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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 for whom employment has not been achieved or employment has been interrupted or intermittent. This service must be co-located within the agency’s behavioral health treatment services to ensure consistent behavioral health integration. 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 agency providing IPS is well informed on the IPS model and services align to the model. Additional approaches, such as Customized Employment, Self-Employment and Business-Led Internships, may be used under the umbrella of IPS to assist beneficiaries in securing competitive employment in the community that fits their particular needs, interests, and skills while enabling workplace success.

1.1 Definitions

1.1.1 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.”

1.1.2 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.”

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1.1.3 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.”

1.1.4 Mobile Work Crew-

A small crew of beneficiaries with disabilities that works as a distinct unit and operates as a self-contained business that generates employment for their crew members by selling a service. The crew works at several locations within the community, under the supervision of a job coach. The type of work usually includes janitorial or grounds keeping.

1.1.5 Enclave-

A work site of a competitive employer where a worker with a disability or a group of workers with disabilities are working and supervised by staff from a work center. The workers remain on the work center’s payroll.

1.1.6 Transitional Employment-

A job that provides a time-limited work experience, that is wage-paid and subsidized, and is in the public, private, or non-profit sectors for individuals with barriers to employment who are chronically unemployed or have inconsistent work history.

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

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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.

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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 the following criteria are met:

- a. The beneficiary is 16 years of age and older; and has:
 1. A primary diagnosis of a serious mental illness (SMI) that includes severe and persistent mental illness (SPMI), a primary diagnosis of a serious emotional disturbance (SED); or a primary diagnosis of substance use disorder (SUD), severe as defined by the current Diagnostic and Statistical Manual of Mental Disorders (DSM-5), or any subsequent editions of this reference material;
 2. Expressed the desire to work at the time of entrance to the program, and
 3. Has an established pattern of unemployment, underemployment, or sporadic employment, or
 4. Has educational goals that relate to employment goals; and

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5. Requires 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 the beneficiary's diagnosis.

3.2.2.1 Entrance Criteria

A standardized independent evaluation completed by a Tailored Plan (TP) or Prepaid Inpatient Health Plan (PIHP) to demonstrate beneficiary eligibility for 1915(i) benefit based on needs-based criteria; AND

An independent assessment completed by a care management agency that indicates the beneficiary would benefit from employment supports;

The assessment must be completed prior to the provision of this service. Relevant diagnostic information must be obtained from the TP Care Manager and independent care management entity and documented in the beneficiary's Care Plan.

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. The beneficiary 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 service plan;
- b. The beneficiary is making progress in meeting employment goals, but the interventions identified in the Employment Plan need to be modified to achieve competitive employment;
- c. The beneficiary has obtained a job, it has been less than a year since starting employment and requires follow-along supports as identified in the Employment Plan;
- d. The beneficiary needs follow-along support in learning how to manage benefits (Social Security, Ticket to Work;) or
- e. The beneficiary needs support to change jobs, increase hours of employment, or advance in their career.

3.2.2.3 Transition and Discharge Criteria

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

- a. The beneficiary's level of functioning has improved with respect to the goals outlined in the Employment Plan, inclusive of a transition plan to step down to a lower level of care;
- b. The beneficiary has achieved positive employment outcomes that support stable and ongoing vocational recovery, and is no longer in need of IPS;
- c. The beneficiary has requested that IPS be discontinued; or
- d. The beneficiary no longer meets criteria for IPS.

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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. 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 Employment Plan;
- 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;

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- 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

Upon admission to IPS, a beneficiary is allowed a 64 unit (16 hour) pass-through. An authorization from the Prepaid Inpatient Health Plan (PIHP) or utilization management (UM) contractor is required after the initial 64 unit (16 hour) pass-through.

5.2 Prior Approval Requirements

5.2.1 General

The provider(s) shall submit to the PIHP or UM 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

Initial Authorization

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.

Services are based upon a finding of medical necessity, must be directly related to the beneficiary's diagnostic and clinical needs, and are expected to achieve the specific rehabilitative goals detailed in the beneficiary's service plan. Medical necessity is determined by North Carolina community practice standards, as verified by the DHHS Utilization Management Review Contractor or the Cherokee Indian Hospital Authority, who evaluates the request to determine if medical necessity supports intensive services.

Medically necessary services are authorized in the most cost-effective modes, if the treatment that is made available is similarly efficacious as services requested by the beneficiary's physician, therapist, or another licensed practitioner. The medically necessary service must be recognized as an accepted method of medical practice or treatment. Reauthorizations should be based on the level of intensity required to acquire stable employment or interventions required for continued employment.

To request an authorization, the individual assessment and independent evaluation, the Employment Plan, service order and the required NC Medicaid authorization request form must be submitted to the DHHS Utilization

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Management Review Contractor or the Cherokee Indian Hospital Authority within the first 30 calendar days of service initiation.

Reauthorization

Reauthorization must be submitted prior to initial or concurrent authorization expiring. Authorizations are based on medical necessity documented in the service plan, the authorization request form, and supporting documentation.

5.3 Additional Limitations or Requirements

IPS providers must refer a beneficiary to the Division of Vocational Rehabilitation Services (DVRS) 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% or more of total scheduled work hours in the community. Frequency and intensity of services must be documented in the beneficiary's Employment Plan. 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 any active authorization period. 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 authorization period as Assertive Community Treatment (ACT).

Note: IPS is not a "first responder" service. As documented in the beneficiary's care plan, or employment plan, 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. Service orders are a mechanism to demonstrate medical necessity for a service and are 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. Ph.D. psychologist;
 4. Physician;
 5. nurse practitioner, or
 6. physician assistant.

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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.

An Employment Plan 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 Employment Plan.

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;
- d. type of contact (in-person, phone call, collateral);
- e. place of service;
- f. purpose of contact;
- g. implementation of the employment plan;
- h. details of beneficiary's response to treatment plan;
- i. description of the provider's interventions. Documentation of the intervention must accurately reflect the beneficiary's personalized goals for the duration of time indicated;
- j. duration of service, amount of time spent performing the intervention;
- k. assessment of the effectiveness and of interventions and the beneficiary's progress towards the beneficiary's goals; and
- l. date, signatures, credentials or job title of staff providing the service.

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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 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;
- 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.

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 the DHHS and the requirements of 10A NCAC 27G .5800 Supported Employment For Individuals Of All Disability Groups.

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.

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.

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

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 implementation 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	1.0 FTE 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)	1.0 FTE must be a QMHP, or Associate Mental Health Professional (AMHP), CIPS, or CESP
Employment Peer Mentor (EPM)	1.0 FTE 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	0.50 FTE must be either a Certified Work Incentives Counselor

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	(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	0.50 FTE 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.

Employment Support Professional (ESP)
<ul style="list-style-type: none"> • Use assertive engagement strategies to engage beneficiaries considering IPS services. • Directly provide IPS services to beneficiaries, maintaining a caseload of no more than 25 beneficiaries. • Develop the Career Profile and Employment Plan 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. • Ensure the integration of IPS with other mental health services.

Employment Peer Mentor (EPM)
<ul style="list-style-type: none"> • 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 and Employment Plan . • Assist in learning how to ask for appropriate services in community.

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- 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.
- Build 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, including any changes to benefits, of the work incentive benefit analysis.
- Provide a list of work incentives available, as applicable.
- Support the beneficiary to access the work incentive they want to use.

Program Assistant

- Organize, coordinate, and monitor all administrative operations of the team.
- Maintain client and programmatic records.
- Enter and track team performance beneficiary outcome data.
- Run reports.
- Receive calls and responds to referral sources.
- Manage authorization requests.
- Assist with organizational record-keeping.
- Manage human resources and continuing education files for ESPs.
- Schedule activities.

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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 for Employment*	IPS Team Lead, ESP, Benefits Counselor	Hours to commensurate with DHHS approved training
Annually	▪ Employment focused training, which can include specialty approaches for the implementation of ethical, person-centered, best practice IPS per population served.	IPS Team Lead, ESP, EPM, Benefits Counselor	8hours

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.

*Motivational Interviewing training must be provided by a Motivational Interviewing Network of Trainers (MINT) trainer. If a staff person is a MINT trainer, they are not required to have this training. The training requirement for MINT Motivational

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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) should 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 Employment Plan. 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 supports.

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.

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 ongoing behavioral health integration. 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*

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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.

6.4 Expected Clinical Outcomes

Expected clinical outcomes include the following:

- a. The beneficiary finds and maintains competitive employment consistent with their employment recovery goals;

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- b. The beneficiary enrolls in or completes credits towards an educational program that can then be leveraged to find employment;
- c. The beneficiary increases the average number of hours worked a week; or
- d. The beneficiary 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 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: Month Day, Year

History:

Date	Section or Subsection Amended	Change
	All Sections and Attachment(s)	

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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, NC Medicaid’s clinical coverage policies and any other relevant documents for specific coverage and reimbursement for Medicaid. 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.

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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//>