Vaya Health

First Episode Psychosis – Assertive Community Treatment (FEP-ACT)

Alternative or "in Lieu of" Service Definition

H0040 HK U5

Service

First Episode Psychosis – Assertive Community Treatment Team (FEP-ACT) is a team-based, comprehensive approach to treating symptoms of a member's first episode of psychosis. FEP-ACT is based on a multi-element treatment approach to FEP called Coordinated Specialty Care (CSC) that has been validated through extensive research and broadly implemented across the nation. A member who is appropriate for FEP-ACT benefits most from receiving mental health services from a single provider and is at risk of hospitalization, homelessness, substance use, victimization, or incarceration. FEP-ACT provides a high frequency and intensity of community-based contacts. Component interventions in CSC include assertive case management, individual or group psychotherapy, supported employment and education services, family education and support, and medication management. In clinical trials, CSC has been restricted to members with non-organic psychotic disorders who are experiencing early onset of psychotic symptomology; empirical evidence regarding the effectiveness of CSC is greatest for members who meet these criteria. FEP-ACT is designed for youth, adolescents, and young adults ages 15-30. It bridges existing services for these groups and eliminates gaps among child, adolescent, and adult mental health programs. At its core, CSC is a collaborative, recovery-oriented approach involving individuals, treatment team members, and when appropriate, relatives, as active participants. CSC emphasizes shared decision-making as a means for addressing the unique needs, preferences, and recovery goals of individuals with FEP. Collaborative treatment planning in CSC is a respectful and effective means for establishing a positive therapeutic alliance and maintaining engagement with members and their family members over time. The service is also highly coordinated with primary medical care, with a focus on optimizing a member's overall mental and physical health.

In contrast to ACT, FEP-ACT does not require members to demonstrate a longstanding established disability. FEP-ACT serves a younger population that is experiencing onset of symptomology and has the capacity for out-of-office visits but does not require them as the modal practice.

Anticipated Outcomes

FEP-ACT services will allow members to maintain symptom stabilization and remain in community-based settings while supporting recovery in life areas valued by the member, which include:

- Maintenance of current areas of functioning and wellness, as desired and valued by the member.
- Increased use of wellness self-management and recovery tools, which includes independence regarding medication management.
- Vocational/educational gains.
- Increased length of stay in independent, community residence.
- Increased functioning in activities of daily living, such as independence with money management and transportation.
- Increased use of natural supports and development of meaningful personal relationships.
- Improved physical health.

Concurrent Services

Up to two of the following services may be provided by non-ACT service providers concurrently with FEP-ACT, provided that such services are medically necessary and otherwise comply with other applicable clinical coverage policies:

-
-
- Outpatient therapy (e.g., dialectical behavior therapy, cognitive behavioral therapy for psychosis, substance use disorder counseling)
- Opioid treatment
- Detoxification services
- Facility-Based Crisis services
- Substance use residential treatment
- Adult mental health residential programs (e.g., supervised living – low or moderate; or group living – low, moderate, or high)
-
-

FEP-ACT services may be billed for up to 30 days at the same time as the following services in accordance with the person-centered plan for members who are transitioning to or from Community Support Team (CST), Partial Hospitalization, Substance Abuse Intensive Outpatient Program (SAIOP), Substance Abuse Comprehensive Outpatient Treatment (SACOT), Psychosocial Rehabilitation (PSR), and/or Inpatient Hospitalization. Reviews of medical necessity for each of the concurrent services will consider services expected to be provided by FEP-ACT and whether traditional NC Medicaid Clinical Coverage Policy (CCP) No. 8A-1 Assertive Community Treatment Team services would better meet the needs of each member requesting the additional service.

Service Exclusions

FEP-ACT is intended to be a bundled comprehensive service that meets all the member's treatment needs. Services other than those listed above, which are to be provided during a transition period, are excluded from being provided at the same time as FEP-ACT. The following services are excluded from being provided at the same time as FEP-ACT:

- Community Support Team (CST), Psychosocial Rehabilitation (PSR), Assertive Community Treatment (ACT), Mobile Crisis Management, Peer Support, and Supported Employment, Intensive in Home, Multisystemic Therapy (MST), Day Treatment, Psychiatric Residential Treatment Facility (PRTF), Residential Group Home Level II and Residential Group Home Level III.
- Tailored Care Management may not be provided during the same authorization period. FEP-ACT is expected to fulfill all TCM functions, including coordination with physical health providers, except for delivering interventions related to Healthy Opportunities and prevention and population health programs. A Behavioral Health and Intellectual/ Developmental Disabilities Tailored Plan (Tailored Plan) or prepaid inpatient health plan (PIHP) care coordinator may be assigned to members to ensure there are no gaps in care.
- Behavioral health inpatient, Facility-Based Crisis, and emergency department services may be accessed for crisis stabilizations and are not excluded.
- The case management component may be billed when provided 30 days prior to discharge when a member resides in a general hospital or psychiatric inpatient setting and retains Medicaid eligibility.
- FEP-ACT services cannot be provided to members in an Institute for Mental Diseases (IMD) (for adults) or in a public institution (e.g., jail, detention center, or prison).

Service Frequency and Intensity

Most services (typically 80-90%) are provided in the home or community settings, with minimal office visits. FEP-ACT services are primarily provided in the community. A fundamental feature of FEP-ACT is that services are taken to the member and family in their natural environment. Services are delivered in various natural environments, such as homes, schools, courts, homeless shelters, libraries, street locations, and other community settings.

Whenever appropriate, case management activities occur in the community with the member/family or during treatment team meetings. All encounter claims should accurately reflect the setting in which they were provided. FEP-ACT also includes telephonic contact with the member and their family or caregivers. FEP-ACT may also include collateral contact with community stakeholders (employers, school officials, physicians, etc.) who help members meet their goals as specified in the person-centered plan. FEP-ACT includes participation and ongoing involvement by treatment team members to develop, implement, and revise the member's person-centered plan.

While the composition of the FEP-ACT is established, the staff providing the direct interventions to the member and family may vary based on member needs. The FEP-ACT team has daily meetings to prioritize activities, share information, and discuss individual members. The team is available to respond 24/7 for crisis de-escalation and assessment, inclusive of availability by phone within 15 minutes and for face-to-face intervention within no more than two hours. This may include face-to-face assessment by the clinician or nurse if this is determined to be needed for the member. The team psychiatric care provider is available by phone 24/7 for consultation and treatment recommendations. The FEP-ACT team assesses the overall needs of the family to ensure all necessary treatment and support are in place for the entire family system.

Program Size:

	Small Team (Up to 50 members)	**Mid-Size Team (51-74 members)**	**Large Team (75-120 members)**
Staff-to-member ratios: Includes all team members, except psychiatrists and program assistants.	One staff per eight or fewer members	One staff per nine or fewer members	One staff per nine or fewer members

A team must maintain a minimum of five full-time equivalent (FTE) staff that include 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. For example, if the team lead and/or clinician do not have experience with substance use disorder (SUD) treatment, and SUD is an identified treatment need, it will be necessary to have an SUD professional on the team. Case coordination activities may be provided by a combination of individuals on the team or may be performed by a designated staff member.

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

Provider Requirements

The provider delivering this service shall meet the following requirements:

1. The provider must meet qualifications for participation in NC Medicaid program, be credentialed by the NC Division of Health Benefits (DHB) and be enrolled in NC Tracks.
2. The provider must be enrolled as a network provider in Vaya Health's (Vaya's) closed provider network, in good standing, and contracted to deliver the service.
3. For any member requiring nursing-level assistance, NC Board of Nursing regulations and requirements must be

followed for tasks that present health and safety risks to the member.

4. The provider must verify employee/independent contractor qualifications at the time the employee is hired/ contracted. Providers must provide verification of staff qualifications at least on an annual basis.
5. The provider must comply with all terms and conditions of their contract with Vaya, other applicable written agreements, and all applicable federal, state, and local laws, rules, and regulations.
6. Supervision is provided according to supervision requirements specified in 10A NCAC 27G and according to licensure/certification requirements of the appropriate discipline.

Staffing Requirements

FEP-ACT is provided by identified ACT team staff within the provider organization. The FEP-ACT team consists of the following staff (note: The staffing FTEs provided below are applicable to large ACT teams serving 75 to 120 members. Lesser FTEs for the psychiatrist and QP may be approved by NC Medicaid for mid-size teams, which serve between 51 to 74 members.):

- Psychiatric care provider (psychiatrist, psychiatric nurse practitioner or physician assistant) at 0.20 FTE (eight hours/week).
- A QP/clinical case manager at 1 FTE. This staff must meet the qualifications of a QP as specified in 10A NCAC 27G .0104. Certification of the QP by the CPSS is preferred.
- A registered FEP-ACT nurse at 0.025 FTE (one hour a week) to provide injections or medication monitoring as needed.

New FEP-ACT teams serving fewer than 20 members must be staffed as above, with the following exceptions to prescriber time based on the number of members enrolled in the service:

- One to six members: Two hours/week
- Seven to 13 members: Four hours/week
- 14 to 20 members: Six hours/week

Most FEP-ACT services are provided by the FEP-ACT psychiatric care provider and the QP. The FEP-ACT psychiatric care provider must also serve on the home ACT team and cannot be exclusively assigned to members receiving FEP-ACT. To honor member choice, ACT team staff may also assist with FEP-ACT services, except for providing ongoing specialty services, such as SUD treatment from the SUD specialist, vocational services from the vocational specialist, and nursing services, except for provision of injections by the registered nurse.

To the extent not otherwise inconsistent with the staffing requirements set forth in this FEP-ACT service definition, the staffing requirements set forth in NC Medicaid CCP 8A-1 apply.

FEP-ACT consists of the following positions:

Position	Minimum staffing	Staff Qualifications
Team Leader/Family Education Specialist – required This position is to be occupied by only one person.	1 FTE	The team leader/family education specialist is a licensed mental health professional holding any of the following licenses: licensed psychologist, licensed psychological associate, licensed clinical social worker, 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 may serve as the team leader/family education specialist conditional upon being fully licensed within 30 months from the date of hire. The team leader/family education specialist must have a minimum of three years of clinical experience working with individuals with severe and persistent mental illness (SPMI), with a minimum of two years of this experience occurring post-graduate school.
Psychiatric Care Provider – required	.5 FTE	Must be a psychiatrist certified by the American Board of Psychiatry and Neurology, licensed to practice in North Carolina, and must meet the credentialing and qualifications as specified in NCAC 27G .0104(16); or Must be a psychiatric nurse practitioner (PNP) licensed as a nurse practitioner in North Carolina and must meet the requirements as specified in 21 NCAC 36.0800, with at least three years of full-time experience treating individuals with SPMI; or Must be a physician assistant (PA) licensed as in North Carolina and must meet the requirements as specified in 21 NCAC 32S.0200, with at least three years of full-time experience treating individuals with SPMI.
Nurse - required	.5 FTE	Must be a registered nurse (RN) or advanced practice registered nurse (APRN) with a minimum of one year of experience working with individuals with serious mental illness and a working knowledge of psychiatric medications.
Licensed Clinician – required	1 FTE	Must be a licensed clinician with at least one year of post-graduate experience providing mental health services. Must have any of the following licenses in North Carolina: 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.
Supported Employment and Education Specialist	1 FTE	Associate professional (AP) or QP. Preference for someone who has at least one year of experience providing employment services or has advanced education that involved field training in vocational services.

Position	Minimum staffing	Staff Qualifications
Individual Resiliency Specialist	1 FTE	Must be a CPSS. 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 that includes a mental health diagnosis.
Case Coordinator	1 FTE	Staff providing this service must meet requirements as a licensed or associated licensed mental health professional or licensed professional and must have one year of post-graduate experience with individuals with SPMI. An associate-level licensed professional must be fully licensed within 30 months from the date of hire.
Office-Based Program Assistant	1 FTE	Office-based program assistant dedicated to supporting the FEP-ACT team.
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 SUD counselor for teams serving primarily members with co-occurring SUD).

For licensed professionals: Provider organizations must ensure all licensed staff complete the Vaya enrollment process, the Counsel for Affordable Quality Healthcare (CAQH), and, if needed, North Carolina Identify Management (NCID) and National Provider Identifier (NPI).

For unlicensed staff: Provider organizations complete primary source verification for education and verify experience. Final determination of paraprofessional, AP, or QP must follow 10A NCAC 27G and NC General Statutes requirements, as well as all applicable provider organization policies and procedures. Provider organizations are responsible for ensuring staff have the knowledge, skills, and abilities required to serve the population.

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

FEP-ACT includes a daily team meeting (Monday-Friday), which serves as a method for overall team supervision. This meeting is facilitated by the team lead/family education specialist or designee in the absence of the team lead/family education specialist.

Staff Training Requirements		
Training	**Initial within 120 days of hire**	**Annual**
Team Leader/Family Education Specialist	• Crisis Response (three hours) • Person-Centered Thinking (12 hours) • Introductory Motivational Interviewing (13 hours) • System of Care (11 hours) • Person-Centered Plan Instructional Elements (three hours) • Alternatives to Restrictive Interventions (eight hours), training in at least one model of care with empirical evidence • Coordinated Specialty Care NAVIGATE intervention protocols **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 CSC Continuing education as required for license
Psychiatric Care Provider	• Person-Centered Thinking (12 hours) • Alternatives to Restrictive Interventions (8 hours) • Coordinated Specialty Care NAVIGATE intervention protocols **20 hours total**	Continuing education as required for license
Nurse	• Alternatives to Restrictive Interventions (eight hours) • Person-Centered Thinking (12 hours) • Coordinated Specialty Care NAVIGATE intervention protocols **20 hours total**	Continuing education as required for license
Licensed Clinician	• Crisis Response (three hours) • Person-Centered Thinking (12 hours) • Introductory Motivational Interviewing (13 hours) • System of Care (11 hours) • Person-Centered Planning Instructional Elements (three hours) • Alternatives to Restrictive Interventions (eight hours), training in at least one model of care with empirical evidence • Coordinated Specialty Care NAVIGATE intervention protocols **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 CSC; Alternatives to Restrictive Interventions Refresher
Individual Resiliency Specialist-	• Peer 2 Peer Training provided by NC Families United (32 hours) • Crisis Response (three 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 • Coordinated Specialty Care NAVIGATE intervention protocols **69 total hours**	Additional 16 hours of Peer 2 Peer training six months after hire

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 (three hours) • Alternatives to Restrictive Interventions (eight hours), training in at least one model of care with empirical evidence • Coordinated Specialty Care NAVIGATE intervention protocols **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 CSC; Alternatives to Restrictive Interventions Refresher
Supported Employment and Education Specialist	• Crisis Response (three hours) • Person-Centered Thinking (12 hours) • Introductory Motivational Interviewing (13 hours) • System of Care (11 hours) • Alternatives to Restrictive Interventions (eight hours), training in at least one model of care with empirical evidence • Individual Placement and Supports (IPS)Model Training • Coordinated Specialty Care NAVIGATE intervention protocols **47 hours total (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 CSC; Alternatives to Restrictive Interventions Refresher

For each year of employment, each FEP-ACT staff member (excluding the office-based program assistant) completes an additional three hours of training in an area that fits with their area of expertise, which they then, in turn, cross-train their fellow team members. This additional training may be in the form of locally provided training, online workshops, or regional or national conferences. Cross-training consists of brief (e.g., 20 minutes), topic-focused lessons shared with fellow team members.

Member Eligibility Criteria

To be eligible for FEP-ACT, the member must have NC Medicaid based on residence in a county located within Vaya's region, be enrolled in the Vaya Tailored Plan or Medicaid Direct PIHP, and meet the following criteria:

- The members must be 15-30 years old, currently experiencing first-episode/onset of psychosis; and
- Sections 2.0 and 3.2.1 and 3.2.2, including the eligibility and entrance criteria, set forth in NC Medicaid CCP 8A-1, apply.
- Has a current Diagnostic and Statistical Manual (DSM)-5 (or its successor) diagnosis that reflects the presence of symptoms of psychosis as a primary or secondary diagnosis.
- Has significant functional impairment as demonstrated by at least one of the following conditions:
  - Significant difficulty consistently performing the range of daily living tasks required for age-appropriate functioning in the community (e.g., functioning in school settings; maintaining primary relationships; caring for personal business affairs; obtaining medical, legal, and housing services; recognizing and avoiding common dangers or hazards to self and possessions; meeting nutritional needs; and attending to personal hygiene).
  - Difficulty performing daily living tasks without significant support or assistance from others, such as friends, family, or relatives.

- Significant difficulty maintaining employment at a self-sustaining level or significant difficulty consistently carrying out the head-of-household responsibilities (such as meal preparation, household tasks, budgeting, or childcare tasks and responsibilities).
- Significant difficulty maintaining a safe living situation (for example, evictions or loss of housing or utilities).
- Significant difficulty consistently performing the range of routine tasks required for basic child/adolescent functioning in the community (e.g., demonstrating safety skills, self-regulation, and basic social interaction) or 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, regular participation without expulsion or repeated suspension).
- Is experiencing symptomology of FEP, excluding onset due to a medical condition.

- One of the following:
  - There are no indications that available alternative interventions would be equally or more effective based on North Carolina community practice standards and within the LME/MCO service array.
  - Early intervention is warranted at this clinical level to decrease longevity and recurrence of psychosis symptomology.

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 individuals.

Prior Approval Requirements

Services are based upon a finding of medical necessity, must be directly related to the member's diagnostic and clinical needs, and are expected to achieve the specific rehabilitative goals detailed in the member'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 member'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.

Prior authorization for FEP-ACT is required in most circumstances. Please note the following:

- No authorization is required for the first 30 days. However, the provider must submit a notification request prior to admission to the service. The notification request should be for 30 days/six units.
- Initial authorization is for 12 months at six units per month and requires the submission of an authorization request. Initial authorization for services may not exceed 12 months and are based on a finding of medical necessity documented on the comprehensive clinical assessment, service authorization request (SAR) form, service order, and applicable supporting documentation.
- Concurrent authorization must be conducted at least every three months at six units per month and requires the submission of an authorization request.

This service shall be covered when the service is 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 member'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;
C. The procedure, product, or service is furnished in a manner not primarily intended for the convenience of the member, the member's caretaker, or the provider; and

D. The member meets and continues to meet the eligibility requirements for this service, and treatment goals have not yet been achieved. Services and interventions must be reviewed for effectiveness, and interventions should be modified, if necessary, so that the individual makes greater progress.

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 period outlined in the member's person-centered plan or the member 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 member has achieved current person-centered plan goals, and additional goals are indicated as evidenced by documented symptoms;
B. The member 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 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; and
D. The member 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.)

Transition or Discharge Criteria

One of the following criteria is met:

A. The member and provider determine that services are no longer needed based on the attainment of goals identified in the person-centered plan, and a less intensive level of care would address current goals.
B. Alternative treatments or providers have been identified that are deemed necessary and are expected to result in greater improvement; or
C. The member's behavior has worsened, such that continued treatment is not anticipated to result in sustainable change; or
D. More intensive levels of care are indicated.

To make timely and seamless transitions to and from FEP-ACT services, members receiving CST and PSR may continue to receive the case management component of these services for the first and last 30 days of the transition to and from FEP team services in accordance with the person-centered plan. All CST transition activities are performed by the QP or FEP QP.

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 their 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 the EPSDT provider page.

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 problem.

Documentation Requirements:

- A Comprehensive Clinical Assessment (CCA) that recommends FEP-ACT or demonstrates the need for the service must be completed prior to provision of this service. If an 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 in all applicable federal and state requirements, it may be used as a part of the current CCA. Relevant diagnostic information must be obtained and be included in the person-centered plan.
- A pass-through notification SAR should be submitted within the 30-day pass-through timeframe.
- Full-service notes that meet the requirements per the Administrative Publication System Manual (APSM) 45-2 Records Management and Documentation Manual are required for all dates of service. The note must include the activities performed and the agencies contacted, if applicable.
- Documentation required for this service must 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 staff providing the service.
- 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, PA, or NP according to their scope of practice. Each service order must be signed and dated by the authorizing professional and 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.
- Providers shall make all documentation supporting claims for FEP-ACT reimbursed by Vaya available to Vaya and the North Carolina Department of Health and Human Services (NCDHHS) upon request.

Claims-Related Information

Providers shall comply with the NC Tracks Provider Claims and Billing Assistance Guide, Medicaid bulletins issued by DHB, DHB 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.

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):** The provider shall report the ICD-10-CM and Procedural Coding to the highest level of specificity that supports medical necessity. The provider shall use the current ICD-10 edition and any subsequent editions in effect at the time of service. The provider shall refer to the applicable edition for code description.
3. **Codes and Modifiers:** The provider shall report the most specific billing code that accurately and completely describes the procedure, product, or service provided. The provider 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. The provider shall refer to the applicable edition for the code description. If no such specific CPT or HCPCS code exists, then the provider shall report the procedure, product, or service using the appropriate unlisted procedure or service code.
4. **Billing Units:** Members who receive FEP-ACT must have at least six contacts with the FEP-ACT team members each calendar month. FEP-ACT is billed on an event basis, also referred to as a "per diem." An FEP-ACT event is a 15-minute face-to-face contact, defined as lasting at least eight minutes. All other contacts, activities, meetings, and travel time are accounted for in the event rate and are not directly billable.
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, courts, homeless shelters, libraries, street locations, and other community settings.
6. **Prior Authorization:** After the pass-through authorization, the provider must obtain prior authorization for the delivery of services. The prior authorization and pass-through notification SAR, as applicable, must be approved by Vaya prior to submission of claims for payment.
7. **NCTracks Enrollment:** The provider 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:** The provider must file with primary payor(s) prior to submission of claims for payment to Vaya, if applicable.
9. **Reimbursement:** Vaya reimburses the provider for clean claims for services rendered in accordance with this service definition.