM team, and have completed all requirements to obtain their CPSS credential prior to employment on the CCM team. At least .50 FTE CPSS should have lived experience managing a substance use disorder.

At least one QP CCM staff must be physically on-site at their identified hospital partner 24/7/365 and accessible to beneficiaries seeking either mental health and/or substance use crisis services from the hospital ED. Hospital on-site responsibilities may not be fulfilled by a CPSS. The on-site CCM staff shall have access to a licensed CCM staff for phone consultation in the case of difficult or complex cases.

5.5 Staff Training and Supervision Requirements

All staff, providing CCM services shall complete a minimum of 24 hours of training as indicated below. New staff must complete this training within the first 30 days of the staff member's date of hire.

a. Comprehensive Case Management for AMI/ASU in a hospital setting (6 hours)
b. *Crisis Response (3 hours)
c. Motivational Interviewing (13 hours)
d. Case Management Planning (3 hours)
e. Person Centered Thinking (3 hours)
f. ED 101 for CCM Teams

*Staff who have documentation of having received this required training 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
- Wellness Management and Recovery interventions (includes WRAP, IMR/WMR)
- Supervising NC Certified Peer Support Specialists
- DHHS Approved Tenancy Support

5.6 Staff Competencies

Policies, procedures, training, and supervision plans shall reflect the following staff competencies:

5.6.1 Case Management Assessment

Knowledge of:

a. Available formal and informal assessment resources in the state; and
b. The population, disability, and culture of the beneficiary being served.

Skills and Abilities to:

a. Apply interviewing skills such as active listening, supportive responses, open-and closed-ended questions, summarizing, and giving options;
b. Collect all recent and relevant clinical and medical assessment and evaluation reports, integrating the findings, results and recommendations to form the basis of the beneficiary's individualized plan of care; engage beneficiaries and families to elicit and gather, and integrate other pertinent information;
c. Recognize indicators of risk (health, safety, mental health, and substance use disorders);
d. Recognize root causes for seeking mental health and/or substance use crisis supports at a hospital ED;
e. Gather and review information through a holistic approach, giving balanced attention to family, community, educational, work, leisure, cultural, contextual factors, and beneficiary preferences;
f. Consult other professionals and formal and natural supports in the assessment process; and
g. Discuss findings and recommendations with the beneficiary in a clear and understandable manner.

5.6.2 Person-Centered Planning

Knowledge of:

a. The values that underlie a person-centered approach to providing service to improve beneficiary functioning within the context of the beneficiary's culture and community;
b. Models of wellness-management and recovery;
c. Biopsychosocial approaches to serving and supports beneficiaries, and evidenced-based standards of care;
d. Processes used in a variety of models for group meetings to promote beneficiary and family involvement in case planning and decision-making; and
e. Interventions appropriate for assessed needs.

Skills and Abilities to:

a. Identify and evaluate a beneficiary's existing and accessible resources and support systems; and
b. Develop an individualized care plan with a beneficiary and his or her supports based on assessment findings that include measurable goals and outcomes.

5.6.3 Linkage and Referral

Knowledge of:

a. Community resources such as medical and behavioral health programs, formal and informal supports, and social service, educational, employment, and housing resources; and
b. Current laws, regulations, and policies surrounding medical and behavioral healthcare.

Skills and Abilities to:

a. Research, develop, maintain, and share information on community and other resources relevant to the needs of beneficiaries;
b. Maintain consistent, collaborative contact with other health care providers and community resources;
c. Facilitate the beneficiary's transition into services in the care plan in order to achieve the outcomes derived for the consumer's goals; and
d. Assist the beneficiary in accessing a variety of community resources.

5.6.4 Monitoring and Follow-Up

Knowledge of:

a. Outcome monitoring and quality management;
b. Wellness-management, recovery, and self-management; and
c. Community consumer-advocacy and peer support groups.

Skills and Abilities to:

a. Collect, compile and evaluate data from multiple sources;
b. Modify care plans as needed with the input of beneficiaries, professionals, and natural supports;
c. Discuss quality-of-care and treatment concerns with the beneficiary, professionals, formal and natural supports;
d. Monitor the motivation and engagement of the beneficiary and his or her supports; and

e. Encourage and assist a beneficiary to be a self-advocate for quality care.

5.6.5 Professional Responsibility

Knowledge of:

a. Importance of ethical behavior, the potential impact of unethical behavior on the beneficiary, and the potential consequences of violating ethical expectations;
b. Quality assurance practices and standards;
c. Confidentiality regulations;
d. Required performance standards and case management best practices
e. Definitions and fundamental concepts of culture and diversity;
f. Origins and tenets of one's individual value system, culture background, and beliefs; understands how this may influence actions and decisions in practice; and
g. Differences in culture and ethnicity of beneficiaries served.

Skills and Abilities to:

a. Use critical thinking skills and consultation with other professionals to make ethical decision and conduct ethical case management;
b. Form constructive, collaborative relationships with beneficiaries of various cultures and use effective strategies for conducting culturally-competent case management;
c. Discern with whom protected health information can be shared;
d. Communicate clearly, both verbally and in writing;
e. Discern the severity of family problems are beyond the case manager's skill or responsibility, and when referrals to other professionals are necessary; and
f. Identify areas for self improvement, pursue necessary education and training, and seek appropriate supervision.

6.0 Additional Requirements

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for Medicaid Beneficiaries under 21 Years of Age.

Coordination with hospital staff will be critical to the implementation of CCM. This service requires the CCM Team Lead to be part of the respective hospitals internal meetings, committees, and staffing as it relates to the integration of CCM. This can include: Quality Improvement and Monitoring Team meetings, Emergency Room staffing meetings,

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
b. All DMA's clinical (medical) coverage policies, guidelines, policies, provider manuals, implementation updates, and bulletins published by the Centers for Medicare and Medicaid Services (CMS), DHHS, DHHS division(s) or fiscal contractor(s).