NC Division of Mental Health, Developmental Disabilities, & Substance Abuse Services	State-Funded Assertive Engagement Service (AE) Published Date: August 1, 2022

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1.0 Description of the Service

Assertive Engagement is a short-term method of outreaching to individuals (adults or children) who have serious mental illness, serious emotional disturbance, or substance use disorders, who have significant functional impairments, and who have not effectively engaged with treatment services. Assertive Engagement can be a necessary step in the process of effectively treating these illnesses by addressing challenges to treatment engagement including identifying and offering what is necessary to establish a trusting relationship and meeting basic needs. Basic needs may include shelter, food, clothing, transportation, and/or arrangement for acute medical care. Successful engagement is the first necessary step in the process that leads to rehabilitation and recovery. Assertive Engagement provides the flexibility to make contact with the individual while in a state hospital, inpatient psychiatric facility, crisis facility, withdrawal management facility, youth detention centers, hospital emergency departments, streets, or jails/prisons for the purposes of engagement. Assertive Engagement also addresses many challenges to engagement that may include, but are not limited to: symptoms, past negative experiences in accessing care, locating the individual, beliefs about mental illness, stigma, etc. Assertive Engagement is a short-term engagement service targeted to populations or specific individual circumstances that prevent the individual from fully participating in needed care for mental health and/or substance use disorder. Assertive Engagement can be used until the individual is connected with a provider for ongoing services.

Assertive Engagement is designed to be an individual service requiring frequent contact to build/re-establish a trusting, meaningful relationship to engage or re-engage the individual into services and/or assess for needs. The service is designed to:

a. Develop and maintain meaningful engagement in services
b. Provide linkage to clinical assessment and the appropriate level of care
c. Identify methods for helping individuals become engaged and involved in their care
d. Reduce hospitalization frequency and duration
e. Reduce utilization of crisis services
f. Reduce criminal/juvenile justice involvement and days incarcerated or in detention
g. Provide continuity of care regardless of life circumstances or recovery environment
h. Reduce out of home placement for those children and youth who are at high risk
i. Increase social networks and improve family relationships

1.1 Definitions

a. **Functional impairment** – Functional impairment is defined as having documented, significant impairment in at least two of the life domains (emotional, social, safety, housing, medical/health, educational, vocational, and legal). This impairment is related to the individual's diagnosis and impedes the individual's use of the skills necessary for independent functioning in the community.

2.0 Eligibility Requirements

2.1 Provisions

2.1.1 General

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 and shall meet the criteria in **Section 3.0 of this policy**.

2.1.2 Specific

State funds shall cover Assertive Engagement for an eligible individual who meets the criteria in **Section 3.0** of this policy.

3.0 When the Service Is Covered

3.1 General Criteria Covered

State funds shall cover the service related to this policy when medically necessary, and:
a. the service is individualized, specific, and consistent with symptoms or confirmed diagnosis 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 caretaker, or the provider.

3.1.1 Telehealth Services

As outlined in Attachment A, select services within this clinical service definition policy may be provided via telehealth. Services delivered via telehealth must follow the requirements and guidance in the State-Funded Telehealth and Virtual Communications, at **https://www.ncdhhs.gov/divisions/mhddsas/servicedefinitions**.

3.1.2 Telephonic Services

As outlined in Attachment A, select services within this clinical service definition policy may be provided via the telephonic, audio-only communication method. Telephonic services may be transmitted between an individual and provider in a manner that is consistent with the CPT and HCPCS code definition for those services.

Refer to subsection 3.2.5.1 for **Telephonic-Specific Criteria**; and subsection 7.1 for **Compliance** requirements.

3.2 Specific Criteria Covered

3.2.1 Specific criteria covered by State Funds

State funds shall cover Assertive Engagement when ALL the following criteria are met:

a. The individual has a mental health or substance use diagnosis as defined by the Diagnostic and Statistical Manual of Mental Disorders Fifth Edition (DSM-5) or any subsequent editions of this reference material, other than a sole diagnosis of intellectual and developmental disability;
b. There is no evidence to support that alternative interventions would be equally or more effective based on North Carolina community practice standards; and
c. The individual has documented identified needs, in ALL of the following areas (related to diagnosis):
    1. Significant impairment in at least two of the life domains (emotional, social, safety, housing, medical/health, educational, vocational, and legal). This impairment is related to the individual's diagnosis and impedes the individual's use of the skills necessary for independent functioning in the community;
    2. Not connected to community-based services that are available to meet their clinical needs;
    3. Are expected to have difficulty engaging in treatment services without additional supports
d. Individuals with a sole diagnosis of intellectual developmental disability are not eligible for Assertive Engagement.

3.2.2 Admission Criteria

Assertive Engagement is pre- engagement service for individuals that are currently not engaged in services. Coverage of Assertive Engagement can be provided up to thirty-two (32) unmanaged units once per episode of care per state fiscal year.

3.2.3 Continued Stay Criteria

The individual meets criteria for continued stay if any ONE of the following applies:

a. The individual has not been successfully connected to a service provider who is meeting their clinical needs; or
b. Individual is not successfully engaged in services.

3.2.4 Transition and Discharge Criteria

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

a. The individual has successfully connected to and engaged in services;
b. The individual is not available or has refused recommended services after reasonable attempts have been made to engage him/her in treatment and no safety concerns are present.

For individuals receiving state funded services who are new to the enhanced MH/DD/SAS service delivery system, a completed LME-MCO Consumer Admission and Discharge Form must be submitted to the LME-MCO.

3.2.5 State-Funded Additional Criteria Covered

3.2.5.1 Telephonic-Specific Criteria:

a. Providers shall ensure that services can be safely and effectively delivered using telephonic, audio-only communication;
b. Providers shall consider an individual's behavioral, physical and cognitive abilities to participate in services provided using telephonic, audio-only communication;
c. The individual's safety must be carefully considered for the complexity of the services provided;
d. In situations where a caregiver or facilitator is necessary to assist with the delivery of services via telehealth, their ability to assist and their safety should also be considered;
e. Delivery of services using telephonic, audio-only communication must conform to professional standards of care including but not limited to ethical practice, scope of practice, and other relevant federal, state and institutional policies and requirements including Practice Act and Licensing Board rules;
f. Providers shall obtain and document verbal or written consent. In extenuating circumstances when consent is unable to be obtained, this should be documented;
g. Providers shall verify the individual's identity using two points of identification before initiating a telephonic, audio-only encounter; and,
h. Providers shall ensure that the individual's privacy and confidentiality is protected.

4.0 When the Service Is Not Covered

4.1 General Criteria Not Covered

State funds shall not cover the service related to this policy when:
a. the individual does not meet the eligibility requirements listed in **Section 2.0;**
b. the individual does not meet the 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.

4.2 Specific Criteria Not Covered

4.2.1 Specific Criteria Not Covered by State Funds

State funds shall not cover the following activities of Assertive Engagement:

a. Transportation for the individual or family members;
b. Habilitation activities;
c. Time spent performing, attending or participating in recreational activities unless tied to specific planned social skill assistance;
d. Clinical and administrative supervision of the provider which is covered as an indirect cost and part of the rate;
e. Covered services that have not been rendered;
f. Childcare services or services provided as a substitute for the parent or other individuals responsible for providing care and supervision;
g. Services provided to teach academic subjects or as a substitute for education personnel;
h. Payment for room and board.

5.0 Requirements for and Limitations on Coverage

5.1 Prior Approval

State-Funded Assertive Engagement shall require prior approval for Assertive Engagement beyond the unmanaged unit limitation. Coverage of Assertive Engagement is limited to thirty-two (32) unmanaged units once per episode of care per state fiscal year. Refer to **Subsection 5.3** for additional limitations.

A service order must be signed prior to or on the first day AE is rendered. Refer to **Subsection 5.4** of this policy.

LME-MCOs can offer less restrictive limitations on unmanaged units but cannot impose more restrictive limitations than the State-Funded Policy. All units beyond state-funded limitations or limitations imposed by the LME-MCO require prior approval.

LME-MCOs that offer less restrictive limitations on unmanaged units than that of the state-funded policy shall provide assurance that there are mechanisms in place to prevent over-billing for services.

Providers shall seek prior approval if they are uncertain that the individual has reached the unmanaged unit limit for the fiscal year.

Providers shall seek prior approval if the individual is engaged in other behavioral health or substance use services. Providers shall collaborate with the individual's existing provider to develop an integrated plan of care.

Prior authorization is not a guarantee of claim payment.

5.2 Prior Approval Requirements

5.2.1 General

The provider(s) shall submit to the LME-MCO the following:

a. the prior approval request (if unmanaged visits have been exhausted or if the individual is engaged in other behavioral health or substance use treatment services of any kind); and
b. any other records that support the individual has met the specific criteria in **Subsection 3.2** of this policy.

5.2.2 Specific

Utilization management of covered services is a part of the assurance of medically necessary service provision. Authorization, which is an aspect of utilization management, validates approval to provide a medically necessary covered service to an eligible individual.

Initial Authorization

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 detailed in Individualized Plan. Medical necessity is determined by North Carolina community practice standards, as verified by the LME-MCO who evaluates the request to determine if medical necessity supports intensive services. Medically necessary services are authorized in the most cost-effective modes, if the treatment that is made available is similarly efficacious as services requested by the individual's physician, therapist, or another licensed practitioner. The medically necessary service must be recognized as an accepted method of treatment.

To request an initial authorization, service order for medical necessity, Individualized Plan, and the required LME-MCO authorization request form must be submitted to the LME-MCO. State funds may cover up to four (4) service hours (16 units) per day and maximum of sixty (60) service hours (240 units) per fiscal year . Refer to **Subsection 5.4** for Service Order requirements.

Reauthorization

Reauthorization requests must be submitted to the LME-MCO 10-days prior to the end date of the individual's active authorization. Reauthorization is based on medical necessity documented in the Individualized Plan, the authorization request form, and supporting documentation.

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. 43B-147(a)(9) and Rules10A NCAC27I .0601-.0609.

5.3 Additional Limitations or Requirements

a. An individual can receive AE from only one provider organization during an active authorization period. The individual may choose a new provider at any time, which will initiate a new service authorization request and a new authorization period.

b. Family members or legally responsible person(s) of the individual are not eligible to provide this service to the individual receiving the service.
c. An individual with a sole diagnosis of Intellectual/Developmental Disabilities is not eligible for AE funded by state funds.
d. Assertive Engagement must not be provided during the same authorization period as Assertive Community Treatment Team (ACTT).
e. Assertive Engagement must not be provided during the same authorization period as Community Support Team (CST).
f. Assertive Engagement must not be provided during the same authorization period as Peer Support Services (PSS).
g. Assertive Engagement must not be provided during the same authorization period as other state funded residential services.
h. Assertive Engagement must not be provided during the same authorization period as other enhanced services including child residential services.
i. Assertive Engagement must not be provided to individuals with active Medicaid.
j. Assertive Engagement must not be duplicative of other state-funded services the individual is receiving.
k. Transportation of an individual receiving state funded AE is not covered as a component for this policy.

5.4 Service Orders

Service orders are a mechanism to demonstrate medical necessity for a service and are based upon an assessment of the individual's needs. A service order must be signed by a physician or other licensed clinician per his or her scope of practice, prior to or on the first day service is rendered.

ALL the following apply to a service order:

a. Backdating of the service order is not allowed;
b. Each service order must be signed and dated by the authorizing professional and must indicate the date on which the service was ordered;
c. A service order must be in place prior to or on the first day that the service is initially provided to bill state funds for the service; and
d. Service orders are valid for one calendar year. Medical necessity must be reviewed, and service must be ordered at least annually, based on the date of the original service order.

5.5 Documentation Requirements

The service record documents the nature and course of an individual's progress in treatment. To bill state funds, providers must ensure that their documentation is consistent with the requirements contained in this policy. The staff member who provides the service is responsible for documenting the services billed to and reimbursed by state funds. The staff person who provides the service shall sign and date the written entry. The signature must include credentials for the staff member who provided the service. Service note for each contact, service event, or intervention needs to be documented in the service record.

5.5.1 Contents of a Service Note

For this service, a full service note for each contact or intervention for each date of service, written and signed by the person who provided the service is required. More than one intervention, activity, or goal may be reported in one service note, if applicable. A service note must document ALL following elements:

a. Individual's name;
b. Service record identification number;
c. Date of the service provision;
d. Name of service provided;
e. Type of contact (in person, telehealth or telephonic, audio-only communication);
f. Place of service;
g. Purpose of contact as it relates to the Individualized goals;
h. Description of the intervention provided. Documentation of the intervention must accurately reflect treatment for the duration of time indicated;
i. Duration of service, start and end time of intervention; total amount of time spent performing the intervention;
j. Assessment of the effectiveness of the intervention and the individual's progress towards the individual's goals; and
k. Date and signature and credentials or job title of the staff member who provided the service.

6.0 Provider(s) Eligible to Bill for the Service

To be eligible to bill for the service related to this policy, the provider(s) shall:

a. meet LME-MCO qualifications for participation;
b. have a current and signed Department of Health and Human Services (DHHS) Provider Administrative Participation Agreement; and
c. bill only for services that are within the scope of their clinical practice, as defined by the appropriate licensing entity.

6.1 Provider Qualifications and Occupational Licensing Entity Regulations

Assertive Engagement must be delivered by practitioners employed by organizations that:

a. meet the provider qualification policies, procedures, and standards established by the NC Division of MH/DD/SAS;
b. meet the requirements of 10A NCAC 27G;
c. demonstrate that they meet these standards by being credentialed and contracted by an LME-MCO;
d. within one calendar year of enrollment as a provider with the LME-MCO, achieve national accreditation with at least one of the designated accrediting agencies; and
e. become established as a legally constituted entity capable of meeting all the requirements of the DMH/DD/SAS Bulletins and service implementation standards.

6.2 Staffing Requirements

AE is provided by licensed professional, Qualified Professional (QP), Associate Professional (AP), or a Certified Peer Support Specialist (CPSS) with the knowledge, skills, and abilities required by the population and age being served.

Licensed professionals and QPs providing this service do not require supervision. APs and Certified Peer Support Specialists require supervision from a licensed professional or a QP.

6.2.1 Staff Training Requirements

To provide effective Assertive Engagement services, all AE program staff shall possess the knowledge and competencies of person centered, trauma informed and culturally competent values and ethics and participate in additional trainings required to provide the service.

Required trainings for PSS program staff are as follows and must be completed within 60-days from the date of hire (or have proof of completion of the required trainings with the last 24 months):

a. Motivational Interviewing (6 hours);
b. Person-Centered Thinking (6 hours);
c. Crisis Response Training (3 hours);
d. Trauma-Informed Care (3 hours);
e. Special population training based on staff experience and training needs (e.g., mental health, substance use disorder, geriatric, traumatic brain injury, deaf and hard of hearing, child, co-occurring mental health and substance use disorders, co-occurring mental health and IDD, co-occurring substance use disorder and IDD, pregnant women, and working with people with criminal justice involvement) (6 hours)

6.3 Expected Outcomes

The expected outcomes for this service are specific to recommendations resulting from Individualized Plan.

Expected outcomes:

a. Individuals will engage or re-engage with a provider agency.
b. Individuals' utilization of community-based services will increase.
c. Individuals' state and community hospital admissions will be reduced.
d. Individuals' involvement with the criminal justice system will be reduced.
e. Individuals' admissions to emergency departments, crisis evaluation and observation services, facility-based crisis, and mobile crisis services will be reduced.

7.0 Additional Requirements

7.1 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 NC Division of MH/DD/SAS's service definitions, guidelines, policies, provider manuals, implementation updates, and bulletins, DHHS, DHHS division(s) or fiscal contractor(s).

8.0 Policy Implementation and History

Original Effective Date: August 1, 2022

History:

Date	Section or Subsection Amended	Change
08/01/2022	All Sections and Attachment(s)	New policy implementing Assertive Engagement.

Attachment A: Claims-Related Information

Provider(s) shall comply with the, *NCTracks Provider Claims and Billing Assistance Guide*, DMH/DD/SAS bulletins, fee schedules, NC Division of MH/DD/SAS's service definitions and any other relevant documents for specific coverage and reimbursement for state funds:

A. Claim Type

Professional (837P transaction)

Institutional (837I transaction)

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

Provider(s) shall report the ICD-10-CM and Procedural Coding System (PCS) 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.

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.

If no such specific CPT or HCPCS code exists, then the provider(s) shall report the service using the appropriate unlisted service code.

Code(s)	Billing Unit	Telehealth Eligible	Telephonic Eligible
YA352 (QP licensed & unlicensed)	1 unit = 15 minutes	Yes	Yes
YA353 (AP & Paraprofessional)	1 unit = 15 minutes	No	No

Note: Telehealth eligible services may be provided to both new and established patients by the eligible providers listed within this policy.

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

HCPCS: The provider(s) shall refer to and comply with the Instructions for Use of 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

Provider(s) shall follow applicable modifier guidelines.
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. This modifier is not appropriate for services provided via telephonic, audio-only communication.

Telephonic Claims: Modifier KX must be appended to the CPT or HCPCS code to indicate that a service has been provided via telephonic, audio-only communication.

E. Billing Units

Provider(s) shall report the appropriate code(s) used which determines the billing unit(s).

Units are billed in 15-minute increments.

LME-MCOs and provider agencies shall monitor utilization of service by conducting record reviews and internal audits of units of service billed. LME-MCOs shall assess their AE network providers' adherence to service guidelines to assure quality services for individuals served.

F. Place of Service

Assertive Engagement is intended to be flexible in its approach to meet the needs of the individual in their own setting or current location. This service can be delivered as part of the discharge planning process from state hospitals, local hospitals, facility-based crisis centers, detox facilities, youth detention centers, jails/prisons, and other 24-hour inpatient facilities. It can also be delivered in the home, community, shelters, and streets.
Service may be provided via telehealth or telephonic, audio-only communication. Telehealth or telephonic, audio-only communication time is supplemental rather than a replacement of in-person contact and is limited to twenty (20) percent or less of total service time provided per individual per fiscal year. Documentation of service rendered via telehealth or telephonic, audio-only communication with the individual or collateral contacts (assisting individual with rehabilitation goals) must be documented according to Subsection **5.5** of this policy.

Telehealth and telephonic, audio-only communication claims should be filed with the provider's usual place of service code(s).

G. Co-payments

Not applicable

H. Reimbursement

Provider(s) shall bill their usual and customary charges.

Note: The Division of MH/DD/SAS will not reimburse for conversion therapy.