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Related Clinical Coverage Policies
Refer to http://dma.ncdhhs.gov/ for the related coverage policies listed below:
1H, Telemedicine and Telepsychiatry
8A, Enhanced Mental Health and Substance Abuse Services
8C, Outpatient Behavioral Health Services Provided by Direct Enrolled Providers

1.0 Description of the Procedure, Product, or Service

Mobile Crisis Management (MCM) is a mobile intervention for a beneficiary experiencing escalating emotional symptoms, behaviors, or traumatic circumstances which have compromised the beneficiary's ability to function at their baseline within their family, living situation, work or community environments. MCM involves all support, services and treatments necessary to provide the following: integrated crisis response, crisis stabilization, and crisis prevention. Interventions can include crisis outreach, crisis de-escalation and stabilization, and. crisis counseling.,

Mobile Crisis Management services are available 24 hours a day, 7 days a week, 365 days a year and can be provided in the beneficiary's private residence or other settings where a crisis may be occurring. Crisis response provides an immediate triage, assessment, evaluation, and access to acute mental health, intellectual or developmental disabilities, or substance abuse services, treatment and supports to effect symptom reduction, harm reduction, or to safely transition individuals in acute crises to appropriate crisis stabilization or detoxification supports or services.

MCM is intended to prevent placement into a more restrictive setting, if possible, and to prevent further behavioral decompensation. MCM also consists of crisis prevention and supports that are designed to reduce the incidence of recurring crises. These supports and services must be specified in a beneficiary's NC DHHS Comprehensive Crisis Plan.,

MCM services are one aspect of a continuum of the crisis system, and are not intended to replace existing services incorporating crisis response or first responder functions. MCM is a short-term, situational crisis response service.

Interventions are primarily face to face in the community, with immediate telephonic triage and face to face evaluation within 30 minutes.

The duration of a MCM episode of care ranges from a brief telephone conversation to multiple weeks of continued engagement, crisis stabilization, and integration into ongoing care.

1.1 Definitions

Preventive means to anticipate the development of a disease or condition and preclude its occurrence.

Diagnostic means to examine specific symptoms and facts to understand or explain a condition.

Therapeutic means to treat and cure disease or disorders; it may also serve to preserve health.

Rehabilitative means to restore that which one has lost, to a normal or optimum state of health

Outreach means bringing services or information to people where they live or spend time.

Engagement means actively involving the beneficiary in planning, assessment, and problem solving, actively coordinating care with other providers and communicating with referrers and other collateral contacts.

Stabilization means identifying and intervening with strategies to deescalate the crisis utilizing trauma informed care to stabilize and improve psychological symptoms of distress, to engage individuals in the most appropriate course of treatment, to facilitate transition to ongoing services and support, and to serve people in the least restrictive setting.

Harm Reduction means policies, programs, and practices designed to lessen the negative social, emotional, and physical consequences associated with various human behaviors without necessarily stopping those behaviors.

First Responder is a behavioral health provider expected to be available to beneficiaries in crisis for telephone consultation 24 hours a day, seven days a week, 365 days a year. Intervention and response by someone with an established relationship can often prevent the crisis from escalating. First responder functions vary by the service provided. For example, PSR, Child and Adolescent Day Treatment, or a direct enrolled outpatient services provider would be expected to be available to receive the initial crisis telephone call, but not necessarily to respond in person. These providers would be able to utilize MCM, as appropriate to assist in the management of crisis situations. Other services such as ACTT, CST, IIH, MST, SAIOP, and SACOT are expected to be able to respond and manage beneficiary crises without calling MCM. Each of these providers are expected to be able to respond face-to-face with the beneficiary in a crisis.

Licensed Professional, Licensed Clinician, Licensed Practitioner: for the purposes of this policy, licensed clinician, licensed professional, and licensed practitioner have the same meaning.

2.0 Eligibility Requirements

2.1 Provisions

2.1.1 General

(*The term "General" found throughout this policy applies to all Medicaid and NCHC policies*)

1. An eligible beneficiary shall be enrolled in either:
   a. the NC Medicaid Program *(Medicaid is NC Medicaid program, unless context clearly indicates otherwise*); or
   b. the NC Health Choice (*NCHC is NC Health Choice program, unless context clearly indicates otherwise)* Program on the date of service and shall meet the criteria in **Section 3.0 of this policy**.
2. Provider(s) shall verify each Medicaid or NCHC beneficiary's eligibility each time a service is rendered.

3. The Medicaid beneficiary may have service restrictions due to their eligibility category that would make them ineligible for this service.
4. Following is only one of the eligibility and other requirements for participation in the NCHC Program under GS 108A-70.21(a): Children must be between the ages of 6 through 18.

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. Occasionally, a beneficiary becomes retroactively eligible for Medicaid while receiving covered services.

b. NCHC

Retroactive eligibility does not apply to the NCHC Program.

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: http://dma.ncdhhs.gov/

2.2.2 EPSDT does not apply to NCHC beneficiaries

2.2.3 Health Choice Special Provision for a Health Choice Beneficiary age 6 through 18 years of age

The Division of Medical Assistance (DMA) shall deny the claim for coverage for an NCHC beneficiary who does not meet the criteria within **Section 3.0** of this policy. Only services included under the NCHC State Plan and the DMA clinical coverage policies, service definitions, or billing codes are covered for an NCHC beneficiary.

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 and NCHC 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.

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3.2 Specific Criteria Covered

3.2.1 Specific criteria covered by both Medicaid and NCHC

Medicaid and NCHC cover MCM services that are medically necessary for meeting specific preventive, diagnostic, therapeutic, and rehabilitative needs of the beneficiary. There must be a current behavioral health diagnosis by a licensed professional reflecting the need for treatment.

3.2.1.1 Entrance Criteria

Medicaid and NCHC shall cover MCM services when the following criteria are met:

a. The beneficiary is experiencing an acute, imminent, emergent, or immediate crisis

AND either (1) or (2) below:

1. is not connected to a service that provides first responder functions; or
2. is connected to a service with first responder responsibility, but the first responder has not responded or the crisis remains acute or emergent, and the first responder is not able to resolve the crisis, and a response from MCM is needed for the safety of the beneficiary.

AND one of the following:

1. The beneficiary has insufficient or severely limited resources or lack the skills necessary to cope with the immediate crisis,
2. The beneficiary exhibits impaired judgment, impaired impulse control, cognitive or perceptual disabilities, **or**
3. The beneficiary is intoxicated or is in withdrawal and in need of substance abuse treatment and unable to access services without immediate assistance.

3.2.1.2 Entrance Process

Providers shall request MCM through the DHHS designated contractor. Most often, a telephonic triage determines the appropriate staff to see the beneficiary face to face for the initial crisis assessment. Crisis assessments must be face to face. The face to face assessment consists of a safety, risk, and acuity screening and initial interventions to begin and stabilize the presenting crisis.

3.2.1.3 Continued Stay Criteria

The beneficiary meets continued stay criteria for this service if:

1. The beneficiary's crisis has not been resolved,

OR

2. The crisis situation has not been stabilized,

OR

3. Referral or placement determined to be clinically appropriate has not occurred.

3.2.2 Medicaid Additional Criteria Covered

None Apply.

3.2.3 NCHC Additional Criteria Covered

None Apply.

3.3 Service Type and Setting

MCM is primarily a periodic service, available 24 hours a day, 7 days a week, 365 days a year.

MCM is used to divert a beneficiary from emergency room admissions. MCM should not be utilized as a step down service from inpatient hospitalization.

MCM provides outreach, de-escalation, and stabilization even if the outcome is an inpatient referral.

MCM's response is primarily face-to-face with the beneficiary in the community within 30 minutes from the time the MCM provider has triaged the call and determined that a face-to-face contact is required or 30 min. after being notified by the DHHS designated contractor that a face-to-face crisis service is required. This service is delivered in the least restrictive environment, and provided in or as close as possible to the beneficiary's private residence, in the beneficiary's natural setting, such as school or work.

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 and NCHC 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 Discharge Criteria

The beneficiary meets the criteria for discharge if any one of the following applies:

a. need for ongoing treatment or supports has been assessed and the crisis has been stabilized,
b. has continuing treatment or support needs and the beneficiary has started and engaged in services with an appropriate provider, or
c. no longer wish to receive MCM services which also can be the legally responsible person.

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4.3 Specific Criteria Not Covered

4.3.1 Specific Criteria Not Covered by both Medicaid and NCHC

Service Exclusions

a. Medicaid and NCHC shall not reimburse MCM beyond the initial 32 units concurrently with the following services:
   1. Assertive Community Treatment Team;
   2. Community Support Team;
   3. Intensive In-Home Services;
   4. Multisystemic Therapy.

b. Medicaid and NCHC shall not cover the following services concurrently with MCM except for on the day of admission:
   1. Substance Abuse Medically Monitored Community Residential Treatment;
   2. Substance Abuse Non-Medical Community Residential Treatment;
   3. Detoxification Services;
   4. Facility Based Crisis;
   5. Inpatient Substance Abuse Treatment;
   6. Inpatient Psychiatric Treatment; and
   7. Psychiatric Residential Treatment Facility.

c. MCM is not covered for services at times during which the MCM staff are not actively involved in assessment, intervention, or prevention activities. The following activities are not covered under this service:
   1. Travel time (this is factored in the rate);
   2. Any habilitation activities;
   3. Any social or recreational activities (or the supervision thereof); and
   4. Clinical and administrative supervision of staff (this is factored in the rate.)

d. Medicaid and NCHC shall not cover MCM services for a beneficiary in the following settings:
   1. inmates of public correctional institutions or for patients in facilities with more than 16 beds that are classified as Institutions of Mental Diseases;
   2. residing in a nursing home facility;
   3. school setting for threat assessments for suicide or placing a child on or removing a child from suspension; or
   4. hospital emergency department.

4.3.2 Medicaid Additional Criteria Not Covered

None Apply.

4.3.3 NCHC Additional Criteria Not Covered

1. NCGS § 108A-70.21(b) “Except as otherwise provided for eligibility, fees, deductibles, copayments, and other cost sharing charges, health benefits coverage provided to children eligible under the Program shall be equivalent

to coverage provided for dependents under North Carolina Medicaid Program except for the following:

a. No services for long term care.
b. No nonemergency medical transportation.
c. No EPSDT.
d. Dental services shall be provided on a restricted basis in accordance with criteria adopted by the Department to implement this subsection."

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 and NCHC shall require prior approval after the first 32 units of MCM services.
If continued MCM services are needed beyond the provision of the first 32 units, a request for authorization with supporting documentation must be submitted to the DHHS designated contractor prior to the exhaustion of the first 32 units.

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

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

The maximum length of an authorization shall be 60 units per authorization period. Prior approval for MCM is an expedited review and should occur within 24 hours of the request being received.

5.3 Additional Limitations or Requirements

Utilization management must be performed by DHHS designated contractor. This may be the Local Management Entity, Managed Care Organization (LME MCO). The LME MCO is referred to in this policy as a Prepaid Inpatient Health Plan (PIHP).

Services to individuals other than the beneficiary may be covered only when the activity is directed exclusively toward the benefit of that beneficiary.

MCM services may be provided to a beneficiary on the same date of service as inpatient psychiatric services for the purpose of planning for the admission to the inpatient treatment setting as well as for the development or revision of the beneficiary's NC DHHS Comprehensive Crisis Plan.

5.4 Program Requirements

5.4.1 General Requirements

MCM services must be delivered by one or more individual practitioners on the team in the least restrictive environment. These services consist of immediate response, either by telephone or face to face, to assess the crisis, determine the risk and the beneficiary's mental status, and effect the appropriate response.

MCM shall be accessible 24 hours a day, seven (7) days a week, 365 days a year. Incoming telephone calls to MCM must be answered by live staff and not by an automated service or diverted to voice mail.
Services must address all psychiatric, substance use disorder, and intellectual and developmental disability crises for all ages to help restore (at a minimum) a beneficiary to his or her previous level of functioning.

At the onset of the crisis whenever possible, but prior to discharge from MCM, the MCM provider shall contact the DHHS designated contractor to determine if the individual is:

a. a Medicaid or North Carolina Health Choice beneficiary; and
b. currently enrolled with another service provider agency that has first responder responsibilities. The MCM provider organization is expected to collaborate with relevant community stakeholders to ensure access, care coordination, and continuity of care.

A beneficiary receives MCM services from only one MCM service provider organization during any active authorization period for this service.

5.4.2 Service Benchmarks

Annually the aggregate services that have been delivered by the agency must be assessed using the following quality assurance benchmark: the team providing this service shall provide at least 80% of their service units face to face with beneficiaries for MCM service.

5.4.3 Crisis Plan

For a beneficiary new to the public service delivery system, MCM staff shall develop a NC DHHS Comprehensive Crisis Plan with the beneficiary, the legally responsible person, or both before discharge. This NC DHHS Comprehensive Crisis Plan must be provided to the beneficiary, caregivers (if appropriate), the DHHS designated contractor, and any agencies that may provide ongoing treatment and supports after the crisis has been stabilized. For a beneficiary who is receiving services, the MCM staff shall, as appropriate, recommend revisions to an existing NC DHHS Comprehensive Crisis Plan.

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5.4.4 Risk Assessment

If the beneficiary presents risk of harm to self or others, a documented risk assessment addressing dangerousness and lethality is completed. The MCM licensed professional shall perform a risk assessment and document the assessment in the service record. The risk assessment must contain the following elements: harm to self or others, sexual aggression, behavioral or emotional symptoms, substance use, functioning in the community, medication use and adherence, legal involvement, domestic violence, strengths or resources.

The assessment must evaluate risk behaviors and functioning problems and result in:

a. identifying the appropriate crisis stabilization intervention;
b. arranging for that intervention service or placement to occur; and
c. developing or revising the, NC DHHS Comprehensive Crisis Plan to assist the beneficiary and his or her supports in better managing future crisis events.

5.4.5 First Responder

If the beneficiary is connected to a service that provides first responder responsibility but:

a. the first responder has not responded or
b. the crisis remains acute or emergent, and the first responder is not able to resolve the crisis, and a response from MCM is needed for the safety of the beneficiary, then MCM can be provided until the service responsible as the first responder is fulfilling that role. When this occurs, the MCM provider shall contact the DHHS designated contractor within two business days to inform them that MCM has intervened.

5.5 MCM Practice Model

MCM consists of two phases:

a. Assessment; and
b. Ongoing Outreach, Stabilization, Engagement, and Transition.

Episodes can be as brief as responding to the initial call or can last for weeks. Some beneficiaries can receive only a portion of the clinical services, whereas others can receive all of the MCM services.

Assessment: The assessment is intended to support initial crisis stabilization and the gathering of clinical information that will inform the rest of the episode of care. There are a number of activities that take place during this phase, including responding to the first call, conducting the first MCM outreach response, assessing initial acuity level, and beginning to administer initial treatment and stabilization measures.

The tasks most often found in the **Assessment Phase are:**

a. Receive all calls and referrals
b. Conduct brief safety screen and determine appropriate response plan
c. Provide appropriate initial response to beneficiary, emphasizing immediate mobile responses over other options
d. Begin to stabilize the presenting crisis

e. Provide accurate acuity assessment to determine immediate risk level
f. Maintain beneficiaries in their primary private residences and communities when MCM and community based care is a safe and effective alternative to emergency departments, inpatient hospitalization, and detention or jail.
g. Administer other screening and assessment measures as appropriate
h. Begin completing the assessment
i. Communicate with family and original referrer

Ongoing Outreach, Stabilization, Engagement, and Transition: Some MCM episodes of care end following an initial call or initial response within the Assessment phase; however, a beneficiary may receive follow up care until the beneficiary is engaged with another service or the crisis is resolved. This phase entails the delivery of ongoing clinical services for the remainder of the episode of care. Many of the activities in the Assessment phase can be, and are, repeated in the Ongoing Stabilization, Engagement, and Transition phase. The emphasis of this phase is on meeting the beneficiary's needs in a way that stabilizes the current crisis, connects the beneficiary to appropriate services, and helps to prevent further crises from occurring.

Tasks found in the **Ongoing Crisis Stabilization and Transition Phase** are:

a. Receive all calls and referrals;
b. Conduct brief safety screen and determine appropriate response plan;
c. Complete the crisis assessment;
d. Provide appropriate initial response to beneficiary, emphasizing immediate mobile responses over other options;
e. Begin to stabilize the presenting crisis;
f. Provide accurate acuity assessment to determine immediate risk level;
g. Maintain beneficiaries in their homes and communities when MCM and community-based care is a safe and effective alternative to emergency departments, inpatient hospitalization;
h. Administer other screening and assessment measures as appropriate; and
i. Communicate with family and original referrer with appropriate consent.

5.6 Documentation Requirements

Medicaid or NCHC services must comply with Medicaid and NCHC reimbursement guidelines.

5.6.1 Responsibility for Documentation

The staff member who provides the service is responsible for accurately documenting the Medicaid or NCHC services:

a. The staff person who provides the service shall sign and date the written entry. The signature contains the credentials for licensed professionals or a job title for qualified professionals and certified peer support specialists.
b. A Qualified Professional (QP) is not required to countersign service notes written by a staff person who does not have QP status.

5.6.2 Contents of a Service Note

For this service, a completed service note is required for each contact or intervention for each date of service. More than one intervention, activity, or goal may be reported in one service note. **Each service note page must** be identified with the beneficiary's name Medicaid or NCHC identification number and record number. Service notes, unless otherwise noted in the service definition, must document ALL of the following:

a. **Date of service** provision;
b. **Name of service** provided (such as MCM);
c. **Type of contact** (face to face, telephone call, collateral);
d. **Place of service**;
e. **Purpose** of the contact as it relates to the treatment plan goal(s);
f. **Description of the intervention** provided. Documentation of the intervention must accurately reflect treatment for the duration of time indicated;
g. **Duration of service**: Amount of time spent performing the intervention;
h. **Assessment of the effectiveness** of the intervention and the beneficiary's progress toward the beneficiary's goal; and
i. **Signature** and credentials or job title of the staff member who provided the service**.**

5.6.3 MCM Specific Documentation Requirements

In addition to the above documentation requirements, MCM providers shall also document in the service record:

a. Discussion with the beneficiary of a discharge plan. This may be a part of the crisis assessment, but the discharge plan must be clearly identified.
b. A crisis assessment to support initial crisis stabilization and the gathering of clinical information containing all the following elements:
    1. a safety screening,
    2. acuity assessment to determine immediate risk level, and
    3. other screening and assessment measures as appropriate.

A copy of the revised, NC DHHS Comprehensive Crisis Plan is filed in the MCM service record.

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 or NCHC 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

In addition to the qualifications in **Section 6.0** above, the provider(s) shall:

a. meet the provider qualification policies, procedures, and standards established by the North Carolina Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS);
b. meet the provider qualification policies, procedures, and standards established by DMA;
c. fulfill the requirements of 10A NCAC 27G;
d. demonstrate that they meet these standards by being certified by the DHHS designated contractor;
e. become established as a legally constituted entity capable of meeting all of the requirements of the Provider Certification, Medicaid Enrollment Agreement, Medicaid Bulletins, and service implementation standards; and
f. comply with all applicable federal and state requirements. This includes the North Carolina Department of Health and Human Services statutes, rules, policies, Medicaid bulletins, and other published instructions.

6.2 Provider Certifications

Refer to the staffing requirements section below.

6.3 Staff Definitions

MCM services must be provided by a team of licensed professionals, qualified professionals, and certified peer support specialists with training and experience in crisis services and population served. Qualifications for the staff are found in 10A NCAC 27G .0104. MCM services can be delivered by one or more individual practitioners on the team.

The team composition is as follows:

a. Psychiatrist

1. 0.1 FTE Board certified;
2. Available 24 hours a day, seven days a week, 365 days a year for interventions (in person or via telepsychiatry according to DMA Clinical Coverage Policy 1H) with the beneficiary and consultation with crisis team;
3. 24/7/365 availability (by telephone or in person) to crisis staff; and
4. psychiatrist must participate in consultation or meetings requested by the team leader.

b. **Team Leader**

1. 1.0 FTE Licensed Clinician per 10A NCAC 27G .0104; and
2. Cannot be a Licensed Clinical Addiction Specialist (LCAS)

c. Substance Use Disorder Professional

a. 0.5 FTE;
b. Licensed Clinical Addiction Specialist (LCAS); or
c. Licensed Clinical Addiction Specialist Associate (LCAS A); or
d. Certified Substance Abuse Counselor (CSAC); or
e. Certified Clinical Supervisor (CCS).

d. **Other Staff**
   a. 2.0 FTE's total;
   b. Qualified Professional or a Certified Peer Support Specialist;
   c. Qualified Professional must meet qualifications in 10A NCAC 27G .0104;
   d. The 2.0 FTE's can be a combination of either one or more Qualified Professionals with one or more Certified Peer Support Specialists. Each individual will be a minimum of 0.5 FTE.

6.4 Staffing Requirements

A MCM team shall have sufficient staffing to meet the varying needs of beneficiaries. MCM team staffing is to be clearly defined and dedicated to the operation of the team. Below is a description of each team member's role.

a. **Psychiatrist:** The psychiatrist provides clinical oversight and leadership to the MCM team and provides physician or psychiatric consultation to the team as needed. A board-certified psychiatrist is available to the MCM team at all times. The psychiatrist shall see a beneficiary face to face or via telepsychiatry as needed.
b. **Team Leader:** The team leader provides clinical and administrative supervision and oversight to the MCM team staff and clinical oversight of the services. The team leader works cooperatively with the psychiatrist to provide clinical leadership and supervision to the MCM team. The team leader is an active part of the team and provide MCM services along with the other team members.
c. **Substance Use Disorder Professional:** The substance use disorder professional brings a specific expertise to the team of working with individuals having substance use disorders. This individual would need expertise in crisis services to individuals with substance use disorders.
d. **Qualified Professional:** The qualified professional has crisis experience with mental health, substance use disorders, or with individuals having intellectual and developmental disabilities.
e. **Certified Peer Support Specialist:** The North Carolina Certified Peer Support Specialist must have experience with one or more of the populations being served. This individual must also have training or experience working in crisis services

In the event a position is vacated due to a leave greater than 30 days or staff termination, an equally qualified staff member in the MCM provider agency may substitute for up to 90 days. The provider agency shall have documented evidence of ongoing efforts to recruit for the vacant position.)

No MCM Team member who is actively fulfilling an MCM Team role may contribute to the staffing ratio required for another service during that time. When fulfilling the responsibilities of MCM services, the staff member must be fully available to respond in the community.

The consultation from the licensed professional or psychiatrist must be either face to face or via Telepsychiatry (for providers able to utilize telepsychiatry, see DMA Clinical Coverage Policy 1H). The consulting psychiatrist or other licensed professional can provide an assessment of the beneficiary. A diagnosis must only be made by a licensed professional.

Employees and contractors shall meet the qualifications s specified (10A NCAC 27G .0104) for the Qualified Professional shall have the knowledge, skills and abilities required by the population and age to be served.

Certified Peer Support Specialist must be an individual who is or has been a beneficiary of mental health or substance abuse services and is committed to his or her own personal recovery. A certified peer support specialist is a fully integrated team member who draws from his or her own experiences and knowledge gained as a beneficiary to provide individualized interventions to a beneficiary of MCM services. The certified peer support specialist validates the beneficiary's experiences and provides guidance and encouragement in taking responsibility for and actively participating in their own recovery. Certified peer support specialists also provide essential expertise and consultation to the entire team to promote a culture in which everyone's point of view and preferences are recognized, understood, respected, and integrated into treatment, rehabilitation, and community self-help activities.

Team members shall have a minimum of one year of experience in a crisis management setting or service during which the individual provided crisis response (such as by serving as a mental health/substance abuse first responder for enhanced services, in an emergency department, or in another service providing 24/7 response in emergent or urgent situations).

6.5 Staff Training and Supervision Requirements

6.5.1 Staff Training

The following are the requirements for training staff in MCM.

All MCM Staff

All MCM staff shall be trained according to the following training schedule:

a. Within 30 days of hire to provide MCM services (for staff who were currently working as an MCM Team member, all staff shall complete the following training requirements:
    1. Three hours of training in the MCM service definition required components;
    2. Crisis Response training (six hours);
b. Within 90 days of hire to provide this service, (for staff who were currently working as an MCM Team member), MCM staff shall complete the following training requirements:
    1. Motivational Interviewing (six hours) (physician exempt);
    2. Person Centered Thinking (six hours);
    3. Overview of Intellectual/Developmental Disabilities (The Intersection of Intellectual/Developmental Disabilities and Mental Health Using Positive Support to Change Behavior).
    4. 3 hours of training on trauma informed care (physician exempt) by December 31, 2018.
    5. A minimum of 10 hours of continuing education relevant to MCM must be completed annually. Physicians must complete continuing education according to their license requirements.

These initial training requirements may be waived, if the employee can produce written documentation certifying their successful completion of the required trainings within 12 months of employment with the MCM provider.

6.5.2 Supervision

Clinical or professional supervision must be provided according to the supervision and staffing requirements outlined in the policy. Supervision must be provided at the frequency and for the duration indicated in the individualized supervision plan created upon hire. Each supervision plan must be reviewed annually. Competencies are documented along with supervision requirements to maintain that competency. This applies to QPs and APs (10A NCAC 27G .0203).

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 DMA's clinical (medical) coverage policies, guidelines, policies, provider manuals, and bulletins published by the Centers for Medicare and Medicaid Services (CMS), DHHS, DHHS division(s) or fiscal contractor(s).

7.2 Expected Clinical Outcomes

The purpose of MCM is to serve beneficiaries in their primary private residences and communities, reduce the number of visits to hospital emergency rooms, and divert from inpatient hospitalization if a lower level of care is a safe and effective alternative. The following are among the outcomes expected for this service:

a. Stabilization of the presenting crisis;
b. Prevention of unnecessary hospitalization or other institutionalization;
c. Increased access to community based clinical services to reduce potential crisis episodes;
d. Decrease in emergency department visits and hospital admissions;
e. Reduction in the number and intensity of crisis episodes;
f. Strengthening of the beneficiary's natural support systems.

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8.0 Policy Implementation and History

Original Effective Date: 10/01/2003

History:

Date	Section or Subsection Amended	Change
	All Sections and Attachment(s)	Service definition for Mobile Crisis Management removed from clinical coverage policy 8A to become a standalone clinical coverage policy 8A-3. This policy reflects a revised version of Mobile Crisis Management Found in 8A

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Attachment A: Claims Related Information

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

A. Claim Type

Professional (CMS-1500/837P transaction)

Institutional (UB-04/837I transaction)

B. International Classification of Diseases and Related Health Problems, Tenth Revision, 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)

MCM provider(s) shall utilize the following code when billing MCM services.

HCPCS Code(s)
H2011

D. Modifiers

Provider(s) shall follow applicable modifier guidelines.

E. Billing Units

Units are billed in 15-minute increments.

F. Place of Service

This service is intended to be delivered in the least restrictive environment in natural settings such as the beneficiary's private residence, school, work, or other community setting where the crisis has occurred.

G. Copayments

For Medicaid refer to Medicaid State Plan, Attachment 4.18-A, page 1, located at http://dma.ncdhhs.gov/.
For NCHC refer to G.S. 108A-70.21(d)Reimbursement
Provider(s) shall bill their usual and customary charges.
For a schedule of rates, refer to: http://dma.ncdhhs.gov/

A qualified provider who renders services to a Medicaid beneficiary shall bill all other third party payers, including Medicare, before submitting a claim for Medicaid reimbursement.

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. (Refer to 10A NCAC 22J. 0106.)