Vaya Health

Child-Focused Assertive Community Treatment (Child ACT) Team

H0040 U5 HA
H0040 U5 HA TS (Encounters)

Service

Child-Focused Assertive Community Treatment (Child ACT) Team is a team-based, multi-disciplinary approach to serving children in their homes, kinship placements, or Department of Social Services (DSS) foster homes, or the service may begin during transition from a more restrictive residential setting. Like the Assertive Community Treatment (ACT) Team service for adults, this service uses a community-based team approach to meet the needs of youth with serious emotional disturbance (SED). This service is used to meet the needs of youth who have any of the following needs:

- Are at high risk for out-of-home residential treatment due to a psychiatric disorder.
- Have a history of multiple hospitalizations or long-term hospitalization(s) at a state facility.
- Have a history of multiple episodes of residential treatment.
- Who are unresponsive to conventional outpatient/community-based treatment (outpatient therapy, intensive in-home services, etc.) after discharge from residential treatment.
- Symptoms are at a severity where typically a psychiatric residential treatment facility (PRTF) would be recommended.

Child ACT Team is the first line (and generally sole provider) of all the behavioral health services that a member needs. Being the single point of responsibility necessitates a higher frequency and intensity of community-based contacts and a very low member-to-staff ratio.

- The service is designed for members ages 12-18 with a primary mental health diagnosis. However, individuals diagnosed with mental health conditions and co-occurring moderate or mild intellectual/developmental disabilities (I/DD) or autism spectrum disorder will be assessed on a case-by-case basis for participation in Child ACT Team.
- A member who is appropriate for this service needs assertive engagement to develop treatment motivation. The member does not benefit from receiving services across multiple, disconnected providers and may be at greater risk of hospitalization, out-of-home placement, substance use, victimization, and juvenile justice involvement.
- The team provides person-centered services addressing all of the member's behavioral health needs, helping them achieve their personal goals.
- The team includes the family/caregiver.
- Services are flexible; teams offer varying levels of care for all members and appropriately adjust service levels given a member's changing needs over time.
- Services address needs in multiple life domains, including family life and social relationships, health, housing, substance use, medication support, financial, activities of daily living, educational/vocational, and wellness self-management/relapse prevention.
- Treatment interventions include evidence-based treatment with the methodologies appropriate for the current needs of the member:
    - Trauma Systems Therapy (underlying organization-wide treatment model)
    - Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)
    - Dialectical Behavior Therapy (DBT)
    - Cognitive Behavioral Therapy (CBT)

- Motivational Interviewing (MI)
- Attachment Self-Regulation and Competency (ARC)
- Wellness Recovery Action Plan (WRAP)
- Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS)
- Seven Challenges
- Other models as determined by youth/family needs

Anticipated Outcomes

The majority (minimum of 80%) of Child ACT Team services must be provided in the home or other community settings. The team members providing the direct interventions to the child and family may vary based on the needs of the individual. The team shall have daily meetings to prioritize activities, share information, and discuss individual members. The team shall be available to respond 24/7 for crisis de-escalation and assessment, inclusive of availability by phone within 15 minutes and face-to-face within one to two hours. The intervention shall include face-to-face assessment by a clinician, or nurse if this is determined to be needed for the individual. The psychiatric prescriber shall be available minimally by phone 24/7 for consultation and treatment recommendations. The team shall continually assess the overall needs of the family to ensure that all necessary treatment and supports are in place.

It is expected that members will reduce the amount of time spent in residential settings and become more integrated within their own community. In addition, the following outcomes are anticipated:

a. Increased adherence to treatment/care plan.
b. Vocational/educational gains.
c. Increased stay in their community residence with family or natural supports.
d. Family or natural supports will be more involved/engaged with the youth and their treatment.
e. Increased engagement in positive supportive activities.

Service Exclusions

This service is intended to be a bundled comprehensive service that meets all of the member's behavioral health treatment needs. Other services (other than previously referenced during a transition period) are excluded from being provided at the same time as Child ACT Team. Tailored Care Management services are duplicative of Child ACT Team and may not be provided during the same authorization period. The provider is required to fulfill all care management duties, including coordinating with physical health providers, with the exception of delivering interventions related to Healthy Opportunities and prevention and population health programs. A care coordinator may be assigned to member to ensure there are no gaps in member care. Inpatient, Facility-Based Crisis, and emergency department services can still be accessed as medically necessary for crisis stabilization. Services under the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit will still be considered as necessary on an individual member basis.

Service Frequency and Intensity

Child ACT Team services are primarily provided in the community. A fundamental feature of Child ACT Team is that services are delivered in the member/family's natural environment, rather than the member/family going to an office or clinic setting to receive services. Services shall be delivered in various natural environments, such as homes, schools, court, homeless shelters, libraries, street locations, and other community settings.

Some supportive coordination activities, such as researching community supports, may be delivered through Child ACT Team. Obtaining progress updates from other treatment providers may be done from the provider's office setting.

Whenever appropriate, coordination may occur in the community with the families or during Child and Family Team meetings. All encounter claims shall accurately reflect the setting in which they were provided. Child ACT Team also includes telephone time with the member and the member's family or caregivers, as well as collateral contact with people who assist the member in meeting the goals as specified in the person-centered plan. Child ACT Team includes participation and ongoing clinical involvement with the Child and Family Team and meetings for the planning, development, implementation, and revision of the member's person-centered plan.

Most services (typically 80-90%) are provided in the home or other community settings. While the composition of the team is established, the team members providing the direct interventions to the member and family may be varied based on the needs of the individual. The team shall have daily meetings to prioritize activities, share information, and discuss individual members. The team shall be available to respond 24 hours a day/seven days a week/365 days a year for crisis de-escalation and assessment, inclusive of availability by phone within 15 minutes and face-to-face within no more than two hours. This includes face-to-face assessment by a clinician, or nurse if this is determined to be needed for the member. The psychiatric provider is available minimally by phone 24/7 for consultation and treatment recommendations. The team shall assess the overall needs of the family to ensure that all necessary treatment and supports are in place for the entire family system. Targeted length of service is six months.

Program size:

a. Small teams: Serve a maximum of 40 members, with one Child ACT Team staff person per eight or fewer members (must have at least five staff if team is full).
b. Mid-size teams: Serve a maximum of 63 members, with one Child ACT Team staff person per nine or fewer members (must have at least seven staff if team is full).

Note: Movement on and off the teams may result in temporary breaches of caseload. Therefore, teams shall be required to maintain an annual average not to exceed the limits above.

Provider Requirements

The provider delivering this service shall meet the following requirements:

Supervision is provided according to supervision requirements specified in 10 NCAC 14V and according to licensure/ certification requirements of the appropriate discipline.

Staffing Requirements

All employees must meet the minimum education, experience, and licensure criteria established for their position as required in rules or service definitions, whichever is most restrictive.

Child ACT Team is delivered by a team comprising the following positions:

Position	Minimum staffing	Staff Qualifications
Team Leader - required This position is to be occupied by only one person.	1 Full-time employee (FTE)	The team leader is a licensed mental health professional holding any of the following licenses: Licensed psychologist, licensed psychological associate, licensed clinical social worker, licensed clinical mental health counselor, licensed marriage and family therapist, licensed psychiatric nurse practitioner, or clinical nurse specialist certified as an advanced practice psychiatric clinical nurse specialist.

Position	Minimum staffing	Staff Qualifications
		The team leader has three years of clinical experience with children with SED, with a minimum of two years post-graduate school experience.
Psychiatric Care Provider – required	.5 FTE	Board-eligible or certified by the American Board of Psychiatry and Neurology, licensed to practice in North Carolina, and meets the credentialing and qualifications as specified in NCAC 27G .0104(16). Psychiatrist must be a child and adolescent psychiatrist. If a psychiatric nurse practitioner is used, they shall be currently licensed as a nurse practitioner in North Carolina and meet the requirements as specified in 21 NCAC 36.0800, approval and practice parameters for nurse practitioners, with at least three years full-time experience treating children with SED. If a physician assistant is used, they shall be currently licensed as a physician assistant in North Carolina and must meet the requirements as specified in 21 NCAC 32S.0200, with at least three years full-time experience treating children with SED.
Nursing – required	1 FTE	A registered nurse(s) (RN) or advanced practice registered nurse (APRN) has a minimum of one year experience working with children with SED and a working knowledge of psychiatric medications
Licensed Clinician – required	1 FTE	Licensed clinician(s) with at least one year of experience working with children with SED. The licensed clinician shall be a licensed mental health professional holding any of the following licenses: Licensed psychologist, licensed psychological associate, licensed clinical social worker, licensed clinical mental health counselor, licensed marriage and family therapist, licensed psychiatric nurse practitioner, or clinical nurse specialist certified as an advanced practice psychiatric clinical nurse specialist. An associate-level licensed professional must be fully licensed within 30 months from the date of hire.
Substance Use Specialist - (May be utilized to make up the additional two required FTE [small team] or contribute to the additional staffing for a mid-sized team)	PRN	The team shall include substance use expertise if serving youth with primary substance use disorder (SUD) diagnosis and this is not within the scope of the team lead or other clinicians on the team; individuals providing substance use expertise shall meet qualified professional credentials and qualifications according to 10A NCAC 27G .0104(19) and have a designation of certified clinical supervisor, licensed clinical addiction specialist, licensed clinical addiction specialist associate, or certified substance abuse counselor.

Position	Minimum staffing	Staff Qualifications
Peer Specialist – Youth (May be utilized to make up the additional two required FTE [small team] or contribute to the additional staffing for a mid-sized team)	.25- .5 FTE	The team includes peer specialist(s). Minimum age is 18. To ensure that the experience of the peer specialist is commensurate with those served by team for this position, the individual must have "lived experience" and a personal recovery story specific to child/adolescent SED.
Family Advocate (May be utilized to make up the additional two required FTE [small team] or contribute to the additional staffing for a mid-sized team)	.25- .5 FTE	Each team has family advocate(s). To ensure that the experience of the family advocate is commensurate with those served by the team, for this position, the individual must have "lived experience" and a personal recovery story specific to being a caregiver for an SED child/adolescent.
Case Coordination (May be utilized to make up the additional two required FTE [small team] or contribute to the additional staffing for a mid-sized team)	1 FTE	Team will include case coordination; staff providing this service meet requirements as an associate licensed professional or licensed professional and must have one year of experience with children with SED. An associate level licensed professional must be fully licensed within 30 months from the date of hire.
Behavioral Specialist (May be utilized to make up the additional two required FTE [small team] or contribute to the additional staffing for a mid-sized team)	.5 FTE	Team will include behavioral specialist(s). Must qualify as QP or AP. Must have one year of experience working with children/adolescents with SED.
Additional Staff		Any additional staffing should reflect the intended program size, number of members served, and needs of the team. Areas of expertise and training may include, for example, supportive housing, money management, empirically supported therapy, family liaison, and forensic and legal issues. If teams are targeting a specific clinical population, it is recommended they hire additional staff reflecting the expertise and training needed for the targeted clinical population (example, a second substance use counselor for teams serving primarily members with co-occurring SUD).

A team shall always have a minimum of five FTE staff. The team must always maintain a team lead, a nurse, a clinician, and a psychiatric practitioner. The fourth and fifth staff can be an FTE or combination of part time FTEs fulfilling the roles most needed based on the members being served by the team or areas that the existing staff do not have sufficient experience and or expertise in. For example, if the team lead and/or clinician have experience with SUD, it may not be necessary to have an additional SUD clinician, even if members on the team have this as an identified treatment need.

However, if neither of those individuals have this background, it may be necessary to have an SUD professional on the team if the members have this as an identified treatment need. The case coordination activities may also be provided by a combination of individuals on the team or may be done by a designated staff member.

The psychiatric care provider is not counted in the minimum FTE, but one must always be assigned to a team. Additional staff will be added based on the caseload served by the team or the clinical needs of the members. Not all members being served by the team will interact with all staff, but all will be seen by the psychiatric care provider.

For licensed professionals: Providers ensure that all licensed staff complete the required credentialing process and maintain their licensure. Provider organizations shall complete CAQH, and if needed NCTracks, NCID, and NPI and submit credentialing application.

For unlicensed staff: Provider organizations complete primary source verification for education and verifies experience. Final determination of paraprofessional, associate professional, or qualified professional must follow all applicable agencies policies and procedures and NC General Statutes. Provider organizations are responsible for ensuring staff have the knowledge, skills, and abilities required by the population and age to be served.

All team members receive ongoing clinical and administrative supervision from team leadership, with the team leader as the primary clinical supervisor. Supervision will be based on staff licensure. Non-licensed staff members receive scheduled supervision bi-weekly, either in individual or group format; no staff will go without a supervision session in each month.

As part of the service, a team meeting occurs daily, which will also serve as a method for overall supervision of the team facilitated by the team lead or designee in the absence of the team lead.

STAFF TRAINING REQUIREMENTS		
Training	**Initial within 120 days of hire**	**Annual**
Team Leader	• Crisis Response (3 hours) • Person-Centered Thinking (12 hours) • Introductory Motivational Interviewing (13 hours) • System of Care (11 hours) • Person-Centered Plan Instructional Elements (3 hours) • Alternatives to Restrictive Interventions (8 hours) Training in at least one model of care with empirical evidence (duration unknown) **50 hours total (plus any specific training required for the treatment modality being used by the team)**	Additional three hours of training that fits with expertise; annual training as required by the model of care
Psychiatric Care Provider	• Person-Centered Thinking (12 hours) • Alternatives to Restrictive Interventions (8 hours) **20 Hours Total**	Continuing education as required for license

STAFF TRAINING REQUIREMENTS		
Training	**Initial within 120 days of hire**	**Annual**
Nursing	• Alternatives to Restrictive Interventions (8 hours) • Person-Centered Thinking (12 hours) **20 Hours Total**	Continuing education as required for license
Licensed Clinician	• Crisis Response (3 hours) • Person-Centered Thinking (12 hours) • Introductory Motivational Interviewing (13 hours) • System of Care (11 hours) • Person-Centered Planning Instructional Elements (3 hours), • Alternatives to Restrictive Interventions (8 hours) Training in at least one model of care with empirical evidence. **50 hours total (plus any specific training required for the treatment modality being used by the team)**	Additional three hours of training that fits with expertise; annual training as required by the model of care, Alternatives to Restrictive Interventions Refresher
Substance Use Specialist	• Crisis Response (3 hours) • Person-Centered Thinking (12 hours) • Introductory Motivational Interviewing (13 hours) • System of Care (11 hours) • Person-Centered Planning Instructional Elements (3 hours) • Alternatives to Restrictive Interventions (8 hours) • Training in at least one model of care with empirical evidence **50 total hours (plus any specific training required for the treatment modality being used by the team)**	Additional three hours of training that fits with expertise; annual training as required by the model of care, Alternatives to Restrictive Interventions Refresher
Peer Specialist - Youth	Peer 2 Peer Training provided by NC Families United (32 hours) **32 total hours**	Additional 16 hours of Peer 2 Peer training six months after hire
Family Advocate	Family Partner 101 provided by NC Families United (24 hours) **24 Total Hours**	Over first year: Motivational Interviewing (8 hours), WRAP (16 hours), Child and Family Teams (11 hours), Trauma Informed Care (4 hours). Two electives (hours unknown).

STAFF TRAINING REQUIREMENTS		
Training	**Initial within 120 days of hire**	**Annual**
Case Coordinator	• Crisis Response (3 hours) • Person-Centered Thinking (12 hours) • Introductory Motivational Interviewing (13 hours) • System of Care (11 hours) • Person-Centered Planning Instructional Elements (3 hours), • Alternatives to Restrictive Interventions (8 hours) • Training in at least one model of care with empirical evidence **50 total hours (plus any specific training required for the treatment modality being used by the team)**	Additional three hours of training that fits with expertise; annual training as required by the model of care, Alternatives to Restrictive Interventions Refresher
Behavioral Specialist	• Crisis Response (3 hours) • Person-Centered Thinking (12 hours) • Introductory Motivational Interviewing (13 hours) • System of Care (11 hours) • Alternatives to Restrictive Interventions (8 hours) • Training in at least one model of care with empirical evidence **47 total hours (plus any specific training required for the treatment modality being used by the team model)**	Additional three hours of training that fits with expertise; annual training as required by the model of care, Alternatives to Restrictive Interventions Refresher
It is important for the various specialists on the team to ensure cross-training of other staff to reinforce strategies, identify unmet needs, etc. For example, the behavioral specialist may be the one developing the specific behavioral strategies, but the other members of the team would also be reinforcing these strategies.		

Member Eligibility Requirements

To be eligible for Child ACT Team, the member must have NC Medicaid based on residence in a county located within Vaya's region and be enrolled in the State of North Carolina MH/IDD/SAS Health Plan waiver authorized pursuant to section 1915(b) of the Social Security Act, and meet the following criteria:

- Must be 12-18 years of age
- Must have a diagnosis of major depressive disorder, psychotic disorder, anxiety disorder, disruptive behavior disorder, and/or bipolar disorder, as these illnesses more often cause long-term psychiatric disability.
- Members with other psychiatric illnesses are eligible depending on the level of the long-term disability, co-occurring disorders, and complex trauma. Members with a primary diagnosis of a substance use disorder, I/DD, traumatic brain injury, or an autism spectrum disorder are not the intended population for this service and would be considered for Child ACT Team on a case-by-case basis.

Utilization Management:

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 eligible beneficiaries.

Prior Approval Requirements:
A comprehensive clinical assessment (CCA) that demonstrates medical necessity must be completed prior to provision of this service. If a substantially equivalent assessment is available, reflects the current level of functioning, and contains all the required elements as outlined in community practice standards, as well as all applicable federal and state requirements, it may be used as a part of the current CCA. Relevant diagnostic information must be obtained and included in the person-centered plan. These documents should be submitted with the service authorization request (SAR).

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 person-centered plan. Medical necessity is determined by North Carolina community practice standards, as verified by Vaya, which will evaluate the request to determine if medical necessity supports more or less intensive services. Medically necessary services are authorized in the most cost-effective mode, as long as the treatment that is made available is similarly efficacious as services requested by the beneficiary's physician, therapist, or other licensed practitioner. Typically, the medically necessary service must be generally recognized as an accepted method of medical practice or treatment.

This service shall be covered when the service is medically necessary and includes the following:
Child ACT Team documents written admission criteria that reflect the following medical necessity criteria required for admission:

1. The member has a primary mental health diagnosis according to the DSM-5 or subsequent editions of this manual; **AND**
2. The member needs assertive engagement to develop treatment motivation and is at high risk of one or more of the following: hospitalization, out-of-home placement, substance use, victimization, or juvenile justice involvement; **AND**
3. The member has significant functional impairment as demonstrated by at least one of the following conditions:
    - Significant difficulty consistently performing the range of routine tasks required for basic child/adolescent functioning in the community (for example, demonstrating safety skills, self-regulation, and basic social interaction) or persistent or recurrent difficulty performing daily living tasks except with significant support or assistance from others such as friends, family, or relatives.
    - Significant difficulty maintaining consistent educational/vocational performance at a self-sustaining level (such as regular attendance or regular participation without expulsion or repeated suspension)

Continued Stay Criteria:
The desired outcome or level of functioning has not been restored, improved, or sustained over the time frame outlined in the member's service plan, or the member continues to be at risk for relapse based on history or the tenuous nature of the functional gains, and any one of the following apply:

a. The member or family has achieved current person-centered plan goals, and additional goals are indicated as evidenced by documented symptoms;
b. The member or family is making satisfactory progress toward meeting goals, and there is documentation that supports that continuation of this service will be effective in addressing the goals outlined in the person-centered plan;
c. The member or family is making some progress, but the specific interventions in the person-centered plan need to

be modified so that greater gains, which are consistent with the member's pre-morbid or potential level of functioning, are possible;

d. **The member or family fails to make progress or demonstrates regression in meeting goals through the interventions** outlined in the person-centered plan. (In this case, the member's diagnosis must be reassessed to identify any unrecognized co-occurring disorders, and treatment recommendations should be revised based on the findings); **OR**
e. If the member is functioning effectively with this service, and discharge would otherwise be indicated, the Child ACT Team services must be maintained when it can be reasonably anticipated that regression is likely to occur if the service is withdrawn. The decision must be based on either of the following:
    - The member has a documented history of regression in the absence of Child ACT Team services, or attempts to titrate Child ACT Team services downward have resulted in regression; **OR**
    - There is an epidemiologically sound expectation that symptoms will persist and that ongoing outreach treatment interventions are needed to sustain functional gains.

Transition or Discharge Criteria:

Members shall meet at least one of the following:

a. The member and team determine that Child ACT Team services are no longer needed based on the attainment of goals as identified in the person-centered plan and a less intensive level of care would adequately address current goals;
b. The member moves out of the catchment area, and the Child ACT Team has facilitated the referral to either a new Child ACT Team provider or other appropriate mental health service in the new place of primary private residence and has assisted the member in the transition process;
c. The member and, if appropriate, the legally responsible person, choose to withdraw from services, and documented attempts by the program to re-engage the member with the service have not been successful; **OR**
d. The member and family have not demonstrated significant improvement following reassessment and several adjustments to the treatment plan over at least three months, and:
    - Alternative treatment or providers have been identified that are deemed necessary and are expected to result in greater improvement; **OR**
    - The member's behavior has worsened such that continued treatment is not anticipated to result in sustainable change; **OR**
    - More intensive levels of care are indicated.

Child ACT Team services may be billed for up to 30 days in accordance with the person-centered plan for members who are transitioning to or from Intensive In-Home, Day Treatment, Residential Levels II-IV, TASK, or Multisystemic Therapy.

EPSDT Special Provision:

Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age

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:

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

EPSDT and Prior Approval Requirements
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.

Important additional information about EPSDT and prior approval is found in the NC Tracks Provider Claims and Billing Assistance Guide and on NC DHHS: Early Periodic Screening, Diagnostic and Treatment Medicaid Services for Children .

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.

Documentation Requirements

- These services shall be properly and contemporaneously documented in accordance with this section and the Division of MHDDSAS Records Management and Documentation Manual 45-2 (RMDM) prior to seeking reimbursement from Vaya.
- Regardless of the service type, significant events in an individual's life that require additional activities or interventions shall be documented over and above the minimum frequency requirements.
- Providers shall make all documentation supporting claims for services reimbursed by Vaya available to Vaya, NCDHHS, and CMS upon request.
- Documentation required for this service should be maintained in the provider's medical record for the individual, and a full-service note is required for all dates of service. This should include a note of the activities performed, amount of time spent, agencies contacted (if applicable), and signature and credentials of the individual providing the service.
- For members with I/DD, a service grid that meets the requirements per the RMDM can be utilized, and for elements that are unable to be captured in the grid alone, detailed notes for each service date should be included that support the time spent. However, a daily note is preferred. Documentation must be maintained in the member's medical record.
- If the services are delivered telephonically or through telehealth methods, the documentation must clearly support why this is the most appropriate service delivery method.
- A signed service order must be completed by a medical doctor (MD), doctor of osteopathic medicine (DO), licensed psychologist, physician assistant (PA), or a nurse practitioner (NP) according to his or her scope of practice. Each service order shall be signed and dated by the authorizing professional and shall indicate the date on which the service was ordered. A service order must be in place prior to or on the day that the service is initially provided to

bill for the service. The service order is valid for one year from the date of the original service order. Service orders may not be backdated.

Claims-Related Information:

Providers shall comply with the NCTracks Provider Claims and Billing Assistance Guide, applicable Medicaid bulletins issued by the NC Division of Health Benefits (DHB), applicable NC Medicaid Clinical Coverage Policies, this service definition, Vaya's fee schedule, and other requirements and any other relevant documents for specific coverage and reimbursement for Medicaid and NC Health Choice.

1. **Claim Type:** Professional (CMS-1500/837P transaction) billed through Vaya.
2. **International Classification of Diseases, Tenth Revisions, Clinical Modification (ICD-10-CM) and Procedural Coding System (PCS):** Provider(s) shall report the ICD-10-CM and Procedural Coding 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.
3. **Codes and Modifiers:** 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. 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.
4. **Billing Units:** Providers bill this service on a unit basis; one unit per week with anticipated units per service, per person, 24 units.
5. **Place of Service:** This service is provided in the community, and services are taken to the member/family in their natural environment. Services can be provided in homes, schools, court, homeless shelters, libraries, street locations, and other community settings.
6. **Prior Authorization:** Provider must have a prior authorization for the delivery of services to the member approved by Vaya prior to submission of claims for payment to Vaya.
7. **NC Tracks Enrollment:** Providers must be enrolled through NCTracks and ensure valid NPIs, taxonomies, sites, ZIP code (+4), and all other provider demographic information provided to Vaya matches the information in NCTracks to bill Vaya and be reimbursed for this service.
8. **Coordination of Benefits:** Providers must file with primary payor(s) prior to submission of claims for payment to Vaya, if applicable.
9. **Reimbursement:** Vaya reimburses providers for clean claims for services rendered in accordance with this service definition.