North Carolina

Division of Mental Health,

Developmental Disabilities and Substance Use Services

State-Funded Enhanced Mental Health and Substance Use Service, Professional Treatment Services in Facility-Based Crisis Program (State-Funded)

Date Amended – October 1st, 2024

Contents

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

1.1 Service Definition and Required Components

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

1.2 Provider Requirements

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

1.3 Service Type and Setting

Therapeutic Relationship and Interventions

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

Structure of Daily Living

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

Cognitive and Behavioral Skill Acquisition

This service is designed to provide support and treatment in preventing,

overcoming, or managing the identified crisis or acute situations on the service plan to assist with improving the individual's level of functioning in all documented domains, increasing coping abilities or skills, or sustaining the achieved level of functioning.

Service Type

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

Resiliency or Environmental Intervention

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

Service Delivery Setting

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

1.4 Eligibility Criteria

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

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

Service Orders

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

LME-MCO regarding their requirements for service orders.

1.5 Continued Service or Utilization Review Criteria

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

a. the individual has achieved initial service plan goals and additional goals are indicated;
b. the individual is making satisfactory progress toward meeting goals;
c. the individual is making some progress, but the service plan (specific interventions) need to be modified so that greater gains, which are consistent with his or her premorbid level of functioning, are possible or can be achieved;
d. the individual is not making progress; the service plan must be modified to identify more effective interventions; or
e. the individual is regressing; the service plan must be modified to identify more effective interventions.

AND

Utilization review by the LME-MCO must be conducted after the first 7 days (168 units). Initial authorization shall not exceed 8 days (192 units). All utilization review activity shall be documented in the service plan.

Units are billed in 1-hour increments up to 24 hours in a 24-hour period. This is a short-term service that may not be provided for more than 45 days in a 12-month period.

When providing evaluation and management services to individuals, the psychiatrist and physician extender may bill additional psychiatric evaluations (excluding the initial evaluation) and other therapeutic services separately.

1.6 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 service plan, inclusive of a transition plan to step-down or no longer benefits or has the ability to function at this level of care and ANY of the following applies:

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

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

1.7 Service Maintenance Criteria

If the individual is functioning effectively with this service and discharge would otherwise be indicated, Facility-Based Crisis services should be maintained when it can be reasonably anticipated that regression is likely to occur if the service is withdrawn. The decision should be based on ANY of the following:

a. Past history of regression in the absence of facility-based crisis service is documented in the service record; or
b. In the event there are epidemiologically sound expectations that symptoms will persist and that ongoing treatment interventions are needed to sustain functional gains, the nature of the individual's DSM-5 (or any subsequent editions of this reference material) diagnosis necessitates a disability management approach.

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

1.8 Documentation Requirements

Minimum documentation is a daily service note per shift.

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 *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.

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HCPCS Code	Billing Unit	Telehealth Eligible
S9484	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.