North Carolina

Division of Mental Health,

Developmental Disabilities and Substance Use Services

State-Funded Enhanced Mental Health and Substance Use Service, Child and Adolescent Day Treatment (State-Funded)

Date Amended – October 1st, 2024

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1.0 Child and Adolescent Day Treatment (State-Funded)

1.1 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-5 or any subsequent editions of this reference material), 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 use disorder 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 (LME-MCO), the Local Education Agency (LEA) (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 use disorder 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 use disorder 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 individual, 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:

a. Functioning in an appropriate educational setting;
b. Maintaining residence with a family or community based non-institutional setting (foster home, Therapeutic Family Services); and
c. 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 use disorder diagnosis. These interventions include, but are not limited to, the following:

a. development of skills and replacement behaviors which can be practiced, applied, and continually addressed with treatment staff in a therapeutic and educational environment;
b. monitoring of psychiatric symptoms in coordination with the appropriate medical care provider;
c. identification and self-management of symptoms or behaviors;
d. development or improvement of social and relational skills;
e. enhancement of communication and problem-solving skills;
f. relapse prevention and disease management strategies;
g. individual, group and family counseling;
h. provision of strengths-based positive behavior supports; and
i. 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 individual. Psycho- education imparts information to children, families, caregivers, or other individuals involved with the individual's care. Psychoeducation helps, explain 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 to benefit and help the individual develop increasingly developmentally appropriate coping skills for handling problems resulting from their condition. The goal of psychoeducation is to reduce symptoms, improve functioning, and meet the goals outlined in the 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 receiving the service 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.

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

a. Assessing the individual's needs for comprehensive services;
b. Convening Child and Family Team meetings to coordinate the provision of multiple services and the development of and revisions to the PCP;
c. Developing and implementing the PCP;
d. Linking the individual or family to needed services and supports (such as medical or psychiatric consultations);
e. Monitoring the provision of services and supports;
f. Assessing the outcomes of services and supports; and
g. 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.

1.2 Provider Requirements

Day Treatment services shall be delivered by practitioners employed by mental health, substance use disorder, or intellectual or developmental disability provider organizations that:

a. meet the provider qualification policies, procedures, and standards established by the Division of MHDDSUS;
b. meet the provider qualification policies, procedures, and standards established by the Division of MH/DD/SUS;
c. fulfill the requirements of 10A NCAC 27G; and
d. are currently certified as a Critical Access Behavioral Healthcare Agency (CABHA) according to 10A NCAC 22P.

These policies and procedures set forth the administrative, financial, clinical, quality improvement, and information services infrastructure necessary to provide services. Provider organizations shall demonstrate that they meet these standards by being credentialed by the LME-MCO. Additionally, within one year of enrollment as a provider with the LME-MCO, the organization shall achieve national accreditation with at least one of the designated accrediting agencies. (Providers who were enrolled prior to July 1, 2008, shall have achieved national accreditation within three years of their enrollment date.) The organization shall be established as a legally 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/SUS Communication Bulletins, the DMH/DD/SUS *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.

1.3 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:

a. One (1) full time program director who meets the requirements specified for a QP (preferably master's level or a Licensed Professional), has a minimum of two years of experience in child and adolescent mental health or substance use disorder treatment services and 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.
b. 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).
c. 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).

d. A minimum of a .5 of a full time 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 date of hire. For substance use disorder 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 children is required to be present, with a minimum of two 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 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:

a. 3 hours of training in the Day Treatment service definition required components
b. 3 hours of crisis response training
c. 11 hours Introduction to System of Care (SOC) training
d. Required training specific to the selected clinical model(s) or evidence-based treatment(s)
e. 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, all Day Treatment staff shall complete the following training requirements:

a. 12 hours of Person-Centered Thinking [PCT] training from a Learning Community for Person Centered Practices certified PCT trainer.
   1. All new hires to Day Treatment must complete the full 12-hour training
   2. 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.
   3. 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.
   4. 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)**

1.4 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.

1.5 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 individual’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 use disorder symptoms related to functioning in an educational setting, family involvement and partnership is a critical component of treatment as clinically indicated.

1.6 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.

1.7 Eligibility Criteria

Children 5 through 17 are eligible for this service when all of the following criteria are met:

a. there is a mental health and/or substance use disorder diagnosis (as defined by the DSM-5 or any subsequent editions of this reference material), other than a sole diagnosis of an intellectual or developmental disability;
b. for children with a substance use disorder diagnosis, the ASAM Criteria

(American Society of Addiction Medicine) are met for Level 2.1;.

c. both of the following shall apply:
   1. evidence that less restrictive mental health and/or substance use disorder 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); and
   2. the individual exhibits behavior resulting in significant school disruption or significant social withdrawal.

d. the individual is experiencing mental health or substance use disorder 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; and

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

Entrance Process

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

1.8 Continued Service Criteria

The individual is eligible to continue this service if 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. The individual:

a. has achieved current PCP goals, and additional goals are indicated as evidenced by documented symptoms;
b. 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. 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. 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 finings. This includes consideration of alternative or additional services.

1.9 Discharge Criteria

The individual meets the criteria for discharge if 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; or
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.

1.10 Expected 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:

a. improved social, emotional, or behavioral functioning in an appropriate educational setting;
b. integration or reintegration into an appropriate educational or vocational setting;
c. reduced mental health and/or substance use disorder symptomatology;
d. Improvement of behavior, anger management, or developmentally appropriate coping skills;
e. development or improvement of social and relational skills;
f. enhancement of communication and problem-solving skills;
g. increased identification and self-management of triggers, cues, and symptoms and decreased frequency or intensity of crisis episodes;
h. engagement in the recovery process, for children with substance use disorders,
i. reduction of negative effects of substance use disorder or psychiatric symptoms that interfere with the individual's daily living;
j. maintaining residence with a family or community based non-institutional setting (foster home, therapeutic family services); or
k. reduction in behaviors that require juvenile justice involvement;
l. increased use of available natural and social supports.

1.11 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:

a. individual's name
b. service record number
c. service provided (for example, Day Treatment services)
d. date of service
e. place of service
f. other staff involved in the provision of the service
g. type of contact (in-person, telephone call, collateral)
h. purpose of the contact
i. description of the provider's interventions
j. amount of time spent performing the interventions
k. description of the effectiveness of the interventions in meeting the individual's specified goals as outlined in the PCP
l. 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.

1.12 Service Exclusions

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:

a. transportation time (this is factored in the rate);
b. any habilitation activities;
c. child care;
d. any social or recreational activities (or the supervision thereof);
e. clinical and administrative supervision of staff (this is factored in the rate); or
f. 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:

a. Intensive In-Home Services;
b. Multisystemic Therapy;
c. Individual, group, and family therapy;
d. Substance Abuse Intensive Outpatient Program;
e. Child Residential Treatment services–Levels II (Program Type) through IV;
f. Psychiatric Residential Treatment Facility (PRTF);
g. Substance use disorder residential services; or
h. Inpatient hospitalization.

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

Refer to https://www.ncdhhs.gov/divisions/mhddsas/servicedefinitionsfor the related coverage policies listed below:

State-Funded Assertive Community Treatment (ACT) Program
State-Funded Diagnostic Assessment
State-Funded Inpatient Behavioral Health Services
State-Funded Opioid Treatment Service
State-Funded Telehealth and Virtual Communications

Note: Information in **Sections 1.0** through **8.0** of this policy supersedes information found in the attachments.

2.0 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 individuals who meet the eligibility criteria for a State-Funded Benefit Plan. It sets forth the basic requirements for qualified providers to bill state-funded mental health and substance use 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 following resources, and the rules, manuals, and statutes referenced in them, give the Division of Mental Health, Developmental Disabilities and Substance Use Services (DMH/DD/SAS) the authority to set the requirements included in this policy:

a. *Rules for Mental Health, Developmental Disabilities and Substance Use; 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 NC Tracks Benefit Plan (Client Eligibility Criteria)*

3.0 Eligibility Requirements

An eligible individual shall be enrolled with the LME-MCO on or prior to the date of service, meet the criteria for a state-funded Benefit Plan that covers this service and shall meet the criteria in Section 3.0 of this policy.

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).

4.0 When State-Funded Services Are Covered

4.1 General Criteria

State funds shall cover 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.

4.1.1 Telehealth Services

As outlined in Attachments A and D, select services within this clinical coverage policy may be provided via telehealth and telephonically. Services delivered via telehealth and telephonically must follow the requirements and guidance set forth in the S*tate-Funded Telehealth, Virtual Patient Communications, and Remote Patient Monitoring* service definition policy.

4.2 Specific Criteria Covered By State Funds

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 **Section 1,** for service-specific medical necessity criteria. Service definitions are also located at: http://www.ncdhhs.gov/mhddsas/providers/servicedefs/index.htm.

5.0 When State-Funded Services Are Not Covered

Services related to this policy are not covered when:
a. the individual does not meet the requirements listed in the DMH/DD/SAS NC Tracks Benefit Plan 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.

6.0 Requirements for and Limitations on Coverage

6.1 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 **Section 1**.

a. Mobile Crisis Management;
c. Substance Abuse Intensive Outpatient Program (SAIOP); and
d. Substance Abuse Comprehensive Outpatient Treatment (SACOT)

6.2 Prior Approval Requirements

6 .2.1 General

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.

6.2.2 Specific

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.

6.3 Utilization Management and Authorization of Covered Services

Refer to **Section 1**the specific service definition for utilization management and authorization requirements.

Utilization management must be performed by the Management Entity-Managed Care Organization (LME-MCO).

6.4 Service Orders

Service orders are a mechanism to demonstrate medical necessity for a service and are based upon an assessment of each individual's needs. For state-funded services, a service order is recommended unless otherwise indicated in the specific service definition policy in **Section 1**. Providers shall coordinate with the LME- MCO regarding their requirements for service orders.

6.5 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.

6.6 Person Centered Plans

Most state-funded services covered by this policy require a PCP. Refer to the service definitions in **Section 1,** 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.

6.6.2 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 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.

6.7.2 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.

6.7 Documentation Requirements

The service record documents the nature and course of an individual's progress in treatment. 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 **Section 1** and the DMH/DD/SAS *Records Management and Documentation Manual*.

6.8.2 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.

6.8.3 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** (in person, telehealth, 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, service record number, and record number.

6.8.4 Other Service Documentation Requirements

Frequency, format, and any other service-specific documentation requirements can be found in the service definitions in **Section 1** 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.

7 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-MCO's provider network; and
c. bill only for services that are within the scope of their clinical practice, as defined by the appropriate licensing entity.

7.2 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 Use Facilities and Services
b. Confidentiality Rules
c. Client Rights Rules in Community MH/DD/SU Services
d. *Records Management and Documentation Manual*
e. DMH/DD/SUS Communication Bulletins
f. Implementation Updates to rules, revisions, and policy guidance
g. *Person-Centered Planning Instruction Manual*
h. DMH/DD/SUS NC Tracks Benefit Plan Criteria

Except for 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 **Section 1** for service-specific requirements.

7.3 Provider Certifications

None Apply.

7.4 Staff Definitions

7.4.2 North Carolina General Statutes Requirements

7.4.2.1 Licensed/Certified Professionals Providing State-Funded Services Under This Policy

Staff members with the following classifications must be licensed or certified, as appropriate, in accordance with North Carolina General Statutes and shall practice within the scope of practice defined by the applicable practice board.

7.4.2.1.1 Licensed Professional Counselor or Licensed Clinical Mental Health Counselor
7.4.2.1.2 Licensed Professional Counselor Associate or Licensed Clinical Mental Health Counselor Associate
7.4.2.1.3 Licensed Clinical Addiction Specialist
7.4.2.1.4 Licensed Clinical Addiction Specialist Associate
7.4.2.1.5 Certified Clinical Supervisor
7.4.2.1.6 Licensed Marriage and Family Therapist
7.4.2.1.7 Licensed Marriage and Family Therapist Associate
7.4.2.1.8 Licensed Clinical Social Worker
7.4.2.1.9 Licensed Clinical Social Worker Associate
7.4.2.1.10 Doctor of Osteopathy
7.4.2.1.11 Licensed Psychologist
7.4.2.1.12 Licensed Psychological Associate
7.4.2.1.13 Nurse Practitioner
7.4.2.1.14 Licensed Physician
7.4.2.1.15 Certified Clinical Nurse Specialist (only if certified as an advanced practice psychiatric clinical nurse specialist)
7.4.2.1.16 Certified Substance Abuse Counselor or Certified Alcohol and Drug Counselor and
7.4.2.1.17 Physician Assistant

Note: To comply with NC General Assembly Session Law 2019-240 Senate Bill 537, licensure name for Licensed Professional Counselor (LPC) is amended to Licensed Clinical Mental Health Counselor (LCMHC); and certification name for Certified Substance Abuse Counselor (CSAC) is amended to Certified Alcohol and Drug Counselor (CADC). Policy amendment(s) will be effective the date the related rule change for 10A NCAC 27G is finalized.

7.4.3 North Carolina Administrative Code Staff 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

8 Additional Requirements

8.1 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), 42 CFR Part 2 and record retention requirements; and
b. All DMH/DD/SAS clinical service definition policies, guidelines, policies, provider manuals, implementation updates, and bulletins published by DHHS, its divisions or its fiscal agent.

8.2 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 use 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 individuals eligible for state funded services 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 use 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/SUS conducts annual monitoring of a sample of mental health and substance use disorder services funded with SUPTRS, CMHBG and state funds. The purpose of the monitoring is to ensure that these services are provided to individuals in accordance with federal & state 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 state funds and federal block grant regulations and requirements.

8.3 Authority

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

8.3.1 Rules for Mental Health, Developmental Disabilities and Substance Abuse Facilities and Services, Administrative Publication System Manuals (APSM)30-1

8.3.2 DMHDDSUS Records Management and Documentation Manual, APSM 45-2

8.3.3 DMHDDSUS Person-Centered Planning Instruction Manual

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

Attachment A: Claims-Related Information

Reimbursement requires compliance with all DMH/DD/SAS NC Tracks Benefit Plan guidelines, including obtaining appropriate referrals for individuals meeting NC Tracks Benefit Plan eligibility criteria.

A. Claim Type

Professional (837P transaction).

B. International Classification of Diseases and Related Health Problems, Tenth Revisions, Clinical Modification (ICD-10-CM) and Procedural Coding System (PCS)

Providers shall bill the ICD-10-CM diagnosis code(s) (or its successors) to the highest level of specificity that supports medical necessity. Provider(s) shall use the current ICD-10 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.

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 state fund reimbursement.

Claims submitted to NC Tracks have coding requirements that are specific to DMH/DD/SAS billing policy. Specifically, diagnosis coding is required on all claims to NC Tracks. NC Tracks recognizes the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) codes or its successors, as directed by DMH/DD/SAS. NC Tracks does not recognize any diagnosis codes in any versions of the Diagnostic and Statistical Manual of Mental Disorders.

Note: Providers using the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC:0–5) manual shall submit claims using the ICD-10 diagnosis code that corresponds to the chosen DC:0-5 diagnosis.

C. Code(s)

Provider(s) shall report the most specific billing code that accurately and completely describes the service provided. Provider(s) shall use the Current Procedural Terminology (CPT), Health Care Procedure Coding System (HCPCS), 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, as it is no longer documented in the policy.

Child and Adolescent Day Treatment

HCPCS Code	Bill with Modifier	Billing Unit	Telehealth Eligible
H2012	HA	1 unit =1 hour	No

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

D. Modifiers

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

Non-Telehealth Claims: Provider(s) shall follow applicable modifier guidelines.

Telehealth Claims: Modifier GT must be appended to the CPT or HCPCS code to indicate that a service has been provided via interactive audio-visual communication.

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 use disorder services settings; and licensed crisis settings.

Telehealth claims should be filed with the provider's usual place of service code(s) and not place of service 02 (Telehealth).

G. Reimbursement

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

Note: DMH/DD/SAS will not reimburse for conversion therapy

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 DMH/DD/SAS NC Tracks Benefit Plan 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.