

To all beneficiaries enrolled in a Prepaid Health Plan (PHP): for questions about benefits and services available on or after implementation, please contact your PHP.

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Related Clinical Coverage Policies

Refer to <https://medicaid.ncdhhs.gov/> for the related coverage policies listed below:

8C- *Outpatient Behavioral Health Services Provided by Direct-Enrolled Providers*

8A- *Enhanced Mental Health and Substance Abuse Services*

8A-1- *Assertive Community Treatment Team (ACT) Program*

1.0 Description of the Procedure, Product, or Service

Individual Placement and Support (IPS) is a person-centered behavioral health service with a focus on employment and education. IPS assists in choosing, acquiring, and maintaining competitive paid employment in the community for a beneficiary 16 years and older, with significant behavioral health needs, for whom employment has not been achieved or employment has been interrupted or intermittent. This service is provided by Employment Support Professionals (ESPs) and Employment Peer Mentors (EPMs) who are trained in the evidence-based practice to support the vocational needs of a beneficiary, to promote community connections, and employment success.

The foundation for this policy is the IPS evidence-based Supported Employment model and IPS-Supported Employment (SE) Fidelity Scale developed by the Dartmouth Psychiatric Research Center and promoted by the Substance Abuse Mental Health Services Administration (SAMHSA). It is required that any provider delivering IPS align service delivery to the fidelity model. IPS assists beneficiaries in securing competitive employment in the community that fits their particular needs, interests, and skills while enabling workplace success. These jobs can be part-time or full-time and can include self-employment.

IPS teams shall have a zero-exclusion criterion, meaning that a beneficiary is not disqualified from engaging in employment because of readiness factors (such as active substance use, criminal background issues, active mental health symptoms, treatment or medication non-adherence, or personal presentation.) A beneficiary is not required to participate in pre-vocational training or other job readiness models. IPS teams assist in addressing barriers to employment through behavioral health integration.

1.1 Definitions

Severe and Persistent Mental Illness (SPMI)-

As defined in NC General Statute 122C-3. Definitions (33a) “a mental disorder suffered by persons of 18 years of age or older that leads these persons to exhibit emotional or behavioral functioning that is so impaired as to interfere substantially with their capacity to remain in the community without supportive treatment or services of a long term or indefinite duration. This disorder is a severe and persistent mental disability, resulting in a long-term limitation of functional capacities for the primary activities of daily living, such as interpersonal relations, homemaking, self-care, employment, and recreation.”

Serious Mental Illness (SMI)-

As defined by the Substance Abuse Mental Health Services Administration (SAMHSA), “SMI is defined by 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.”

Serious Emotional Disturbance (SED)-

As defined by SAMHSA, “for people under the age of 18 years of age, the term Serious Emotional Disturbance refers to a diagnosable mental, behavioral, or emotional disorder in the past year which resulted in functional impairment that substantially interferes with or limits the child’s role or functioning in family, school, or community activities.”

Career Profile-

A comprehensive vocational assessment of a beneficiary’s strengths, abilities, and interests relating to employment and education. Identifies work preferences, supports needed, and other information pertinent to a beneficiary’s employment and education goals.

2.0 Eligibility Requirements

2.1 Provisions

2.1.1 General

(The term “General” found throughout this policy applies to all Medicaid policies)

- a. An eligible beneficiary shall be enrolled in the NC Medicaid Program (*Medicaid is NC Medicaid program, unless context clearly indicates otherwise*).
- b. Provider(s) shall verify each Medicaid beneficiary’s eligibility each time a service is rendered.
- c. The Medicaid beneficiary 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. Medicaid

An applicant may be approved for Medicaid if the applicant meets all eligibility requirements. A beneficiary may become retroactively eligible for Medicaid while receiving covered services.

Retroactively eligible beneficiaries are entitled to receive Medicaid 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. The qualified provider may file for reimbursement with Medicaid for these services.

Medicaid shall cover IPS services for an eligible beneficiary who is 16 years of age and older and meets the criteria in **Section 3.0** of this policy.

2.2 Special Provisions

2.2.1 EPSDT Special Provision: Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age

a. 42 U.S.C. § 1396d(r) [1905(r) of the Social Security Act]

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or procedures for Medicaid beneficiary under 21 years of age **if** the service is **medically necessary health care** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination (includes any evaluation by a physician or other licensed practitioner).

This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his or her health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

Medically necessary services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the beneficiary's physician, therapist, or other licensed practitioner; the determination process does not delay the delivery of the needed service; and the determination does not limit the beneficiary's right to a free choice of providers.

EPSDT does not require the state Medicaid agency to provide any service, product or procedure:

1. that is unsafe, ineffective, or experimental or investigational.
2. that is not medical in nature or not generally recognized as an accepted method of medical practice or treatment.

Service limitations on scope, amount, duration, frequency, location of service, and other specific criteria described in clinical coverage policies may be exceeded or may not apply as long as the provider's documentation shows that the requested service is medically necessary "to correct or ameliorate a defect, physical or mental illness, or a condition" [health problem]; that is, provider documentation shows how the service, product, or procedure meets all EPSDT criteria, including to correct or improve or maintain the beneficiary's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

b. EPSDT and Prior Approval Requirements

1. If the service, product, or procedure requires prior approval, the fact that the beneficiary is under 21 years of age does **NOT** eliminate the requirement for prior approval.
2. **IMPORTANT ADDITIONAL INFORMATION** about EPSDT and prior approval is found in the *NCTracks Provider Claims and Billing Assistance Guide*, and on the EPSDT provider page. The Web addresses are specified below.

NCTracks Provider Claims and Billing Assistance Guide:
<https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html>

EPSDT provider page: <https://medicaid.ncdhhs.gov/>.

3.0 When the Procedure, Product, or Service Is Covered

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.

3.1 General Criteria Covered

Medicaid shall cover the procedure, product, or service related to this policy when medically necessary, and:

- a. 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 beneficiary's needs;
- b. the procedure, product, or service can be safely furnished, and no equally effective and more conservative or less costly treatment is available statewide; and
- c. the procedure, product, or service is furnished in a manner not primarily intended for the convenience of the beneficiary, the beneficiary's caretaker, or the provider.

3.2 Specific Criteria Covered

3.2.1 Specific criteria covered by Medicaid

None Apply.

3.2.2 Medicaid Additional Criteria Covered

Medicaid shall cover IPS when ALL following criteria are met:

- a. The beneficiary is 16 years of age and older;
- b. The beneficiary meets criteria for one or more of the following as defined in **Section 1.1:**
 1. Serious Mental Illness (SMI);
 2. Severe and Persistent Mental Illness (SPMI);
 3. Serious Emotional Disturbance (SED); or
 4. a severe substance use disorder as defined by the Diagnostic and Statistical Manual of Mental Disorders-5 (DSM-5), or any subsequent versions.
- c. The beneficiary has expressed the desire to work at the time of entrance to the program;
- d. The beneficiary has at least ONE or more of the following:
 1. an established pattern of unemployment, underemployment, or sporadic employment; or
 2. educational goals that relate to employment goals;**and**
- e. A need for assistance in obtaining or maintaining employment in addition to what is typically available from the employer because of functional limitations as described above and behaviors associated with SMI, SPMI, SED, or a severe SUD.

3.2.2.1 Admission Criteria

- a. A standardized independent evaluation completed by the Division of Health Benefits to determine beneficiary eligibility for 1915(i) benefit based on the needs-based criteria; and
- b. An Independent Assessment completed by a tailored care manager or the Cherokee Indian Hospital Authority (CIHA) for Tribal members that indicates the beneficiary would benefit from Individual Placement and Support.

3.2.2.2 Continued Service Criteria

The beneficiary shall continue receiving IPS services if they meet at least one of the following requirements:

- a. has made little progress in meeting employment goals, and there is documentation that supports that continuation of IPS is effective in meeting employment goals identified in the Career Profile;
- b. is making progress in meeting employment goals, but the interventions identified in the Career Profile need to be modified to maintain competitive employment;
- c. has obtained a job, it has been less than a year since starting employment and requires follow-along supports as identified in the Career Profile;
- d. needs follow-along support in learning how to manage benefits (Social Security); or
- e. needs support to change jobs, increase hours of employment, or advance in their career.

3.2.2.3 Discharge Criteria

The decision to discharge must be based on one or more of the following and documented in the service record of the beneficiary:

- a. has achieved positive employment outcomes that support stable and ongoing vocational recovery, and is no longer in need of IPS;
- b. has requested that IPS be discontinued; or
- c. no longer meets eligibility for 1915(i) services.

4.0 When the Procedure, Product, or Service Is Not Covered

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.

4.1 General Criteria Not Covered

Medicaid shall not cover the procedure, product, or service related to this policy when:

- a. the beneficiary does not meet the eligibility requirements listed in **Section 2.0**;
- b. the beneficiary 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 Medicaid

None Apply

4.2.2 Medicaid Additional Criteria Not Covered

In addition to the specific criteria not covered in **Subsection 4.2.1** of this policy, Medicaid shall not cover:

- a. Services provided to teach academic subjects or as a substitute for educational personnel, including a teacher, teacher's aide, or an academic tutor;
- b. Pre-vocational classes;
- c. Supports or services to help with volunteering;
- d. Services that support beneficiaries in set-aside jobs for people with disabilities, enclaves, mobile work crews, or transitional employment positions;
- e. Group employment searches or classes;
- f. Habilitative services for the beneficiary to acquire, retain, and improve the self-help, socialization, and adaptive skills necessary to reside successfully in community settings;
- g. Non-employment-related transportation for the beneficiary or family members;
- h. Any services provided to family, friends, or natural supports of the beneficiary receiving IPS to address problems not directly related to the beneficiary's issues and not listed on the Career Profile;
- i. Clinical and administrative supervision of staff IPS staff, which is covered as an indirect cost and part of the rate;
- j. Time spent in meetings where the eligible beneficiary is not present;
- k. Time spent attending or participating in recreational activities;
 - l. Covered services that have not been rendered;
- m. Childcare services or services provided as a substitute for the parent or other individuals responsible for providing care and supervision;
- n. Interventions not identified on the beneficiary's service plan;
- o. Service provided under the Rehabilitation Act of 1973;
- p. Special education provided under the Individuals with Disabilities Education Act (IDEA); or
- q. Payment for room and board.

5.0 Requirements for and Limitations on Coverage

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.

5.1 Prior Approval

Medicaid shall not require prior approval of Individual Placement and Support.

5.2 Prior Approval Requirements

5.2.1 General

None Apply.

5.2.2 Specific

None Apply.

5.3 Additional Limitations or Requirements

IPS providers must refer a beneficiary to the Division of Vocational Rehabilitation Services (DVRS) or Vocational Opportunities of Cherokee for eligibility determination of employment services. A referral must be made at the initiation of IPS.

IPS services are community based, individualized, and are provided as the beneficiary needs and requests the interventions. IPS staff must spend 65 percent or more of total scheduled work hours in the community. Frequency and intensity of services must be documented in the beneficiary's Career Profile and must be individualized. Interventions may be provided on-site, at the beneficiary's place of employment, or off-site. ESPs must pay special attention to disclosure preferences and business relations.

A beneficiary can receive IPS from only one provider organization during an episode of care. IPS services can only be billed when providing employment services and supports directly to the beneficiary or on behalf of the beneficiary. IPS cannot be billed for meetings, paperwork, documentation, or travel time.

IPS services must not be provided during the same episode of care as Assertive Community Treatment (ACT).

Note: IPS is not a "first responder" service. As documented in the beneficiary's care plan, or Career Profile, the service provider shall coordinate with other service providers to ensure "first responder" coverage and crisis response for the beneficiary.

5.4 Service Orders

- a. A service order is a mechanism to demonstrate medical necessity for a service and is based upon an assessment of the beneficiary's needs. A signed service order must be completed by one of the following per their scope of practice:
 1. a qualified professional;
 2. licensed behavioral health clinician;
 3. licensed psychologist;
 4. physician;
 5. nurse practitioner, or
 6. physician assistant.

Note: A service order is valid for one calendar year. Medical necessity must be revisited, and service must be ordered at least annually, based on the date of the original service order.

- b. **ALL the following apply to a service order:**
1. Backdating of the service order is not allowed;
 2. Each service order must be signed and dated by the authorizing professional and must indicate the date on which the service was ordered; and
 3. A service order must be in place prior to or on the first day that the service is initially provided, to bill Medicaid for the service. Even if the beneficiary is retroactively eligible for Medicaid, the provider cannot bill Medicaid without a valid service order.

5.5 Documentation Requirements

The service record documents the nature and course of a beneficiary's progress in treatment. To bill Medicaid, providers must ensure that their documentation is consistent with the requirements contained in this policy. A full-service note must be written per date of service. The staff member who provides the service is responsible for accurately documenting the services billed to and reimbursed by Medicaid. The staff person who provides the service must sign and date the written entry. The signature must include credentials for the staff member who provided the service.

A Career Profile is required. If the beneficiary receives an enhanced service, employment and other services received must be identified by the clinical home on the integrated Person-Centered Plan with an attached in-depth Career Profile.

A documented discharge plan must be discussed with the beneficiary and contained in the service record and coordinated with other providers when engaged in an enhanced service.

5.5.1 Contents of A Service Note

A full-service note is required for each contact or intervention provided to a beneficiary that is written and signed by the person who provided the service. A service note must document ALL following elements:

- a. Beneficiary name;
- b. Medicaid identification number;
- c. Date of service provision;
- d. Name of service provided;
- e. Type of contact (in-person, phone call, collateral);
- f. Place of service;
- g. Purpose of contact as it relates to the Career Profile and care plan goals;
- h. Description of the interventions provided. Documentation of the intervention must accurately reflect treatment for the duration of time indicated;
- i. Duration of service, amount of time spent performing the intervention;
- j. Assessment of the effectiveness and of interventions and the beneficiary's progress towards the beneficiary's goals; and
- k. Date, signature, credentials or job title of staff member who provided the service; and
- l. Each service note page must be identified with the beneficiary's name, Medicaid identification number and record number.

6.0 Provider(s) Eligible to Bill for the Procedure, Product, or Service

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

- a. meet Medicaid qualifications for participation;
- b. have a current and signed North Carolina Department of Health and Human Services (DHHS) Provider Administrative Participation Agreement; and
- c. bill only for procedures, products, and 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

IPS services must be delivered by providers employed by behavioral health organizations that:

- a. meet the provider qualification policies, procedures, and standards established by NC Medicaid;
- b. meet the requirements of 10A NCAC 27G or substantially equivalent federal/IHS regulations;
- c. demonstrate that they meet these standards by being credentialed and contracted by the DHHS designated contractor or the Cherokee Indian Hospital Authority;
- d. within one year of enrollment as a provider with NC Medicaid, achieve national accreditation with at least one of the designated accrediting agencies;
- e. become established as a legally constituted entity capable of meeting all the requirements of the Provider Certification Medicaid Enrollment Agreement, Medicaid Bulletins and service implementation standards; and
- f. are a current Division of Vocational Rehabilitation Services (DVRS) vendor for IPS services or are in the process of becoming a vendor with DVRS or a vendor with Vocational Opportunities of Cherokee.

6.2 Provider Certifications

IPS must be delivered by a behavioral health provider organization that meets the provider qualification policies, procedures and standards established by DHHS and the requirements of 10A NCAC 27G .5800 Supported Employment For Individuals Of All Disability Groups or substantially equivalent federal/IHS regulation.

Providers operating IPS teams shall be evaluated by DHHS or state approved contractor according to a standardized fidelity measure to evaluate the extent to which defining elements of the program model are being implemented. The IPS-SE Fidelity Tool, or its successor as approved by DHHS, must be used to measure a team's level of implementation of the IPS model. The aim of these evaluations is not only to ensure that the model is being implemented as intended, but also to provide a mechanism for quality improvement feedback and guided consultation.

DHHS shall track adherence to the IPS model through their participation in the administration of the most current IPS fidelity assessment. PIHPs and providers shall monitor adherence to the IPS model, overall fidelity and zero exclusion scores, and competitive employment rates for population served by conducting record reviews and audits.

A tiered certification process for IPS teams must be used to guide technical assistance and consultation. These tiers define ranges for exceptional practice and provide opportunities for growth for marginal teams through strategic plans for improvement of practice.

Programs must participate in a baseline fidelity review after a minimum of six consecutive months of continuous operation.

New IPS teams that do not have the required staffing or are serving less than 20 beneficiaries after six months of continuous operation shall meet with DHHS and PIHP staff to review the barriers to completing a baseline fidelity evaluation. An IPS Fidelity Action Plan that clearly identifies all current barriers as well as specific steps to address the barriers to program implementation must be developed and shared with DHHS and PIHP Provider Network staff. In these cases, a baseline fidelity evaluation must be scheduled three consecutive months after the development of the IPS Fidelity Action Plan.

An IPS team must score a minimum of 74 on fidelity evaluations to maintain certification.

Subsequent fidelity reviews are required to be scheduled based on the most recent fidelity review score.

Table 1. Tiered Certification Process for IPS Based on the IPS- Fidelity Tool Total Rating and Subsequent Fidelity Evaluation Timeframe		
<i>Certification</i>	<i>Score Range</i>	<i>Follow Up Timeframe</i>
Fair Fidelity Level	Rating 74-99	6 months after final report is received
Good Fidelity Level	Rating 100-114	12 months after final report is received
Exemplary Fidelity Level	Rating 115-125	18 months after final report is received

After receiving and reviewing the draft IPS fidelity report, IPS teams that score a 74 or higher are allowed to contest no more than three scoring items. IPS teams that score 73 or lower are allowed to contest more than three scoring items. IPS teams contesting scoring items must submit concrete data that was current at the time of the on-site evaluation. Any data provided that reflects practice after the last day of the on-site fidelity evaluation must not be considered or reviewed. Contesting data must be submitted to the fidelity evaluation team no later than 10 business days after the receipt of the draft IPS fidelity report.

6.2.1 Staffing Requirements:

Table 1. IPS Staffing Level Requirements, Experience and Qualifications:

IPS Team Lead	Must be a Qualified Mental Health Professional (QMHP), with at least 6 months of vocational experience. Certified IPS (CIPS) or Certified Employment Support Professional (CESP) credential recommended
Employment Support Professional (ESP)	Must be a QMHP, or Associate Mental Health Professional (AMHP), CIPS, or CESP
Employment Peer Mentor (EPM)	Must be a NC Certified Peer Support Specialist (CPSS), who has a minimum education of a High School (HS) Diploma or has passed a General Educational Development (GED) exam. Recommend a CPSS with an employment history in the recent past.
Benefits Counselor	Must be either a Certified Work Incentives Counselor (CWIC) or a Credentialed Work Incentives Planner-Credentialed (WIP-C CWIP) and have a minimum of a HS diploma or has passed a GED exam. A benefits counselor must have either their CWIC or WIP-C CWIP certification within six months of hire date.
Program Assistant	Must have minimum of a HS diploma or has passed a GED exam

The following charts reflect the activities and appropriate scopes of practice for the IPS team members:

IPS Team Lead
<ul style="list-style-type: none"> • Drive the delivery of the service. • Oversee the operations of the program or team to support high fidelity program implementation. • Provide oversight of employment services and collaborates with behavioral health supports. • Supervise staff to assure the delivery of evidence-based and ethical practices. • Provide weekly outcome-based supervision and monthly field mentoring with each staff member. • Collaborate with DVRS to discuss referrals and problem solve barriers. • Directly provide IPS services, maintaining a caseload of no more than nine beneficiaries. • Provide psychiatric rehabilitation interventions that support employment and educational goals. • Ensure the integration of IPS with other mental health services. • Use assertive engagement strategies to continuously engage beneficiaries in IPS services.

Employment Support Professional (ESP)
<ul style="list-style-type: none"> • Use assertive engagement strategies to continuously engage beneficiaries in IPS services. • Directly provide IPS services to beneficiaries, maintaining a caseload of no more than 25 beneficiaries. • Promote self-determination, recovery, self-advocacy, and self-direction. • Assist in identifying strengths, wellness goals, setting objectives, and identifying barriers. • Explore career and educational aspirations. • Develop the Career Profile and the ongoing revisions and guides their implementation for beneficiaries on their caseload.

- Collaborate with EPMs, DVRS, behavioral health providers, families, natural supports, housing, transportation, Tailored Care Management (TCM) or Care Coordination provider and other community service providers who support the beneficiary.
- Assist in obtaining the proper documentation necessary for employment.
- Case management functions shall not exceed more than five percent of the ESP's FTE.
- Coordinate services and assuring person-centeredness in the employment planning process.
- Develop relationships with employers by learning about their businesses, hiring practices, hiring preferences, and business priorities over multiple in- person visits that will meet the employment goals of the beneficiary.
- Provide psychiatric rehabilitation interventions that support employment and educational goals.

Employment Peer Mentor (EPM)

- Use assertive engagement strategies to continuously engage beneficiaries in IPS services.
- Promote self-determination, recovery, self-advocacy, and self-direction.
- Assist in identifying strengths, wellness goals, setting objectives, and identifying barriers.
- Explore career and educational aspirations.
- Attend treatment team meetings to promote the use of self-directed advocacy tools.
- Assist in the vocational assessment and employment goal planning and participates in the development of the Career Profile.
- Assist in learning how to ask for appropriate services in community.
- Model self-advocacy skills for addressing disclosure issues or requesting job accommodations.
- Teach wellness management strategies and help develop self-management plan and tools to use in the workplace and in their personal lives.
- Use manualized strategies such as Illness Management and Recovery (IMR), Wellness Management and Recovery (WMR), Wellness Recovery Action Plan (WRAP), Vocational IMR, and others.
- Connect to support groups in the community to learn from other peers, promote hope, problem-solve through work situations, and decrease social isolation.
- Provide education to increase the IPS team's understanding of self-advocacy and peer support roles, and promote a culture in which beneficiary's point of view and preferences are recognized, understood, respected, and integrated into service delivery.
- Share their personal story to model how to choose, obtain, and keep employment.
- Support making informed decisions about employment and building community connections.
- Assist with building social skills in the community that enhance job acquisition and tenure.
- Attend community recovery support groups meetings with the beneficiary, if appropriate.
- Assist with financial wellness using tools for money management and asset development.
- Provide psychiatric rehabilitation interventions that support employment and educational goals.

Benefits Counselor

- Create a written Work Incentive Benefits Analysis or amends a written Work Incentive Benefits Analysis in the event of changes in income.
- Support the beneficiary in accessing work incentives, (1916b) subsidies, Impairment Related Work Expense (IRWE), Plan to Achieve Self Support (PASS).
- Develop IRWEs, Subsidies, Special Conditions, and PASS.
- Gather and report accurate information about benefits.
- Support a better understanding of benefits and working and address any concerns regarding the impact of working on benefits.

- Support the development of a plan to maximize earning potential, report earnings, and navigate the benefit systems the beneficiary is involved in or seeks to gain involvement in.
- Provide a report explaining the results of the work incentive benefit analysis, including any changes to benefits.
- Provide a list of work incentives available, as applicable.
- Support the beneficiary to access the work incentive they want to use.

Program Assistant
<ul style="list-style-type: none"> • Organize, coordinate, and monitor all administrative operations of the team. • Maintain client and programmatic records. • Enter and track team performance and beneficiary outcome data. • Run reports. • Receive calls and responds to referral sources. • Assist with organizational record-keeping. • Manage human resources and continuing education files for ESPs. • Schedule activities.

6.2.2 Staff Training Requirements

Time Frame	Training Required	Who	Total Minimum Hours Required
Within 90 <u>calendar days</u> of hire to provide service	▪ DHHS approved Individual Placement and Support 101	IPS Team Lead, ESP, EPM, Benefits Counselor	Hours to commensurate with DHHS approved training
	▪ DHHS approved person-centered Employment Planning	IPS Team Lead, ESP, EPM	Hours to commensurate with DHHS approved training
	▪ Supervising NC Certified Peer Support Specialists	IPS Team Lead	Hours to commensurate with DHHS approved training
Within six consecutive months of hire to provide this service	▪ DHHS approved Employment Peer Mentoring	EPM	Hours to commensurate with DHHS approved training
	▪ Motivational Interviewing or Motivational Interviewing for Employment*	IPS Team Lead, ESP, Benefits Counselor	Hours to commensurate with DHHS approved training

Time Frame	Training Required	Who	Total Minimum Hours Required
Annually	<ul style="list-style-type: none"> ▪ Employment and IPS fidelity focused training and training related to the populations being served 	IPS Team Lead, ESP, EPM, Benefits Counselor	10 hours

DMHDDSUS shall maintain the authority to approve DHHS trainers and to monitor and update training curricula as needed.

The initial training requirements may be waived by the hiring agency if the employee can produce documentation certifying that training appropriate for the population being served was completed no more than 48-months prior to hire date.

* Training must be approved and certified by a nationally recognized program that issues continuing education for licensed or clinical professionals. Some examples of approved programs include North Carolina Addictions Specialist Professional Practice Board (NCASPPB), National Association for Addiction Professionals (NAADAC), National Board for Certified Counselors (NBCC) Approved Continuing Education Provider (ACEP), National Association of Social Work (NASW), and Motivational Interviewing Network of Trainers (MINT). If a staff person is a MINT trainer, they are not required to have this training. The training requirement for MINT Motivational Interviewing may be waived by the hiring agency if the employee can provide documentation certifying prior completion.

IPS teams that score between a 74 and a 99 on their fidelity evaluation shall be required to participate in technical assistance provided by a DHHS approved technical assistance vendor. The IPS team shall meet with their PIHP(s) to review the Fidelity Action Plan, and the PIHP(s) shall identify the number of hours of technical assistance the team shall receive in the next 12 months. The PIHP(s) monitor the team’s progress toward completing the Fidelity Action Plan.

6.3 Program Requirements

IPS is a clearly defined evidence-based practice for supporting beneficiaries with serious mental illness and substance use disorders in finding and maintaining competitive employment. Agencies providing IPS services shall reference the materials provided by the model developers, which can be found at ipsworks.org and institutebestpractices.org. Services are community based, individualized, and are provided as the beneficiary needs and requests the interventions (daily, weekly, monthly). Services are not provided in groups or congregate settings. IPS staff spend 65 percent or more of total scheduled work hours in the community. Frequency and intensity of services must be documented in the Career Profile. Interventions can be provided on-site (at the beneficiary’s place of employment) or off-site.

ESP shall pay special attention to disclosure preferences and business relations. Not every beneficiary needs daily or weekly support, and not every beneficiary wants on-site support.

The IPS Team shall have weekly vocational unit meetings inclusive of all IPS staff to review caseloads, share beneficiaries' progress, successes, and needs, job leads, and other issues. In-person meetings are preferred. IPS teams can use a virtual telehealth platform that is Health Insurance Portability and Accountability Act (HIPAA) compliant for vocational unit meetings for no more than three meetings a month. It is recommended that cameras are used during this meeting. Telephonic participation in the vocational unit meetings is not allowed.

The IPS model requires behavioral health integration. This service is co-located with a provider's behavioral health treatment services to ensure consistent behavioral health integration. If a provider does not offer integrated behavioral health services, the provider must partner with a behavioral health provider(s), with a signed Memorandum of Understanding (MOU) or Memorandum of Agreement (MOA). The signed MOU or MOA must be submitted to the PIHP prior to providing IPS service and shall include all the behavioral health components of the IPS Fidelity Model. The IPS team works side by side with a behavioral health team(s), meeting frequently to discuss beneficiaries they mutually serve. The IPS staff shall attend the behavioral health treatment team meeting weekly with their assigned behavioral health team(s). The treatment team meeting is hosted by the behavioral health team(s) and can include prescribers, therapists, counselors, nurses, or other staff that support the beneficiary in their psychiatric rehabilitation. In-person meetings are preferred. IPS teams can use a virtual telehealth platform that is HIPAA compliant for all treatment team meetings. It is recommended that cameras are used during this meeting. Telephonic participation in the behavioral health treatment team meetings is not allowed. Guidance is provided in the *Employment Behavioral Health Team for Individual Placement & Support (IPS)* policy, published November 15, 2017.

- a. IPS teams shall be a DVRS vendor, and actively collaborate with DVRS on the following areas:
 1. Referrals;
 2. shared beneficiaries;
 3. benefits counseling;
 4. shared outcomes, and
 5. access to funding.

Collaboration with DVRS must occur through scheduled, documented meetings at least monthly. In-person meetings are preferred. IPS teams can use a virtual telehealth platform that is HIPAA compliant for all vocational rehabilitation meetings. It is recommended that cameras are used during this meeting. Telephonic participation in the vocational rehabilitation meetings is not allowed.

- b. IPS teams shall provide services that align with the Practice Principles of Evidence-Based Supported Employment:
 1. Focus on Competitive Employment;
 2. Eligibility Based on Client Choice (Zero-Exclusion);
 3. Integration of Rehabilitation and Mental Health Services;
 4. Attention to Beneficiary Preferences;

5. Personalized Benefits Counseling;
 6. Rapid Job Search;
 7. Systematic Job Development; and
 8. Time Unlimited and Individualized Support.
- c. Critical elements of IPS are:
1. Development of the Career and Educational Profile;
 2. Ongoing Benefits Counseling;
 3. Behavioral Health Integration;
 4. Addressing Barriers to Employment;
 5. Employment Peer Mentor;
 6. Rapid Job Search and Systematic Job Development;
 7. Disclosure;
 8. Job Accommodations and Assistive Technology; and
 9. Follow-Along Supports.

IPS teams shall complete the Quarterly Outcome Tracking form and submit completed forms to DHHS for outcome monitoring. All IPS teams shall complete North Carolina-Treatment Outcomes and Program Performance System (NC-TOPPS) assessments on beneficiaries receiving services. This requirement is not applicable to Federally recognized tribal and Indian Health Service providers.

6.4 Expected Clinical Outcomes

Expected clinical outcomes for the beneficiary include the following:

- a. finds and maintains competitive employment consistent with their employment recovery goals;
- b. enrolls in or completes credits towards an educational program that can then be leveraged to find employment;
- c. increases the average number of hours worked a week; or
- d. increases their average pay.

7.0 Additional Requirements

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.

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) and record retention requirements; and
- b. All NC Medicaid's clinical (medical) coverage policies, guidelines, policies, provider manuals, implementation updates, and bulletins published by the Centers for Medicare and Medicaid Services (CMS), DHHS, DHHS division(s) or fiscal contractor(s). Federally recognized tribal and Indian Health Service (IHS) providers may be exempt to one or more of these items in accordance with Federal law and regulations.

8.0 Policy Implementation and History

Original Effective Date: November 1, 2023

History:

Date	Section or Subsection Amended	Change
11/01/2023	All Sections and Attachment(s)	New Policy
11/01/2023		Policy posted 11/06/2023 with an amended date of 11/01/2023
01/01/2025	Section 5.0	To comply with the Mental Health Parity and Addiction Equity Act and Code of Federal Regulations Title 42 Chapter IV Subchapter C Part 438 Subpart K, § 438.900 language referencing prior approval was revised; and language referencing, authorizations, and utilization management have been removed.
01/01/2025	Subsection 6.2.1	Program Assistant: Removed “Manage authorization requests”.

Attachment A: Claims-Related Information

Provider(s) shall comply with the *NCTracks Provider Claims and Billing Assistance Guide*, Medicaid bulletins, fee schedules, NC Medicaid’s clinical coverage policies and any other relevant documents for specific coverage and reimbursement for Medicaid.

Note: Federally recognized tribal and Indian Health Service providers may be exempt from one or more of these items in accordance with Federal law and regulations:

A. Claim Type

Professional (CMS-1500/837P transaction)

Institutional (UB-04/837I transaction)

Unless directed otherwise, Institutional Claims must be billed according to the National Uniform Billing Guidelines. All claims must comply with National Coding Guidelines.

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 procedure, product or 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 procedure, product or service using the appropriate unlisted procedure or service code.

HCPCS Code(s)	Billing Unit
H2023	1 unit =15 minutes

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.

HCPCS Modifier
U4

E. Billing Units

Provider(s) shall report the appropriate code(s) used which determines the billing unit(s). Federally recognized tribal or IHS providers may be entitled to alternate reimbursement methodologies under Federal Law.

F. Place of Service

Individual Placement and Support can be provided in the beneficiary's private primary residence, in a shelter, licensed group home, adult care home, the community or in an office setting.

G. Co-payments

For Medicaid refer to Medicaid State Plan:

<https://medicaid.ncdhhs.gov/meetings-notices/medicaid-state-plan-public-notices>

H. Reimbursement

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

For a schedule of rates, refer to: <https://medicaid.ncdhhs.gov//>