North

Carolina Division

of Mental Health,

Developmental Disabilities and Substance Use Services

State-Funded Peer Support Service

NC DEPARTMENT OF
HEALTH AND
HUMAN SERVICES
Division of Mental Health,
Developmental Disabilities and
Substance Use Services

DRAFT

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Related Clinical Coverage Policies

Refer to https://medicaid.ncdhhs.gov/ for the related coverage policies listed below:
State-Funded Enhanced Mental Health and Substance Abuse Services
State-Funded Assertive Community Treatment (ACT) Program
State-Funded Telehealth, Virtual Patient Communications and Remote Patient Monitoring

1.0 Description of the Service

Peer Support Services (PSS) is an evidenced-based mental health model of care that provides community-based recovery services directly to a Medicaid-eligible adult individual diagnosed with a mental health or substance use disorder. PSS provide structured, scheduled interventions that promote recovery, self-determination, self-advocacy, engagement in self-care and wellness and enhancement of community living skills of beneficiaries.

PSS is directly provided by North Carolina Certified Peer Support Specialists (CPSS) who have self-identified as a person(s) in recovery from a mental health or substance use disorder. PSS is intended to complement clinical and other medically necessary services and are typically provided in coordination with services that address the individual's diagnosed condition.

PSS is based on the belief that individuals diagnosed with serious mental health or substance use disorders can and do recover. The focus of the service is on the individual's strengths, rather than the identified mental health or substance use disorder and emphasizes the acquisition, development, and expansion of rehabilitative skills needed to establish and maintain recovery. The service promotes skills for coping with and managing symptoms while utilizing natural supports and community resources.

Peer Support Services (PSS) is provided one-on-one to the individual or in a group setting. Providing one-on-one support builds on the relationship of mutuality between the individual and CPSS; supports the individual in accomplishing self-identified goals; and may further support the individual's engagement in treatment. Peer Support Services provided in a group setting allow the individual the opportunity to engage in structured services with others that share similar recovery challenges or interest; improve or develop recovery skills; and explore community resources to assist the individual in their recovery. PSS is based on the individual's needs and coordinated within the context of the individual's Person-Centered Plan. Structured services provided by PSS include:

a. **Peer mentoring or coaching (one-on-one)** –
to encourage, motivate, and support individual moving forward in recovery. Assist individual with setting self-identified recovery goals, developing recovery action plans, and solving problems directly related to recovery, such as finding housing, developing natural support system, finding new uses of spare time, and improving job skills. Assist with issues that arise in connection with collateral problems such as legal issues or co-existing physical or mental challenges.

b. **Recovery resource connecting** – connecting an individual to professional and nonprofessional services and resources available in the community that can assist an individual in meeting recovery goals.

c. **Skill Building Recovery groups** – structured skill development groups that focus on job skills, budgeting and managing credit, relapse prevention, and conflict resolution skills and support recovery.

d. **Building community** – assist an individual in enhancing his or her social networks that promote and help sustain mental health and substance use disorder recovery. Organization of recovery-oriented services that provide a sense of acceptance and belonging to the community, promote learning of social skills and the opportunity to practice newly learned skills.

1.1 Definitions

Periodic:

means occurring at occasional intervals.

Planned:

is decided on and arranged in advance.

Recovery:

Recovery is a process of change through which an individual improves their health and wellness, lives a self-directed life and strives to reach their full potential; to live, work, learn, and participate fully in their communities.

Self-Determination:

Self- Determination is the right of an individual to direct his or her own services, to make decisions concerning their health and well-being, and to have help to make decisions from whomever they choose.

Self-Advocacy:

Self – Advocacy is the ability to identify and purposefully ask for what one needs.

Health:

Health is learning to overcome, manage or more successfully live with the symptoms and making healthy choices that support one's physical and emotional wellbeing.

Community:

Community is defined as relationships and social networks that provide support, friendship, love and hope.

Serious Mental Illness:

As defined by the Substance Abuse Mental Health Services Administration (SAMHSA), "SMI is defined as someone over 18 years of age having within the past year a diagnosable mental, behavior, or emotional disorder that causes serious functional impairment that substantially interferes with or limits one or more major life activities."

Substance Use Disorder (SUD):

As defined by SAMHSA, "SUD is defined when the recurrent use of alcohol or drugs causes clinically significant impairment, including health problems, disability, and failure to meet major responsibilities at work, school, or home.

Lived Experience:

Personal knowledge and experience with strategies that aim to address social, health, public health, or other challenges associated with mental health or substance use disorder recovery.

Peer Modeling:

Demonstration of hope, resilience, and positive recovery behaviors by a CPSS to help an individual in establishing or maintaining recovery.

2.0 Eligibility Criteria

2.1 Provisions

2.1.1 General

(***The term "General" found throughout this policy applies to all State-funded policies***)

a. An eligible individual shall be enrolled with the Local Management Entity-Managed Care Organization (LME/MCO) on or prior to the date of service, meet the criteria for SED, or moderate or severe SUD or I/DD state-funded Benefit Plans and shall meet the criteria in Section 3.0 of this policy.
b. Provider(s) shall verify each State-funded individual's eligibility each time a service is rendered.
c. The State-funded individual may have service restrictions due to their eligibility category that would make them ineligible for this service.

2.1.2 Specific

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

a. **State-funded**
An applicant may be approved for State-funded PSS service if the applicant meets all eligibility requirements. An individual may become retroactively eligible for State-funded PSS services while receiving covered services.

A retroactively eligible individual is entitled to receive State-funded covered services and to be reimbursed by the provider for all money paid during the retroactive period except for any third-party payments

or cost-sharing amounts provided that such filing meets State-funded claim submission requirements.

State-funded shall cover Peer Support Services for an eligible individual who is 18 years of age and older and meets the criteria in **Section 3.0** of this policy.

3.0 When the Service is Covered

3.1 General Criteria Covered

State-funded shall cover the procedure, product, or service related to this policy when medically necessary, and: the procedure, product, or service is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the individual's needs;

3.1.1 Telehealth Services

As outlined in Attachment A, select services within this clinical coverage policy may be provided via telehealth. Services delivered via telehealth must follow the requirements and guidance in clinical coverage Policy 1-H, Telehealth, *Virtual Patient Communications, and Remote Patient Monitoring,* at https://state-funded.ncdhhs.gov/.

3.1.2 Telephonic Services

As outlined in Attachment A, selected services within this clinical coverage 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-funded shall cover Peer Support Services when ALL following criteria are met:

a. The individual has a serious mental illness or substance use diagnosis as defined by in **Section 1.1** along with a corresponding 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.

c. The individual has documented recovery-oriented needs (related to diagnosis) in at least TWO or more of the following areas:

1. Acquisition of self-advocacy skills to navigate the behavioral health system and access community resources.
2. Empowerment to take responsibility for their own recovery; or
3. Develop recovery skills to engage in and maintain recovery: and

d. The individual has documented recovery-oriented needs, in at least ONE or more of the following areas (related to the diagnosis):

1. Adaptive skills (communication, problem-solving, or organizational skills);
2. Employment or education to gain employment;
3. Maintaining personal safety;
4. Maintenance of abstinence from substance use, including for those receiving medication assisted treatment, and maintenance of relapse prevention skills.

3.2.2 Admission Criteria

A comprehensive clinical assessment (CCA), that demonstrates medical necessity must be completed by a licensed clinician prior to the provision of this service. If a substantially equivalent assessment is available, reflects the current level of functioning, and contains all the required elements as outlined in community practice standards as well as in all applicable federal and state requirements, it may be used as part of the current CCA. Relevant clinical information must be obtained and documented in the individual's Person-Centered Plan (PCP).

3.2.3 Continued Stay Criteria

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

a. The desired outcome or level of functioning is achievable with PSS but has not been restored, improved, or sustained over the time frame documented in the individual's PCP;

b. The individual has a high risk for relapse or self-harm based on current clinical assessment or reassessment and PSS interventions are expected to reduce the high risk, or the tenuous nature of the functional gains; or

c. Continuation of service is supported by documentation of individual's progress toward goals within the individual's PCP.

d. The individual has been assessed for either a step-down to natural supports or a transition to more intensive clinical services; PSS remains the most clinically appropriate option at this time, and

The individual meets ONE of the following conditions:

a. Has achieved current PCP goals but additional goals are indicated by a current assessment or reassessment.

b. Continuation of service is supported by documentation of individual's progress toward goals within the individual's PCP.
c. The desired outcome or level of functioning is achievable with PSS but has not been restored and it is necessary to amend interventions in the individual's PCP.

3.2.4 Transition and Discharge Criteria

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

a. The individual's level of functioning has improved with respect to the goals outlined in the PCP, inclusive of a transition plan to step down to a lower level of care;
b. The individual has achieved positive life outcomes that support stable and ongoing recovery and are no longer in need of Peer Support Services;
c. The individual is not making progress or is regressing, and all reasonable strategies and interventions have been exhausted, indicating a need for more intensive services; or
d. The individual chooses to withdraw from Peer Support Services, or the legally responsible person(s) chooses to withdraw the individual from services.

Transition and discharge planning shall begin at admission and be documented in the service record. The discharge plan shall be developed in collaboration with the individual and reviewed every 60 calendar days with Peer Support Service (PSS) Program Supervisor.

State-funded Additional Criteria Covered

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, 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 from the individual or their legally responsible person. 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 individual privacy and confidentiality is protected.

4.0 When the Service is Not Covered

4.1 General Criteria Not Covered

State-funded shall not cover the procedure, product, or 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 procedure, product, or service duplicates another provider's procedure, product, or service; or
d. the procedure, product, or service is experimental, investigational, or part of a clinical trial.

4.2 Specific Criteria Not Covered

4.2.1 Specific Criteria Not Covered by State-funded

State-funded shall not cover the following activities of Peer Support Services:

a. Transportation for the individual or family members;
b. Habilitation activities or goals;
c. Time spent performing, attending or participating in recreational activities unless to address a recovery goal in an individual's Person-Centered Plan;
d. Clinical and administrative supervision of the Peer Support Specialist 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 others responsible for providing care and supervision;
g. Services provided to teach academic subjects or as a substitute for education personnel;
h. Interventions not identified in the individual's Person-Centered Plan;
i. Services provided to children, spouse, parents or siblings of the individual under treatment or others in the individual's life to address problems not directly related to the individual's recovery needs and not listed on the Person-Centered Plan;
j. Payment for room and board; and

k. Digital text-based messages via mobile device or internet applications and email correspondence.

4.2.2 State-funded Additional Criteria Not Covered

None Apply.

5.0 Requirements for and Limitations on Coverage

5.1 Prior Approval

State-funded shall not require prior approval for Peer Support Services.

5.2 Prior Approval Requirements

5.2.1 General

None Apply.

5.2.2 Specific

None Apply.

5.3 Limitations or Requirements

a. An individual can receive PSS from only one provider organization during an episode of care.
b. Family members or legally responsible person(s) of the individual are not eligible to provide this service to the individual.
c. An individual with a sole diagnosis of Intellectual/Developmental Disabilities is not eligible for PSS funded by State-funded.
d. PSS must not be provided to an individual to address primary medical diagnosis not related to mental health or substance use disorder recovery.
e. PSS must not be billed or provided to substitute or supplement staffing requirements of any facility-based service.
f. PSS must not be provided to an individual receiving Assertive Community Treatment (ACT), as a peer support specialist is a required position of that team.
g. PSS must not be provided to an individual receiving Community Support Team (CST), as peer support may be a component of the service and an individual who is in need of CST and peer support will be offered CST providers who have peers on the team.
h. PSS must not be provided during the same time of day when an individual is receiving Substance Abuse Intensive Outpatient Program (SAIOP) or Substance Abuse Comprehensive Outpatient Treatment (SACOT), Partial Hospitalization, Psychosocial Rehabilitation (PSR), Respite, or Individual and Transitional Support (ITS) services.
i. PSS must not be provided during the same time of day when an individual is receiving Individual Placement and Support (IPS).

j. PSS must not be provided during the same episode of care as other State-funded services with duplicative components.
k. Transportation of an individual is not covered as a component for this policy. This limitation does not impact an individual's ability to access non-emergency medical transportation (NEMT).
l. PSS must not be provided to an individual receiving Clinically Managed Population Specific High-Intensity Residential Program; Clinically Managed Residential Services; or Medically Monitored Intensive Inpatient Services.

Note: PSS is not a "first responder" service. The PSS provider shall coordinate with an individual's health plan, clinical home, care manager, care coordinator or a crisis service provider to ensure crisis response services are accessible as documented in the individual's PCP.

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, physician assistant, nurse practitioner, licensed clinical mental health counselor, licensed clinical addiction specialist, licensed marriage and family therapist, licensed clinical social worker, or licensed psychologist per their scope of practice, prior to or on the first day service is rendered.

ALL the following apply to a service order:

If an urgent or emergent situation presents the need for a verbal order, standard procedures must be followed for the verbal order to be valid. Treatment may proceed based on a verbal order by the appropriate professional as long as the verbal order is documented in the recipient's service record on the date that the verbal order is given. The documentation must specify the following:

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-funded for the service. Even if the individual is retroactively eligible for State-funded the provider shall not bill State-funded without a valid service order; and
d. Service orders are valid for nine months. Medical necessity must be reviewed,
and service must be ordered at least every nine months, based on the date of the original PCP service order.

5.5 Documentation Requirements

The service record documents the nature and course of an individual's progress in treatment. To bill State-funded, 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-funded. 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. The PCP and a documented discharge plan must be discussed with the individual and documented in the service record.

Documentation is required as specified in the Records Management and Documentation Manual and service definition.

5.5.1 Contents of a Service Record

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. State-funded 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 PCP 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, amount of time spent delivering the intervention(s), must include the start time and end time;
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; and
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

Peer Support Services must be delivered by practitioners employed by organizations

that:

a. meet the provider qualification policies, procedures, and standards established by the NC State-funded;
b. meet the requirements of 10A NCAC 27G or equivalent federally recognized tribal code or federal regulation;
c. demonstrate that they meet these standards by being credentialed and contracted by a Prepaid Health Plan or Prepaid Inpatient Health Plan, or the Cherokee Indian Hospital Authority;
d. within one calendar year of enrollment as a provider with NC State-funded, 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 Provider Certification State-funded Enrollment Agreement, State-funded Bulletins and service implementation standards.

6.2 Provider Certifications

PSS services must be provided by a legally constituted entity that meets all of the requirements of the LME-MCO and is contracted with the LME-MCO to serve individuals with SED, moderate or severe SUD or I/DD or TBI. PSS must be provided by a Peer Support Specialist certified by North Carolina's Certified Peer Support Specialist Program (NC CPSS Program). CPSS must maintain an active NC certification to provide services included in this policy.

Providers of PSS shall maintain a roster of NC CPSS they employ to provide services included in this policy. The roster must include at a minimum:

a. The full name of the NC CPSS;
b. Date of hire;
c. Date of initial certification;
d. Date of recertification, when applicable; and
e. Date of separation, when applicable.

Providers shall ensure the NC CPSS Roster is accessible and ready to share with their contracted PHP or PIHP upon request.

6.2.1 Staffing Requirements

The Peer Support Services (PSS) program is provided by qualified providers with the capacity and adequate workforce to offer this service to eligible State-funded beneficiaries. PSS must be available during times that meet the needs of the individual which may include evening, weekends, or both. The PSS program must be under the direction of a full-time Qualified Professional (QP) who meets the requirements according to 10A NCAC 27G .0104 or equivalent federally recognized tribal code or federal regulation.

The PSS program must have designated competent mental health or substance use professionals to provide supervision to CPSS during the times of service provision.

The maximum program staff ratios are as follows: QP-to-CPSS is 1:8; CPSS-to-individual is 1:15; and group ratio for CPSS Group Facilitator-to-beneficiaries is 1:12.

CPSS shall not work outside the scope of their certification or core competencies. CPSS shall only provide services to an individual with similar lived experiences.

The following charts provide required services of the PSS Program Supervisor and core competencies of relationship building and peer support interaction for the CPSS (according to NC's Certified Peer Support Specialist Program).

Certified Peer Support Specialist
• Knowledge of peer support principles, values, and ethics. • Share lived experience to support, encourage and enhance an individual's treatment and recovery. • Possess recovery-oriented skills and knowledge to provide peer support services. • Collaborate with the program QP to assess their own strengths and areas of growth and develop an individual supervision plan. • Explore and identify barriers to accessing community resources or treatment providers with an individual. • Model and mentor recovery values, attitudes, beliefs, and personal actions to encourage wellness and resilience for beneficiaries served and to promote a recovery environment in their community, residence, and workplace. • Collaborate with an individual in identifying their strengths; establishing recovery goals and short-term objectives that reflect the individual's preferences and encourage self-determination. • Model the use of self-directed recovery tools, such as Wellness Recovery Action Planning (WRAP), and empower utilization of tools by an individual. • Explore with an individual served, the importance and creation of a wellness identity through open sharing and challenging viewpoints. • Identify teachable moments for building relationship skills to empower the individual and enhance personal responsibility ~~and growth~~. • Model and share decision-making tools to enhance an individual's healthy decision-making process. • Provide examples of healthy social interactions and facilitate familiarity with, and connection to, the local community. • Recognize and appropriately respond to conditions that constitute an emergency to include both physical and behavioral health crisis utilizing the emergency response procedure of employer. • Educate and coach an individual in navigating systems (medical, social services, or legal). • Promote self-advocacy and empowerment by facilitating each individual's learning about their human and legal rights and supporting an individual while exercising those rights • Collaborate with program QP and an individual after discharge from a mental health or substance use disorder crisis service to review recovery tools and strategies for crisis prevention; and update the crisis plan. • Explore and identify challenges of transitioning to the community from an incarceration or institutional stay with an individual to develop strategies to maintain recovery in the community. • Collaborate with the individual's health plan, clinical home, care manager, care coordinator or other service provider(s) to support an individual's recovery.

6.2.2 Staff Training Requirements

To provide effective peer support services, all PSS program staff shall possess the knowledge and competencies of peer support principles,

values and ethics and participate in additional training required to provide the service. Required training for PSS program staff is as follows:

Timeframe	Training Required	Who
Within **30 calendar days** of hire to provide service	• Peer Support Services Policy components review • Documentation Training • Opioid Antagonist administration (Administering Naloxone or other Federal Food and Drug Administration approved opioid antagonist for drug overdose)	• All staff
	• NC Peer Support Supervisor Training	• Peer Support Services Program Supervisor
Within **60 calendar days** of hire to provide service	• Person-Centered Thinking • PCP Instructional Elements with Comprehensive Prevention and Intervention Crisis Plan Training	• Peer Support Services Program Supervisor
Annually	• Continuing education related to the population being served.	All staff

Peer support program staff shall complete initial requirements of training identified above within identified timeframes. The initial training requirements may be waived by the hiring agency if the employee can produce documentation certifying that training was completed no more than 24 months prior to hire date.

Peer support program staff shall participate in additional hours of peer support related training that is appropriate for the population being served. Additional training options for all PSS program staff include:

a. Trauma Informed Care
b. Wellness and Recovery Action Plan (WRAP)
c. Whole Health Action Management (WHAM)
d. Basic Mental Health and Substance Use 101
e. Mental Health First Aid
f. Housing First, Permanent Supportive Housing, Tenancy Support Training

6.3 Program Requirements

Peer support services are not a replacement for clinical care, but rather a complementary element that enhances the effectiveness of other mental health and substance use services. PSS work best when integrated into a broader, coordinated care system. If the provider of PSS does not offer other MH or SUD services, the PSS provider must partner with a MH or SUD provider, with a signed Memorandum of Understanding (MOU) or Memorandum of Agreement (MOA). The signed MOU or MOA must be submitted to the provider's contracted health plan(s) prior to providing PSS.

The MOA or MOU is an assurance that an individual receiving PSS will have access to medically necessary clinical services to enhance recovery and improve quality of life for beneficiaries with a mental health or substance use diagnosis.

Providers of PSS shall link an individual to needed mental health and substance use disorder services within 30 days of identifying a need.

The PSS program must follow the NC Certified Peer Support Specialist Program Code of Ethics and Conduct-and principles when rendering PSS services. All ethical issues must be reported to the NC CPSS Program and addressed under policies and procedures established by the hiring provider agency.

Providers of PSS are responsible for verifying CPSS providing the services in this policy are certified by the NC CPSS Program. Providers are required to:

a. Verify NC CPSS certification at the time of hire via the NC Certified Peer Support Specialist Program website;
b. Request and maintain a copy of the employee's active NC CPSS certificate in the employee's record;
c. Restrict CPSS from providing services when NC CPSS certification is expired or has been revoked; and
d. Report violations of the NC CPSS Program Code of Ethics and Conduct

6.3.1
Providers of PSS shall maintain a roster of NC CPSS they employ to provide services included in this policy. The roster must include at a minimum:

a. the full name of the NC CPSS;
b. date of hire; and
c. date of separation; when applicable

Providers shall submit the NC CPSS Roster to their contracted health plan(s) prior to the
last day of each quarter.

6.4 Expected Outcomes

The expected outcomes for this service are specific to recommendations resulting from clinical assessments and meeting the identified goals in the individual's PCP.
Expected outcomes:

a. increased engagement in self-directed recovery process;
b. increased natural and social support networks;
c. increased ability to engage in community activities;
d. increased ability to live independently as possible and use recovery skills to maintain a stable living arrangement;
e. higher levels of empowerment and hopefulness in recovery;
f. improved emotional, behavioral, and physical health;
g. improved quality of life;
h. improved vocational skills;
i. decreased substance use;

j. decreased frequency or intensity of crisis episodes; or
k. decreased use of crisis services or hospitalizations.

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/SUS's service definitions, guidelines, policies, provider manuals, implementation updates, and bulletins, DHHS, DHHS division(s) or fiscal contractor(s).

7.2 Audits and Compliance Reviews

LME-MCOs 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 LME-MCOs 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/SUS to ensure compliance with state funds and federal block grant regulations and requirements.

7.3 Regulatory Authority

The following resources, and the rules, manuals, and statutes referenced in them, give the Division of MH/DD/SUS the authority to set the requirements included in this policy:

a. Rules for Mental Health, Developmental Disabilities and Substance Abuse Facilities and Services, Administrative Publication System Manuals (APSM)30-1
b. DMHDDSUS Records Management and Documentation Manual, APSM 45-2
c. DMHDDSUS Person-Centered Planning Instruction Manual
d. N.C. Mental Health, Developmental Disabilities, and Substance Abuse Laws, 2001 (G.S. 122-C)

8.0 Policy Implementation and History

Original Effective Date:

History:

Date	Section or Subsection Amended	Change
	All Sections and Attachment(s)	
8/1/19	All Sections and Attachment(s)	New policy implementing Peer Support Services.
11/1/19	5.3 Additional Limitations or Requirements	5.3 d. & e. Clarification regarding PSS during ACT and CST authorizations; 5.3 f. Inclusion of PSR, respite and individual support services;
11/1/19	5.4 Service Orders	Revised language to include signature by a physician or other licensed clinician per his or her scope of practice prior to or on the first day service is rendered.
11/1/19	6.2.1 Staff Requirements	Provided clarification regarding PSS availability; Code of Ethics requirements and PSS supervision. Added requirement to PSS Supervisor responsibility to conduct routine reviews of service notes for quality assurance.
11/1/19	Attachment A: Claims-Related Information F.	Added emergency department as a place of service.
12/15/19	Attachment A	Added Note: The Division of MH/DD/SAS will not reimburse for conversion therapy.
11/1/21	Related Service Definition Policies	State-Funded Telehealth and Virtual Communications
	Subsection 3.1.1	Added new subsection 3.1.1 Telehealth Services.

	Subsection 3.1.2	Added new subsection 3.1.2 Telephonic Services
	Subsection 3.2.5.1	Added new subsection 3.2.5.1 Telephonic Specific- Criteria
	Subsection 5.5.1	Updated policy language. Deleted: “face-to face, phone”. Added: “in person, telehealth or telephonic, audio-only communication”.
	Subsection 6.2.1	Updated policy language. Deleted: “face-to-face” and “telephone”. Added: “in-person, telehealth or telephonic, audio-only communication”.
	Attachment A, letter C	Added columns to service codes indicating if the services were eligible for telehealth and telephonic, audio-only communication. Added “Note: Telehealth and telephonic, audio-only communication eligible services may be provided to both new and established individuals by the eligible providers listed within this policy
	Attachment A, Letter D	Added the following language for telehealth services: 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.
	Attachment A, Letter F	Deleted: “telephone” and “face-to-face”. Added: “telehealth or telephonic, audio-only” and “in-person”. Added language: Telehealth and telephonic, audio-only communication claims should be filed with the provider’s usual place of service code(s).
	Added beginning of Policy	Added the language: This service definition policy has an effective date of November 1, 2021; however, until the end of the public health emergency, the temporary coverage and reimbursement flexibilities enabled by the Division of MH/DD/SAS through a series of Joint Communication Bulletins will remain in effect.
8/15/22	Subsection 3.2.1, Letter b.	Technical change: deleted “the Level of Care criteria for Locus Level 1”.

Attachment A: Claims-Related Information

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

A. Claim Type

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

Provider(s) shall report the ICD-10-CM and Procedure 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 procedure, product or service provided. Provider(s)shall use the Current Procedural Terminology (CPT), Healthcare Common 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 procedure, product or service using the appropriate unlisted procedure or service code.

HCPCS Code(s)	

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 the applicable modifiers.

E. Billing Units

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

Units are billed in fifteen(15) minute increments.

Only services provided by NC Certified Peer Support Specialist may be billed. Services and supervision provided by Peer Support Program Supervisor is covered as an indirect cost and therefore must not be billed separately.

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 XXX network providers' adherence to service guidelines to assure quality services for recipients served.

F. Place of Service

For a recipient with a mental health diagnosis or substance use disorder. PSS is a direct periodic service provided in a range of community settings. It may be provided in the beneficiary's place of residence, community, in an emergency department, or in an office setting. It may not be provided in the residence of PSS staff.

The intent of the service is to be community-based rather than office-based. 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 contacts and is limited to twenty (20) ten percent or less of total service time provided per beneficiary per fiscal year. Documentation of service rendered via telehealth or telephonic, audio-only communication with the beneficiary or collateral contacts (assisting beneficiary 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).

OR

This service is not Medicaid billable.

G. Co-payments

Not applicable

H. Reimbursement

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

Note: DMH/DD/SUS will not reimburse for conversion therapy.