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:

1.0 Description of the Procedure, Product, or Service

Mental Health/Substance Abuse Targeted Case Management (MH/SA TCM) is a service for:

a. a NC Medicaid (Medicaid) beneficiary who has either a serious emotional disturbance, mental illness or a substance related disorder; or
b. a pregnant Medicaid beneficiary who has either a serious emotional disturbance, mental illness or a substance related disorder. Refer to **Subsection 2.0.**

The MH/SA case manager is required to coordinate and communicate with Community Care of North Carolina (CCNC) (if Medicaid the beneficiary is enrolled in CCNC), the beneficiary's primary care physician, and the Medicaid beneficiary's obstetrician and gynecologist (OBGYN), when applicable. CCNC and the primary care physician shall be responsible for coordination of the beneficiary's overall health care.

Note: The age at which a beneficiary is considered an adult is determined by the funding source. State-funded services for adults begin at age 18; Medicaid-funded services for adults begin at age 21, unless the beneficiary is eligible through EPSDT.

1.1 Case Management (MH/SA TCM)

Case management (MH/SA TCM) is an activity that assists beneficiaries to gain access to necessary care: medical, behavioral, social, and other services appropriate to their needs. Case management is individualized, person-centered, empowering, comprehensive, strengths-based, and outcome-focused. The functions of case management include:

a. Case Management Assessment;
b. Person-Centered Planning;
c. Referral and linkage; and
d. Monitoring and follow-up.

1.1.1 Case Management Assessment

A comprehensive and culturally appropriate case management assessment documents a beneficiary's service needs, strengths, resources, preferences, and goals to develop a Person-Centered Plan (PCP). The case manager gathers information regarding all aspects of the beneficiary, including medical, physical and functional, psychosocial, behavioral, financial, social, cultural, environmental, legal, and vocational or educational areas. The case management assessment integrates all current assessments including the comprehensive clinical assessment and medical assessments, including assessments and information from CCNC and the primary care physician. The case management assessment includes early identification of conditions and needs for prevention and amelioration. The case management assessment involves consultation with other natural and paid supports such as family members, medical and behavioral

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health providers, and educators to form a complete assessment. The case management assessment includes periodic reassessment to determine whether a beneficiary's needs or preferences have changed.

1.1.2 Person Centered Planning

The goal of person-centered planning is to assist the beneficiary to obtain the outcomes, skills, and symptom reduction that they desire. This is accomplished through listening to the beneficiary, beneficiary's family, and treatment providers, and developing action plans that will assist the beneficiary in moving toward achievement of their goals. A PCP is revised as the beneficiary's needs, preferences, and goals change.

Person centered planning is at the center of self-direction and self-management. All good plans are done in partnership with the beneficiary. The case manager, who knows the requirements for a plan and what must be accomplished, works in concert with the content experts who know the detail of what the plan needs to say. The content experts tend to be the beneficiary's family, friends, and providers who have lengthy experience with the beneficiary. The case manager uses a variety of person-centered practice tools and works with the beneficiary to whom the plan belongs, and others identified who know the beneficiary best to determine what is important to and for that beneficiary. The tools are also used to determine (from the perspectives of the beneficiary, the family and paid providers) what is currently working or not working, what is appropriate or not appropriate, what needs to be maintained or changed for the beneficiary.

Person centered planning is an ongoing process that drives the development and periodic revision of a plan based on the information collected from the beneficiary, family, other individual supports, and comprehensive clinical assessments or reassessments. The information gathered is translated into goals, outcome statements, and the actions necessary to address the medical, behavioral, social, and other service needs of the beneficiary.

The process of person-centered planning includes the case manager or plan facilitator thinking about what the beneficiary wants to learn, gathering information, developing a first plan, using that plan and continuing to record new learning. It is the new learning, based on documenting what has been successful, that then drives person-centered revisions to the plan.

The primary reference documents for person-centered planning and Person-Centered Plans are the Division of Mental Health/Developmental Disabilities/Substance Abuse Services (DMH/DD/SAS) *Person-Centered Planning Instruction Manual* and the *Records Management and Documentation Manual*. Primary source information on person-centered thinking and person-centered planning are referenced in the Division of Medical Assistance (NC Medicaid) / DMH/DD/SAS Implementation Update #73, dated June 3, 2010, located at: ttps://medicaid.ncdhhs.gov/. The case manager is required to contact the primary care physician to obtain clinical information pertinent to establishing person-centered goals. For managed care beneficiaries through CCNC, the case manager also contacts CCNC to obtain clinical information pertinent to establishing person-centered goals.

1.1.3 Referral and Linkage

Referral and linkage activities connect a Medicaid beneficiary with medical, behavioral, social and other programs, services, and supports to address identified needs and achieve goals specified in the PCP. Referral and linkage activities include:

a. Coordinating the delivery of services to reduce fragmentation of care and maximize mutually agreed upon outcome;
b. Facilitating access to and connecting the beneficiary to services and supports identified in the PCP;
c. Making referrals to providers for needed services and scheduling appointments with the beneficiary;
d. Assisting the beneficiary as he or she transitions through levels of care;
e. Facilitating communication and collaboration among all service providers and the beneficiary;
f. Assisting the beneficiary in establishing and maintaining a medical home with a CCNC physician or other primary care physician; and
g. Assisting the pregnant Medicaid beneficiary in establishing obstetrician and prenatal care as necessary.

1.1.4 Monitoring and Follow-Up

Monitoring and follow up includes activities and contacts that are necessary to ensure that the PCP is effectively implemented and adequately addresses the needs of the Medicaid beneficiary. Monitoring activities may involve the beneficiary, his or her supports, providers, and others involved in care delivery. Monitoring activities helps determine whether:

a. services are being provided in accordance with the beneficiary's PCP;
b. services in the PCP are adequate and effective;
c. there are changes in the needs or status of the beneficiary; and
d. the beneficiary is making progress toward his or her goals.

1.1.5 Expected Outcomes

a. The Medicaid beneficiary:
    1. has a single, comprehensive PCP that addresses all service and support needs;
    2. is linked to natural supports as available;
    3. has less than two crisis episodes requiring intervention through the Emergency Department, Mobile Crisis, Facility Based Crisis, hospitalization, or detoxification within the most recent past three-month period; and
    4. becomes increasingly independent in managing his or her own care (e.g., making treatment appointments, attending treatment, taking medications as prescribed, etc.) as appropriate.
b. The pregnant Medicaid beneficiary:
    1. is linked to a CCNC primary care physician or obstetrician and gynecologist (OBGYN);

2. is receiving appropriate and timely medical assessment or intervention including OBGYN care and other prenatal care as necessary; and
3. becomes increasingly independent in managing her own care (e.g., making treatment appointments, attending treatment or prenatal appointments, taking medications as prescribed, etc.).

c. The Medicaid beneficiary (age 21 and under) has transitioned from a residential setting to an alternative lower level of care.

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. <u>Medicaid</u>

None Apply.

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/

2.3 Specific Criteria

2.3.1 Comprehensive Clinical Assessment

The provider shall complete a comprehensive clinical assessment that documents medical necessity prior to provision of this service. If a substantially equivalent assessment is available, it may be used as part of the current comprehensive clinical assessment if it:

a. reflects the current level of functioning; and
b. contains all the required elements as outlined in community practice standards and all applicable federal and state requirements.

In addition, the provider shall complete and submit a Local Management Entity (LME) Consumer Admission and Discharge Form to the LME.

2.3.2 Eligibility Criteria

A beneficiary is eligible for this service when:

a. There is a MH/SA 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 an intellectual or developmental disability, and the Medicaid beneficiary is pregnant;

OR

b. The Medicaid beneficiary requires coordination between two or more agencies, including medical or non-medical providers.

AND

c. The beneficiary is unable to manage his or her symptoms or maintain abstinence, (independently or with family/caregiver support), due to at least three unmet basic needs, such as safe and adequate housing or food, or legal, educational, vocational, financial, health care, or transportation assistance for necessary services.

OR

d. The beneficiary is in a residential setting and needs coordination to transition to an alternate level of care.

OR

e. The beneficiary has experienced two or more crisis episodes requiring intervention through emergency department, Mobile Crisis Management, hospitalization, or detoxification services within the last three months.

2.3.3 Continued Service Criteria

The beneficiary is making measurable progress toward meeting the goals that require case management functions and there is documentation that supports that continuation of this service will be effective in assisting the beneficiary in meeting those goals identified in the PCP.

AND

Eligibility criteria listed above continue to be met with the exception that:

a. The beneficiary requires coordination between **one** (or more) agency (-ies), including medical or non-medical providers

AND

b. The beneficiary is unable to manage his or her symptoms or maintain abstinence, [independently or with family or caregiver support], due to at least **one** basic need identified in the initial assessment for services continuing to be unmet;

OR

At least three unmet basic needs have been identified through additional assessments during the course of service.

2.3.4 Discharge Criteria

The beneficiary has met the goals in the goals outlined in the PCP that require case management functions.

OR

The beneficiary no longer meets continued service criteria.

OR

The beneficiary or his legally responsible guardian no longer wishes to receive case management services.

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

Medicaid shall cover MH/SA TCM when the beneficiary meets the following criteria:

a. There is a current diagnosis reflecting the need for treatment; and
b. All covered services are medically necessary for meeting specific preventive, diagnostic, therapeutic, and rehabilitative needs of the beneficiary as defined below:
   1. **Preventive** means to anticipate the development of a disease or condition and preclude its occurrence.
   2. **Diagnostic** means to examine specific symptoms and facts to understand or explain a condition.
   3. **Therapeutic** means to treat and cure disease or disorders; it may also serve to preserve health.
   4. **Rehabilitative** means to restore that which one has lost, to a normal or optimum state of health.

3.2.2 Medicaid Additional Criteria Covered

None Apply.

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 Medicaid Beneficiaries under 21 Years of Age.

4.1 General Criteria

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 Non-Covered Criteria

4.2.1 Specific Criteria Not Covered by Medicaid

The following are not covered under this service:

a. transportation time;
b. transportation services;
c. any treatment interventions (for example, habilitation or rehabilitation activities);
d. any social or recreational activities (or the supervision of these activities);
e. clinical and administrative supervision of staff, including team meetings;
f. writing assessment reports, PCPs, or service notes; or
g. service record reviews.

4.2.2 Medicaid Additional Criteria Not Covered

None Apply.

5.0 Requirements for and Limitations on Coverage

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

5.1 Prior Approval

Medicaid shall require prior approval for MH/SA TCM.

5.2 Prior Approval Requirements

5.2.1 General

The provider(s) shall submit to the Department of Health and Human Services (DHHS) Utilization Review Contractor the following:

a. the prior approval request; and
b. all health records and any other records that support the beneficiary has met the specific criteria in **Subsection 3.2** of this policy.

5.2.2 Specific

Prior authorization is required on the first day of this service.

Reimbursement for case management is limited to 1 unit per calendar (Sunday-Saturday) week.

Case management services may be provided by only a provider agency that is a certified Critical Access Behavioral Health Agency (CABHA). A Medicaid beneficiary may receive case management services from only one CABHA during any active authorization period for this service**.**

In situations where more than one beneficiary within a family qualifies for MH/SA Targeted Case Management and the family has chosen the same CABHA, that CABHA shall assign the same case manager to serve each beneficiary in the family only as long as that case manager has the required qualifications to serve both populations and is clinically appropriate.

Service delivery to beneficiaries other than the beneficiary(s) may be covered only when the activity is directed exclusively toward the benefit of the beneficiary(s).

Case management services can be provided for up to 60 consecutive days for beneficiaries transitioning to a community setting from a medical institution. Reimbursement will be made to the CABHA rather than the medical institution.

Services, based upon a finding of medical necessity, shall be directly related to the beneficiary's diagnostic and clinical needs, and are expected to achieve the goals specified in the beneficiary's PCP.

Medically necessary services are authorized in the most cost-efficient mode, as long as the treatment that is made available is similarly efficacious to services requested by the beneficiary's physician, therapist, or other licensed practitioner. Typically, a medically necessary service shall be generally recognized as an accepted method of medical practice or treatment.

Case Management is a short-term service. NC Medicaid or NC Medicaid's designee shall approve up to 90 consecutive days for the initial authorization period and up to 60 consecutive days for reauthorization based on the medical necessity documented in the beneficiary's PCP, the authorization request form, and supporting documentation.

Note: Case management will not be reimbursed for adult Medicaid beneficiaries (age 22-64) who are served in Institutions for Mental Disease (IMD) or who are inmates of public institutions in accordance with [42 U.S.C. 1396d(a)(29)(A) and 42 C.F.R. 441.13].

5.3 Limitations or Requirements

5.3.1 Service Limitations

MH/SA Targeted Case Management services cannot be provided during the same authorization period as the following services: Intensive In-Home Services, Community Support Team, Assertive Community Treatment Team, Multisystemic Therapy, Child and Adolescent Day Treatment, Substance Abuse Intensive Outpatient Program, Substance Abuse Comprehensive Outpatient

Treatment, or Substance Abuse Non-Medical Community Residential Treatment. Case Management is a component of these services.

Medicaid beneficiaries receiving MH/SA TCM cannot receive other Medicaid-reimbursable case management services during the same period, including:

a. Community Alternatives Program (CAP), including CAP for Disabled Adults (CAP/DA), CAP for Children (CAP/C);
b. At-Risk Case Management for Adults and Children At Risk for Abuse, Neglect, or Exploitation; and
c. Targeted Case Management for Beneficiaries with Intellectual Disabilities (ID)

Medicaid payments for targeted case management shall not duplicate payments under other program authorities (such as child welfare and foster care services).

This service is billed on a weekly case rate basis. In order to bill for case management services, there must be documentation in the service record to reflect at least 15 minutes of weekly activity within any of the four case management functions (assessment, beneficiary centered planning, linking, monitoring). These weekly case management activities do not need to be face-to-face with the beneficiary, but a minimum monthly face-to-face contact with the beneficiary is required. The amount of weekly case management activity shall be determined by the level of acuity and the needs of the beneficiary based on the comprehensive clinical assessment and PCP. It is the expectation that the level of case management activity including face-to-face contacts shall be commensurate with the complexity of MH/SA needs of the beneficiary.

5.3.2 Service Orders

For Medicaid MH/SA TCM services, a signed service order shall be completed by a physician, licensed psychologist, physician assistant, or nurse practitioner according to his or her scope of practice. Each service order shall be signed and dated by the authorizing physician, licensed psychologist, physician assistant, or nurse practitioner and shall indicate the date on which the service was ordered. A service order shall be in place prior to or on the day that the service is initially provided in order to bill for the service. The service order shall be based on a comprehensive clinical assessment of the beneficiary’s needs.

Service orders are valid for one year from the Date of Plan entered on a PCP. The provider shall review medical necessity and order services at least annually, based on the Date of Plan. Please refer to the *DMH/DD/SAS Person-Centered Planning Instruction Manual* and the *Records Management and Documentation Manual* at https://medicaid.ncdhhs.gov/ for more detailed information.

5.3.3 Documentation Requirements

The service record documents the nature and course of a beneficiary’s progress in treatment. In order to bill Medicaid, providers must ensure that their documentation is consistent with the requirements contained in this policy and the *DMH/DD/SAS Records Management and Documentation Manual*.

5.3.3.1 Responsibility for Documentation

The case manager who provides the service is responsible for accurately documenting the services billed to and reimbursed by Medicaid. The case manager must sign the written entry. The signature must include credentials.

5.3.3.2 Contents of a Service Note

Refer to NC Medicaid clinical coverage policies on NC Medicaid's website at https://medicaid.ncdhhs.gov/, and the *DMH/DD/SAS Records Management and Documentation Manual* for a complete listing of documentation requirements.

For this service, **one** of the documentation requirements is a full service note for each contact, or a full service note for each date of service, written and signed by the individual(s) who provided the service that includes the following:

a. Beneficiary's name;
b. Medicaid identification number;
c. Service Record Number;
d. Service provided;
e. Date of service;
f. Place of service;
g. Type of contact (face-to-face, telephone call, collateral;)
h. Purpose of the contact;
i. Description of the case management activity (-ies);
j. Amount of time spent performing the intervention;
k. Description of the results or outcome of the case management activity (-ies), any progress noted, and next steps, when applicable; or
l. Signature and credentials of the staff member(s) providing the service.

A documented discharge plan shall be discussed with the beneficiary and must be included in the service record.

6.0 Providers 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 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

MH/SA TCM shall be delivered by practitioners employed by mental health or substance use disorder provider organizations that:

a. have been certified as a Critical Access Behavioral Health Agency (CABHA);
b. meet the provider qualification policies, procedures, and standards established by NC Medicaid;
c. meet the provider qualification policies, procedures, and standards established by the Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS); and
d. fulfill the requirements of 10A NCAC 27G.

These policies and procedures set forth the administrative, financial, clinical, quality improvement, and information services infrastructure necessary to provide services. The organization shall be established as a legally constituted entity capable of meeting all of the requirements of the Provider Endorsement, Enrollment Agreement, Medicaid Bulletins, and service implementation standards.

6.1.1 Qualifications for Case Managers

Case managers must meet **one** of the following qualifications based on the target population being served:

a. currently licensed by the appropriate North Carolina licensure board as a licensed clinical addiction specialist, licensed clinical social worker, licensed marriage and family therapist, licensed professional counselor or licensed clinical mental health counselor, psychiatrist, licensed psychologist or a licensed psychological associate;
b. a graduate of a college or university with a master’s degree in a human service field with one year of full-time, post-graduate degree accumulated MH/DD/SAS experience with the population served or a substance use disorder professional who has one year of full-time, post-graduate degree accumulated supervised experience in alcoholism and drug abuse counseling;
c. a graduate of a college or university with a bachelor's degree in a human service field with two years of full-time, post-bachelor's degree accumulated MH/DD/SAS experience with the population served or a substance use disorder professional who has two years of full-time, post-graduate degree accumulated supervised experience in alcoholism and drug abuse counseling or a registered nurse who is licensed to practice in the State of North Carolina by the North Carolina Board of Nursing who also has four years of full-time accumulated experience in MH/DD/SAS with the population served; or
d. a graduate of a college or university with a bachelor's degree in a field other than human services with four years of full-time, post-bachelor's degree accumulated MH/DD/SAS experience with the population served, or a substance use disorder professional who has four years of full-time, post-graduate degree accumulated supervised experience in alcoholism and drug abuse counseling.

Note: Degrees in a human service field include but are not limited to, the following degrees: psychology, social work, mental health counseling, rehabilitation counseling, addictions, psychiatric nursing, special education, and therapeutic recreation.

a. The CABHA Clinical Director is responsible for ensuring appropriate supervision of the case manager(s).
b. The case manager-to-beneficiary ratio shall not exceed 1:50 for each case manager.
c. The caseload shall be determined by the level of acuity and the needs of the beneficiary based on the comprehensive clinical assessment and PCP.

Note: To comply with NC General Assembly Session Law 2019-240 Senate Bill 537, licensure name for Licensed Professional Counselor (LPC) is amended to Licensed Clinical Mental Health Counselor (LCMHC). Policy amendment(s) will be effective the date the related rule change for 10A NCAC 27G is finalized.

6.2 Staff Training

All staff providing Case Management services shall complete a minimum of 24 hours of training as indicated below. Current staff providing case management functions must complete the training within 180 calendar days of the effective date of this policy. New staff must complete this training within the first 30 days of the staff member's date of hire.

a. Training specific to the required functions of the case management service definition (6 hours)
b. *Crisis Response (3 hours)
c. Person-Centered Thinking (12 hours)
d. *PCP Instructional Elements (3 hours).

*Staff who have documentation of having received this required training shall be deemed to have met this requirement

In addition, all staff serving children must complete the following training:

a. **Introduction to System of Care (11 hours)

**Staff who have documentation of having received the required training hours since January 1, 2007 shall be deemed to have met this requirement.

MH/SA TCM providers must ensure that all staff delivering these services prior to July 1, 2010 are informed of and adhere to all clinical coverage policy requirements.

Case management activities provided by new staff cannot be billed until all training requirements have been completed.

6.3 Staff Competencies

Policies, procedures, training, and supervision plans shall reflect the following staff competencies:

6.3.1 Case Management Assessment

Knowledge of:

a. Available formal and informal assessment resources in the state; and
b. The population, disability, and culture of the beneficiary being served.

Skills and Abilities to:

a. Apply interviewing skills such as active listening, supportive responses, open-and closed-ended questions, summarizing, and giving options;
b. Collect all recent and relevant clinical and medical assessment and evaluation reports, integrating the findings, results and recommendations to form the basis of the beneficiary's individualized plan of care; engage beneficiaries and families to elicit and gather, and integrate other pertinent information;
c. Recognize indicators of risk (health, safety, mental health, and substance use disorders);
d. Gather and review information through a holistic approach, giving balanced attention to family, community, educational, work, leisure, cultural, contextual factors, and beneficiary preferences;
e. Consult other professionals and formal and natural supports in the assessment process; and
f. Discuss findings and recommendations with the beneficiary in a clear and understandable manner.

6.3.2 Person-Centered Planning

Knowledge of:

a. The values that underlie a person-centered approach to providing service to improve beneficiary functioning within the context of the beneficiary's culture and community;
b. Models of wellness-management and recovery;
c. Biopsychosocial approaches to serving and supports beneficiaries, and evidenced-based standards of care;
d. Processes used in a variety of models for group meetings to promote beneficiary and family involvement in case planning and decision-making; and
e. Interventions appropriate for assessed needs.

Skills and Abilities to:

a. Identify and evaluate a beneficiary's existing and accessible resources and support systems; and
b. Develop an individualized care plan with a beneficiary and his or her supports based on assessment findings that include measurable goals and outcomes.

6.3.3 Linkage and Referral

Knowledge of:

a. Community resources such as medical and behavioral health programs, formal and informal supports, and social service, educational, employment, and housing resources; and
b. Current laws, regulations, and policies surrounding medical and behavioral healthcare.

Skills and Abilities to:

a. Research, develop, maintain, and share information on community and other resources relevant to the needs of beneficiaries;
b. Maintain consistent, collaborative contact with other health care providers and community resources;
c. Facilitate the beneficiary's transition into services in the care plan in order to achieve the outcomes derived for the consumer's goals; and
d. Assist the beneficiary in accessing a variety of community resources.

6.3.4 Monitoring and Follow-Up

Knowledge of:

a. Outcome monitoring and quality management;
b. Wellness-management, recovery, and self-management; and
c. Community consumer-advocacy and peer support groups.

Skills and Abilities to:

a. Collect, compile and evaluate data from multiple sources;
b. Modify care plans as needed with the input of beneficiaries, professionals, and natural supports;
c. Discuss quality-of-care and treatment concerns with the beneficiary, professionals, formal and natural supports;
d. Monitor the motivation and engagement of the beneficiary and his or her supports; and
e. Encourage and assist a beneficiary to be a self-advocate for quality care.

6.3.5 Professional Responsibility

Knowledge of:

a. Importance of ethical behavior, the potential impact of unethical behavior on the beneficiary, and the potential consequences of violating ethical expectations;
b. Quality assurance practices and standards;
c. Confidentiality regulations;
d. Required performance standards and case management best practices;

e. Definitions and fundamental concepts of culture and diversity;
f. Origins and tenets of one's individual value system, culture background, and beliefs; understands how this may influence actions and decisions in practice; and
g. Differences in culture and ethnicity of beneficiaries served.

Skills and Abilities to:

a. Use critical thinking skills and consultation with other professionals to make ethical decision and conduct ethical case management;
b. Form constructive, collaborative relationships with beneficiaries of various cultures and use effective strategies for conducting culturally competent case management;
c. Discern with whom protected health information can be shared;
d. Communicate clearly, both verbally and in writing;
e. Discern the severity of family problems are beyond the case manager's skill or responsibility, and when referrals to other professionals are necessary; and
f. Identify areas for self-improvement, pursue necessary education and training, and seek appropriate supervision.

6.4 Provider Certifications

None Apply.

7.0 Additional Requirements

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for Medicaid Beneficiaries 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).

7.2 Audits and Compliance Reviews

DMH/DD/SAS and NC Medicaid (DHHS team) jointly conduct annual audits of a sample of mental health, intellectual/developmental disabilities, and substance use disorder services. The purpose of the Division of Medical Assistance audits is to ensure that these services are provided to Medicaid beneficiaries in accordance with federal and state regulations and that the documentation and billing practices of directly enrolled providers demonstrate accuracy and integrity. It is a quality control process used to ensure that medical necessity has been determined and to monitor the quality of the

documentation of services provided. The LME may also conduct compliance reviews and monitor provider organizations under the authority of NC Medicaid.

Any deficiencies identified in an audit are forwarded to NC Medicaid's Program Integrity Section, with the following information:

a. A report of findings that summarizes the issues identified, time period covered by the review, and type of sampling.
b. Copies of supporting documentation, showing the specific billing errors identified in the audit and including the beneficiary's name, identification number, date(s) of service, procedure code, number of units billed in error, and reason for error.

Refunds or requests for withholdings from future payments should be sent to

Office of Controller
NC Medicaid Accounts Receivable
2022 Mail Service Center
Raleigh, N.C. 27699-2022

8.0 Policy Implementation/Revision Information

Original Effective Date: July 1, 2010

Revision Information:

Date	Section Revised	Change
07/01/2010	Throughout	Initial promulgation of new Medicaid coverage
07/01/2010	Throughout	Policy Conversion: Implementation of Session Law 2009-451, Section 10.32 “NC HEALTH CHOICE/PROCEDURES
03/01/2012	Throughout	Initial promulgation of coverage of NC Health Choice Program Clinical Coverage Policy implemented to be equivalent to NC Medicaid Program Clinical Coverage Policy 8L pursuant to SL2011-145, Section 10.41(b)
09/01/2012	Throughout	Technical changes to merge Medicaid and NCHC current coverage into one policy.
08/01/2014	All Sections and Attachments	Updated: DSM-IV to DSM-5 language, American Society for Addiction Medicine language pertaining to substance use disorder, 2013 CPT codes, language pertaining to intellectual/ developmental disabilities.
08/01/2014	All Sections and Attachments	Reviewed policy grammar, readability, typographical accuracy, and format. Policy amended as needed to correct, without affecting coverage.
10/01/2015	All Sections and Attachments	Updated policy template language and added ICD-10 codes to comply with federally mandated 10/1/2015 implementation where applicable.
03/15/2019	Table of Contents	Added, “To all beneficiaries enrolled in a Prepaid Health Plan (PHP): for questions about benefits and services available on or after November 1, 2019, please contact your PHP.”
03/15/2019	All Sections and Attachments	Updated policy template language.
12/15/2019	Attachment A	Added: Note: Providers using the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC:0–5) manual shall submit claims using the ICD-10 diagnosis code that corresponds to the chosen DC:0-5 diagnosis.
12/15/2019	Table of Contents	Updated policy template language, “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.”
12/15/2019	Attachment A	Added, “Unless directed otherwise, Institutional Claims must be billed according to the National

Date	Section Revised	Change
07/01/2010	Throughout	Initial promulgation of new Medicaid coverage
07/01/2010	Throughout	Policy Conversion: Implementation of Session Law 2009-451, Section 10.32 "NC HEALTH CHOICE/PROCEDURES
		Uniform Billing Guidelines. All claims must comply with National Coding Guidelines.
10/1/2020	Subsection 6.1.1	Added: "licensed clinical mental health counselor" to comply with NC General Assembly Session Law 2019-240 Senate Bill 537. Policy amendment(s) will be effective the date the related rule change for 10A NCAC 27G is finalized.
10/1/2020	Subsection 6.1.1	Added: "Note**:** To comply with NC General Assembly Session Law 2019-240 Senate Bill 537, licensure name for Licensed Professional Counselor (LPC) is amended to Licensed Clinical Mental Health Counselor (LCMHC). Policy amendment(s) will be effective the date the related rule change for 10A NCAC 27G is finalized."
4/15/2023	All Sections and Attachment(s)	Updated policy template language due to North Carolina Health Choice Program's move to Medicaid. Policy posted 4/15/2023with an effective date of 4/1/2023.

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.

A. Claim Type

Professional (CMS-1500/837P 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.

Note: Providers using the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC:0–5) manual shall submit claims using the ICD-10 diagnosis code that corresponds to the chosen DC:0-5 diagnosis.

C. Code(s)

Provider(s) shall report the most specific billing code that accurately and completely describes the 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	Description
H0032	Mental health service plan development by nonphysician

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.

E. Billing Units

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

Weekly case rate (1 unit per calendar [Sunday-Saturday] week)

F. Place of Service

Various environments, such as homes, office settings, schools, courts, secure juvenile detention centers* and jails*, homeless shelters, libraries, street locations, and other community settings.

* **Note:** For all services, federal Medicaid laws and regulations [42 U.S.C. 1396d(a)(29)(A) and 42 C.F.R. 441.13] prohibit Federal Financial Participation payment for services delivered to inmates of public institutions as defined in 42 C.F.R. 435.1010 unless the beneficiary is a patient in a medical institution; and patients less than 65 years of age in Institutions for Mental Diseases as defined in 42 C.F.R. 435.1010 unless the beneficiary is less than 22 years of age and receiving inpatient psychiatric services as described in Subpart D of 42 C.F.R. 441.

* For all services, federal State Children's Health Insurance Program laws and regulations [42 U.S.C. 1397jj(b)(2)(A) and 42 C.F.R. 457.310(c)(2)] prohibit Federal Financial Participation payment for services delivered to inmates of public institutions as defined in 42 C.F.R. 435.1010 and patients in Institutions for Mental Diseases as defined in 42 C.F.R. 435.1010**. Therefore, 100% of the reimbursement for services in these settings is paid with state funding.**

G. Co-payments

For Medicaid refer to Medicaid State Plan:
https://medicaid.ncdhhs.gov/meetings-notices/medicaid-state-plan-public-notice

H. Reimbursement

Provider(s) shall bill their usual and customary charges.
For a schedule of rates, refer to: https://medicaid.ncdhhs.gov/