DRAFT

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:
8A-1, Assertive Community Treatment (ACT program)
8A-6, Community Support Team (CST)
8D-1, Psychiatric Residential Treatment Facilities for Children under the Age of 21
8D-2, Residential Treatment Services

1.0 Description of the Procedure, Product, or Service

Individual and Transitional Support is a direct, one-on-one service provided to a beneficiary aged 16 and older with a Serious Emotional Disturbance (SED), Serious Mental Illness (SMI), Severe and Persistent Mental Illness (SPMI) or a severe substance use disorder (SUD) diagnosis. This service provides structured, scheduled interventions to improve a beneficiary's ability to manage Instrumental Activities of Daily Living (IADL) and promote independent functioning in the community and recovery. Activities are provided in partnership with a beneficiary to develop skills needed to:

a. engage in their self-directed recovery process;
b. obtain, maintain employment;
c. access transportation;
d. obtain, maintain housing;
e. improve, maintain financial responsibility; or
f. continue their education.

Activities are individualized according to a beneficiary's strengths, interests, skills, and goals.

1.1 Definitions

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."

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."

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."

2.0 Eligibility Requirements

2.1 Provisions

2.1.1 General

(*The term "General" found throughout this policy applies to all Medicaid and 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>

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 beneficiary is 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 can file for reimbursement with Medicaid for these services.

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

2.2 Special Provisions

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

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

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

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

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

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

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

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

b. **EPSDT and Prior Approval Requirements**

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

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

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

3.0 When the Procedure, Product, or Service Is Covered

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

3.1 General Criteria Covered

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

a. the procedure, product, or service is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the beneficiary's needs;
b. the procedure, product, or service can be safely furnished, and no equally effective and more conservative or less costly treatment is available statewide; and
c. the procedure, product, or service is furnished in a manner not primarily intended for the convenience of the beneficiary, the beneficiary's caretaker, or the provider.

3.2 Specific Criteria Covered

3.2.1 Specific criteria covered by Medicaid

None Apply.

3.2.2 Medicaid Additional Criteria Covered

Medicaid shall cover Individual and Transitional Support when ALL following criteria are met:

a. The beneficiary meets criteria for one or more of the following as defined in **Section 1.1**:

   1. Serious Mental Illness (SMI);
   2. Severe and Persistent Mental Illness (SPMI);
   3. Serious Emotional Disturbance (SED); or
   4. a severe substance use disorder as defined by the Diagnostic and Statistical Manual of Mental Disorders-5 or any subsequent versions.

   and

b. The beneficiary has documented identified needs in at least ONE or more of the following areas (related to diagnosis):
   1. Adaptive skills (communication, problem-solving, or organizational skills);
   2. Employment;
   3. Education;
   4. Financial management;
   5. Health management;
   6. Residence establishment and management;

7. Meal preparation and cleanup (grocery shopping, cooking, using kitchen appliances, properly storing food);
8. Purchase and care for clothes;
9. Maintaining personal safety;
10. Self-care management; or
11. Maintenance of Abstinence from substance use, including for those on medication assisted treatment, and maintenance of relapse prevention skills.

and

c. There is no evidence to support that alternative interventions would be equally or more effective based on North Carolina community practice standards.

3.2.3 Admission Criteria

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

3.2.4 Continued Stay Criteria

Medicaid shall cover a continued stay if the desired outcome or level of functioning has not been restored, improved, or sustained over the time frame outlined in the beneficiary's care plan or the beneficiary continues to be at risk for relapse based on current clinical assessment, history, or the tenuous nature of the functional gains; and one of the following applies:

a. The beneficiary has achieved current care plan goals and additional goals are indicated, as evidenced by documented symptoms;
b. The beneficiary is making satisfactory progress toward meeting goals. There is documentation to support continuing this service is effective in addressing the goals outlined in the care plan;
c. The beneficiary is making some progress, but the specific interventions in the care plan need to be modified so that greater gains, which are consistent with the beneficiary's pre-morbid or potential level of functioning are possible; or
d. The beneficiary fails to make progress or demonstrates regression in meeting goals through the interventions outlined in the care plan. In this case a reassessment of the beneficiary's diagnosis, functional and support needs must occur to identify any unrecognized needs, such as co-occurring disorders; and the beneficiary's treatment recommendations must be revised based on the findings.

3.2.5 Transition and Discharge Criteria

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

a. The level of functioning has improved with respect to the goals outlined in the care plan, inclusive of a transition plan to step down to a lower level of care;

b. has achieved positive life outcomes that support stable and ongoing recovery, and is no longer in need of Individual and Transitional Support;

~~c.~~ has made limited or no progress, and all reasonable strategies and interventions have been exhausted, indicating a need for more intensive services;

d. The beneficiary or legally responsible person for the beneficiary requests discharge from the service; or

e. The beneficiary no longer meets eligibility criteria for 1915(i) services.

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

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

4.1 General Criteria Not Covered

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

a. the beneficiary does not meet the eligibility requirements listed in **Section 2.0;**
b. the beneficiary does not meet the criteria listed in **Section 3.0;**
c. the procedure, product, or service duplicates another provider's procedure, product, or service; or
d. the procedure, product, or service is experimental, investigational, or part of a clinical trial.

4.2 Specific Criteria Not Covered

4.2.1 Specific Criteria Not Covered by Medicaid

None Apply.

4.2.2 Medicaid Additional Criteria Not Covered

In addition to the Specific Criteria Not Covered in **Subsection 4.2.1** of this policy, Medicaid shall not cover:

a. Transportation for the beneficiary or family members;

b. Any habilitation activities;

c. Time spent doing, attending or participating in recreational activities unless tied to specific planned social skill assistance;

d. Covered services that have not been rendered;

e. Childcare services or services provided as a substitute for the parent or other individuals responsible for providing care and supervision;

f. Services provided to teach academic subjects or as a substitute for education personnel;

g. Interventions not identified on the beneficiary's care plan;

~~h. Services provided without prior authorization;~~

i. Services provided to children, spouse, parents or siblings of the beneficiary under treatment or others in the beneficiary's life to address problems not directly related to the beneficiary's needs and not listed on the care plan; and

j. Payment for room and board.

5.0 Requirements for and Limitations on Coverage

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

5.1 Prior Approval

Medicaid shall not require prior approval of Individual and Transitional Support. ~~The provider shall obtain prior approval before rendering service.~~

5.2 Prior Approval Requirements

5.2.1 General

None Apply.

~~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

None Apply.

~~Utilization management of covered services is 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.~~

~~**Initial Authorization**~~

~~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 care 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.~~

~~To request an initial authorization, the individual assessment and individual evaluation, service order for medical necessity, care plan, and the required NC~~

~~Medicaid authorization request form must be submitted to the DHHS-approved Utilization Management Review Contractor or the Cherokee Indian Hospital Authority prior to service being rendered. Medicaid can cover up to 240 units of service per month. Initial authorization of services cannot exceed 180 calendar days. Authorization is based on medical necessity documented on the authorization request form and supporting documentation.~~

~~**Reauthorization**~~
~~Reauthorization request must be submitted to the DHHS-approved Utilization Management Review Contractor or the Cherokee Indian Hospital Authority prior to the initial or concurrent authorization expiring. Medicaid may cover up to 240 units of service per month for 90 calendar days for reauthorization periods. Reauthorization is based on medical necessity documented in the care plan, the authorization request form, and supporting documentation. The duration and frequency at which ITS is provided must be based on medical necessity and progress made by the beneficiary toward goals outlined in the care plan. It is expected that service intensity titrates down as the beneficiary demonstrates improvement in targeted life domains.~~

~~**Note:** Any denial, reduction, suspension, or termination of ITS requires the beneficiary or legally responsible person(s) of the beneficiary to be notified of their appeal rights~~.

5.3 Additional Limitations or Requirements

a. A beneficiary can receive ITS from only one provider organization during an episode of care. ~~any active authorization period~~.
b. Family members or legally responsible individuals of the beneficiary are not eligible to provide this service.
c. This service cannot be provided in a group.
d. Housekeeping, homemaking, or basic services solely for the convenience of a child or adult receiving the service are not covered.
e. This service cannot be provided if the service is otherwise available under a program funded under the Rehabilitation Act of 1973, P.L. 94-142, or under the Individuals with Disabilities Education Act, 20 U.S.C. 1401 et seq.).
f. This service cannot be provided during the same time as another direct support Medicaid service.
g. This service cannot be provided during the same episode of care ~~authorization period~~ as Assertive Community Treatment, Community Support Team, Intensive In-Home,-Multisystemic Therapy, Psychosocial Rehabilitation or any other duplicative service or component of the service.
h. This service cannot be provided to a beneficiary age 16 to 21 who resides in a Medicaid funded group residential treatment facility. Residential facilities provide duplicative components of Individual and Transitional Support services.
i. This service cannot be provided to a beneficiary residing in Institutions for Mental Disease (IMD) regardless of the facility type.
j. A beneficiary transitioning from an adult mental health or SUD residential setting or an adult care home into independent housing may receive this service up to 90 days prior to their discharge.

Note: Individual and Transitional Support is not a crisis "first responder" service. As documented in the beneficiary's care plan, the Crisis Prevention and Intervention Plan, the service provider shall coordinate with other service providers to ensure "first responder" coverage and crisis response for the beneficiary.

5.4 Service Order

A Service order is 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;

a. qualified professional;
b. licensed behavioral health clinician;
c. licensed psychologist;
d. physician;
e. nurse practitioner; or
f. physician assistant per their scope of practice.

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

ALL the following apply to a service order:

a. Backdating of the service order is not allowed;
b. Each service order must be signed and dated by the authorizing professional and must indicate the date on which the service was ordered; and
c. 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 shall ensure that their documentation is consistent with the requirements contained in this policy. The staff member who provides the service is responsible for documenting the services billed to and reimbursed by Medicaid. The staff person who provides the service must sign and date the written entry. The signature must contain the credentials for professional or job title for associate professional. The care plan and discharge plan must be discussed with the beneficiary and documented in the service record.

5.5.1 Contents of a Service Note

For Individual and Transitional Support, a complete-service note is a progress note required for each contact or intervention for each date of service, written and signed by the staff who provided the service. More than one intervention, activity, or goal can be reported in one service note, if applicable. A service note must contain ALL the following elements:

a. Beneficiary's name;
b. Medicaid identification number;
c. Date of the service provision;
d. Name of service provided;
e. Type of contact (in-person, phone call or collateral);
f. Place of service;

g. Purpose of contact as it relates to the care plan goals;
h. Description of the intervention provided. Documentation of the intervention must accurately reflect treatment for the duration of time indicated;
i. Duration of service, amount of time spent performing the intervention;
j. Assessment of the effectiveness of the intervention and the beneficiary's progress towards the beneficiary's goals;
k. Date, signature, credentials or job title of the staff member who provided the service; and
l. Each service note page must be identified with the beneficiary's name Medicaid identification number and record number.

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

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

a. meet Medicaid qualifications for participation;
b. have a current and signed 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

Individual and Transitional Support must be delivered by providers employed by mental health provider organizations that:

a. meets the provider qualification policies, procedures, and standards established by the NC Medicaid;
b. meets the requirements of 10A NCAC 27G - Rules for Mental Health, Developmental Disabilities, and Substance Abuse Facilities and Services;
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.

6.2 Provider Certifications

None Apply.

6.2.1 Staff Requirements

Individual and Transitional Support is provided by qualified providers with the capacity and adequate workforce to offer this service to eligible Medicaid beneficiaries. The provider must have the ability to offer this service at any time of the day, including evening times or weekends, as needed by the beneficiary, and specified in the beneficiary's care plan.

Individual and Transitional Support staff must be supervised by a full-time Qualified Professional (QP) who meets the requirements according to 10A NCAC 27G .0104.

Individual and Transitional Support is provided by Paraprofessional (PP) staff who meet the requirements according to 10A NCAC 27G .0104.

The maximum program staff ratio is 1 QP to 8 Paraprofessionals. The QP determines beneficiary to staff caseload ratio by the intensity of needs of the beneficiaries served.

The following charts reflect the activities and appropriate scopes of practice for the following staff:

Qualified Professional
• Knowledge and skills needed to provide services to population served.
• Provide supervision and collaborate with paraprofessional staff to develop an individualized supervision plan upon hiring and review plan annually.
• Determines staff caseload by the needs of the beneficiary served.
• Monitor and evaluate the effectiveness of services, interventions, and activities provided by staff.
• Linkage and referral to formal and informal supports.
• Collaborate with Paraprofessional (PP) staff, beneficiary and care management agency to integrate service into existing care plan or PCP.
• Support the beneficiary in identifying their goals and the necessary skills and supports needed to reach their goals.
• Support the beneficiary in completing an evaluation of their skills and support strengths and deficits in relation to their goals.
• Support the beneficiary in completing a thorough assessment of their strengths and resources that support goal attainment, and a thorough assessment of deficits or barriers that could prevent goal attainment.
• Assist beneficiary in understanding the role, rights and responsibilities of the tenant and landlord and provide coaching to resolve disputes with landlord.
• Assist the beneficiary with identifying resources to cover set-up fees for utilities or service access, including telephone, electricity, heating and water, and services necessary for the beneficiary's health and safety, consisting of pest eradication and one-time cleaning prior to occupancy

Paraprofessional
• Knowledge and skills needed provide services to population served.
• Collaborate with supervisor to develop individualized supervision plan upon hiring and review plan annually.
• Monitor and evaluate the effectiveness of services, interventions, and activities provided.
• Provides recovery focused psychoeducation (harm reduction, prevention of return to use, coping skill strategies) as indicated in the care plan.

• Assist beneficiary with housing search, completion of rental applications, moving and rehousing activities, and housing recertification.
• Assist beneficiary in understanding the role, rights and responsibilities of the tenant and landlord.
• Assist the individual with identifying resources to cover set-up fees for utilities or service access, including telephone, electricity, heating and water, and services necessary for the individual's health and safety, consisting of pest eradication and one-time cleaning prior to occupancy.
• Assist beneficiary with the development of skills to complete IADLs
• Ability to assess beneficiary's performance and capacity to complete IADLs.
• Promote beneficiary self-efficacy.
• Model and teach positive social skills.
• Model and teach effective communication skills.
• Model and teach positive self-care skills (personal grooming, physical health management, household management, coping skills, budgeting skills, personal safety).
• Ensure that all skill development work is done in natural environments (home, school, community) the beneficiary resides in, or will reside in.
• Support the beneficiary in overcoming barriers to using skills.
• Link the beneficiary directly to existing resources that are tied to goal achievement and overall satisfaction.
• Assist the beneficiary in developing social skills for spending leisure time with others (how to make a date, how to host a get-together, dining in a restaurant, going to a movie or bowling).
• Assist beneficiary with the development of a healthy living environment, that supports recovery, including development of a strong support network.
• Assist beneficiary with development of parenting skills impacted by substance use disorders, mental health diagnoses, and other co-occurring diagnoses.
• Provide coaching related to life skills, including stress management, personal development, and focus on strategies for achievement of long-term goals

6.2.2 Training Requirements

Individual and Transitional Support staff shall participate in training related to the population being served. Staff must complete a minimum of 20 hours of initial training in the following areas within the 90 calendar days of the date of hire to provide this service:

a. Training on Opioid Antagonist administration (Administering Naloxone or other federal Food and Drug Administration approved opioid antagonist for drug overdose);
b. Clinical and psychosocial needs of the SMI, SPMI, SED or SUD population;
c. Trauma Informed Care;
d. Wellness and Recovery Action Plan (WRAP);
e. Whole Health Action Management (WHAM);
f. Basic Mental Health and Substance Use 101;
g. Mental Health First Aid;
h. Psychotropic medications and possible side effects;
i. Permanent Supportive Housing or Tenancy Support;
j. Psychiatric Rehabilitation and Recovery;

k. Substances of use and related symptoms;
l. Crisis management;
m. Principles of recovery, resiliency and empowerment;
n. Community resources and services, such as pertinent referral criteria;
o. Member and family support networking;
p. Diagnoses and clinical issues regarding the population served;
q. Crisis intervention and response;
r. Individual and Transitional Support Planning to contain development of goals and interventions;
s. Protective devices and usage as applicable for the beneficiary;
t. Cultural diversity and awareness;
u. Knowledge of the service delivery system;
v. Pregnancy and SUD;
w. Positive Parenting Skills;
x. Child Development; and
y. Harm Reduction.

The initial training requirements may be waived by the hiring agency if the employee can provide documentation certifying that training was completed no more than 24-consecutive months prior to hire date. Staff shall complete 10 hours of continuing education annually related to the population being served.

Individual and Transitional Support interventions must be based on the *Psychiatric Rehabilitation and Recovery* model (Http://cpr.bu.edu/). The goal of psychiatric rehabilitation is to help people with severe and persistent mental illness develop the skills needed to live, learn and work in the community with the least amount of professional support possible.

Individual and Transitional Support uses the basic *Tenancy Support* within the *Permanent Supportive Housing* model, per the toolkit through SAMHSA, to help individuals chose their home, learn skills to maintain their home, and ensure long term housing retention in the community with the same rights and responsibilities as everyone else.

6.3 Expected Outcomes

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

a. Increased engagement in self-directed recovery process;
b. Improved personal, social, and community living skills;
c. Increased ability to engage in community activities;
d. Increased ability to live as independently as possible;
e. Improved emotional, behavioral and physical health;
f. Improved vocational skills;
g. Increased housing retention; and
h. Decreased utilization of crisis services.

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).

7.2 Electronic Visit Verification

Electronic Visit Verification (EVV) is a tracking system that requires electronic verification when a beneficiary receives personal care or home health service funded by Medicaid to ensure the service is provided. Providers of Individual and Transitional Support Services are subject to EVV (in-home visits only) and must comply with the following minimum requirements:

a. Comply with Section 12006 of the 21st Century Cures Act of the Social Security Act (SSA) and any subsequent amendments.
b. Register with the State's EVV solution or procure an alternate EVV solution. If provider selects alternate solution, the solution must be compliant with the 21st Century Cures Act and all state requirements.
c. Provider agencies must have written documentation in each beneficiary's file that they have informed beneficiaries of the EVV requirement.
d. Provider agencies must ensure staff are trained in the use of the EVV system selected and maintain written documentation of initial and at least annual staff training in each employee's file.

7.2.1 Electronic Visit Verification (EVV) Technology Options and Requirements

Providers must use an Electronic Visit Verification EVV solution to verify in-home visits through mobile device application, telephone, or fixed visit verification devices. EVV data elements required by the 21st Century Cures act are as follows:

a. Date service was provided;
b. Location service was provided;
c. Time the service begins and ends;
d. Type of service provided;
e. Individual receiving the service; and
f. Individual providing the service.

8.0 Policy Implementation and History

Original Effective Date: Month Day, Year

History:

Date	Section or Subsection Amended	Change
09/15/2023	All Sections and Attachment(s)	Initial Implementation of Policy
	Section 5.0	To comply with the Mental Health Parity and Addiction Equity Act and the Code of Federal Regulations Title 42 Chapter IV Subchapter C Part 438 Subpart K, § 438.900, language referencing prior approval was revised; and language referencing authorizations, and utilization management removed.
	Subsection 4.2.2	Removed: h. Services provided without prior authorization;
	Subsection 5.3	Language revised: "any active authorization period" replaced with "an episode of care".

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)

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)
T1019

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.

Modifier(s)
U4
U4 TS (non-EVV, only in the community)

E. Billing Units

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

Units are billed in 15-minute increments.

Individual and Transitional Support services provided in the community may be billed at a case rate.

F. Place of Service

Individual and Transitional Support can be provided in the beneficiary's private primary residence, in a shelter, licensed group home, adult care home, mental health and SUD residential setting, the community or in an office setting. It may not be provided in the residence of provider staff.

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//