

**North Carolina
Division of Mental Health,
Developmental Disabilities and Substance Use Services**

**State-Funded Enhanced Mental Health and Substance Use Service,
Multisystemic Therapy (MST) (State-Funded)**

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1.0 Multisystemic Therapy (MST) (State-Funded)

1.1 Service Definition and Required Components

Multisystemic Therapy (MST) is a program designed for youth generally between the ages 7 through 17 who:

- a. have antisocial, aggressive or violent behaviors;
- b. are at risk of out-of-home placement due to delinquency;
- c. adjudicated youth returning from out-of-home placement;
- d. chronic or violent juvenile offenders; or
- e. youth with serious emotional disturbances or a substance use disorder and their families.

MST provides an intensive model of treatment based on empirical data and evidence-based interventions that target specific behaviors with individualized behavioral interventions. The purpose of this program is to keep youth in the home by delivering an intensive therapy to the family within the home. Services are provided through a team approach to beneficiaries and their families.

Services include:

- a. an initial assessment to identify the focus of the MST intervention;
- b. individual therapeutic interventions with the individual and family;
- c. peer intervention;
- d. case management; and
- e. crisis stabilization.

Specialized therapeutic and rehabilitative interventions are available to address special areas such as:

- a. a substance use disorder;
- b. sexual abuse;
- c. sex offending; and
- d. domestic violence.

Services are available in-home, at school, and in other community settings. The duration of MST intervention is 3 to 5 months. MST involves families and other systems such as the school, probation officers, extended families, and community connections.

MST services are delivered in a team approach designed to address the identified needs of children and adolescents with significant behavioral problems who are transitioning from out of home placements or are at risk of out-of-home placement and need intensive interventions to remain stable in the community. This population has access to a variety of interventions 24-hours-a-day, 7-days-a-week, by staff that will maintain contact and intervene as one organizational unit.

This team approach consists of is structured face-to-face therapeutic interventions to that provide support and guidance in all areas of the following functional domains:

- a. adaptive;
- b. communication;
- c. psychosocial;
- d. problem solving; and
- e. behavior management.

The service promotes the family's capacity to monitor and manage the individual's behavior.

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

1.2 Provider Requirements

MST services shall be delivered by a team of practitioners employed by mental health, substance use disorder, or intellectual or developmental disability provider organizations that meet the requirements of 10A NCAC 27G and the provider qualification policies, procedures, and standards established by DMH/DD/SUS. These policies and procedures set forth the administrative, financial, clinical, quality improvement, and information services infrastructure necessary to provide services. Provider organizations shall demonstrate that they meet these standards by being credentialed by the LME-MCO. Additionally, the organization shall achieve national accreditation with at least one of the designated accrediting bodies within one year of enrollment as a provider with the LME-MCO. The organization shall be established as a legally recognized entity in the United States and qualified or registered to do business as a corporate entity in the State of North Carolina, capable of meeting all the requirements of the LME 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.

MST providers must have the ability to deliver services in various environments, such as homes, schools, homeless shelters, street locations, etc. Organizations that provide MST must provide "first responder" crisis response on 24 hours a day, 7 days a week, 365 days a year, basis to individuals who are receiving this service.

1.3 Staffing Requirements

This service model includes at a minimum a master's level QP who is the team supervisor and three QP staff who provide available 24-hour coverage, 7 days a week. Staff is required to participate in MST introductory training and quarterly training on topics directly related to the needs of individuals receiving MST and their family on an ongoing basis. All staff on the MST team shall receive a minimum of 1 hour of group supervision and 1 hour of telephone consultation per week. MST team member-to-family ratio shall not exceed 1:5 for each member.

1.4 Service Type and Setting

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

1.5 Clinical Requirements

A minimum of 12 contacts must occur within the first month. For the second and third months of MST, an average of 6 contacts must occur each month. It is the expectation that service frequency will be titrated over the last 2 months.

Units are billed in 15-minute increments.

Program services are primarily delivered in-person with the individual and/or his or her family and in locations outside the agency's facility. The aggregate services that have been delivered by the agency will be assessed annually for each provider agency using the following quality assurance benchmarks:

- a. A minimum of 50% of the contacts occur in-person with the individual and/or family.
The remaining units may either be phone or collateral contacts; and
- b. A minimum of 60% of staff time must be spent working outside of the agency's facility, with or on behalf of individuals receiving the service.

1.6 Utilization Management

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

Utilization management must be performed by the LME-MCO.

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

1.7 Eligibility Criteria

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

- a. there is a mental health and/or substance use disorder diagnosis present, other than a sole diagnosis of an intellectual or developmental disability.
- b. the individual should be between the ages of 7 through 17.
- c. the individual displays willful behavioral misconduct (e.g., theft, property destruction, assault, truancy, or substance use or juvenile sex offense), when in conjunction with other adjudicated delinquent behaviors
- d. the individual is at imminent risk of out-of-home placement or is currently in out-of-home placement due to delinquency and reunification is imminent within 30 days of referral.
- e. the individual has a caregiver that is willing to assume long term parenting role and caregiver who is willing to participate with service providers for the duration of the treatment.

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 at risk for relapse based on history or the tenuous nature of the functional gains or any one of the following apply:

- a. The individual continues to exhibit willful behavioral misconduct.
AND
- b. There is a reasonable expectation that the individual will continue to make progress in reaching overarching goals identified in MST in the first 4 weeks.
OR
- c. The individual is not making progress; the PCP must be modified to identify more effective interventions.
OR
- d. The individual is regressing; the PCP must be modified to identify more effective interventions.

1.9 Discharge Criteria

The individual meets the criteria for discharge if any one of the following applies:

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

- a. The individual has achieved 75% of the PCP goals; discharge to a lower level of care is indicated.
- b. The individual is not making progress or is regressing, and all realistic treatment options within this modality have been exhausted.
- c. The individual or family requests discharge and is not imminently dangerous to self or others.
- d. The individual requires a higher level of care (i.e., inpatient hospitalization or PRTF).

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

1.10 Expected Outcomes

- a. The individual has improved in domains such as: adaptive, communication, psychosocial, problem solving and behavior.
- b. Willful behavioral misconduct has been reduced or eliminated (e.g. theft, property destruction, assault, truancy or substance use, or juvenile sex offense, when in conjunction with other delinquent behaviors).
- c. The family has increased capacity to monitor and manage the individual's behavior; need for out of home placement has been reduced or eliminated.

1.11 Documentation Requirements

The minimum standard is a daily full service note that includes the:

- a. individual's name;
- b. service record number;
- c. date of service;
- d. purpose of contact;
- e. description of the provider's interventions;
- f. time spent performing the interventions;
- g. effectiveness of the intervention; and
- h. signature of the staff providing the service.

1.12 Service Exclusions

An individual may receive MST services from only one MST provider organization at a time.

MST services may not be billed for individuals who are receiving:

- a. Intensive In-Home Services;
- b. Day Treatment;
- c. Hourly Respite;
- d. individual, group or family therapy;
- e. SAIOP;
- f. child residential Level II–IV; or
- g. substance use disorder residential services.

Refer to <https://www.ncdhhs.gov/divisions/mhddsas/servicedefinitions> for 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 *State-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.

Multisystemic Therapy

HCPCS Code	Billing Unit	Telehealth Eligible
H2033	1 unit =15 minutes	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.