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Note: The service definitions for Intensive In-Home Services and Community Support Team have been revised effective July 1, 2010. Other service definitions are currently undergoing revision. Please check the DMA policy index page (http://www.ncdhhs.gov/dma/mp/) frequently to see updates as they become available.

Intensive In-Home Services: Medicaid Billable Service

Service Definition and Required Components

Intensive In-Home (IIH) service is a team approach designed to address the identified needs of children and adolescents, who due to serious and chronic symptoms of an emotional, behavioral, and/or substance use disorders, are unable to remain stable in the community without intensive interventions. This service may only be provided to individuals through age 20. This medically necessary service directly addresses the recipient's mental health and/or substance-related diagnostic and clinical needs. The needs are evidenced by the presence of a diagnosable mental, behavioral, or emotional disturbance (as defined by DSM-IV-TR and its successors), with documentation of symptoms and effects reflected in the comprehensive clinical assessment and the Person Centered Plan. This team provides a variety of clinical rehabilitative interventions available 24 hours a day, 7 days a week, 365 days a year.

This is a time-limited, intensive child and family intervention based on the clinical needs of the youth (through the age of 20 for Medicaid-funded services and through the age of 17 for State-funded services). The service is intended to:

- reduce presenting psychiatric or substance abuse symptoms,
- provide first responder intervention to diffuse current crisis,
- ensure linkage to community services and resources, and
- prevent out of home placement for the child.

IIH services are authorized for one individual child in the family, The parent/caregiver must be an active participant in the treatment. The team provides individualized services that are developed in full partnership with the family. Effective engagement, including cultural sensitivity, is essential in providing services in the family's living environment. Services are generally more intensive at the beginning of treatment and decrease over time as the youth's skills develop.

This team service includes a variety of interventions that are available 24 hours a day, 7 days a week, 365 days a year and are delivered by the IIH staff, who maintain contact and intervene as one organizational unit. IIH services are provided through a team approach; however, discrete interventions may be delivered by any one or more team members as clinically indicated. Not all team members are required to provide direct intervention to each child on the caseload. The Team Leader must provide direct clinical interventions with each child. The team approach involves structured, face-to-face, scheduled therapeutic interventions to provide support and guidance across multiple functional domains including emotional, medical and health. This service is not delivered in a group setting.

IIH staff shall designate and utilize Motivational Interviewing as well as one or more of the following therapies, practices, or models as appropriate for the individuals being served by the team:

- Cognitive Behavior Therapy or
- Trauma-focused therapy (For Example: Seeking Safety*, Trauma Focused Cognitive Behavior Therapy*, Real Life Heroes*) or

- Family Therapy (For Example: Brief Strategic Family Therapy*, Multidimensional Family Therapy*, Family Behavior Therapy*, Child Parent Psychotherapy, or Family Centered Treatment)

* These examples have been designated as Evidenced Based Practices on SAMHSA's National Registry of Evidence-Based Programs and Practices (NREPP) (http://www.nrepp.samhsa.gov/).

Motivational Interviewing and all selected therapies, practices and models specific to the population to be served must be designated in the provider's program description.

The selected therapies, practices, and models must address the clinical needs of the recipient as identified in the comprehensive clinical assessment and on the Person Centered Plan. All criteria (program, staffing, clinical and other) for the IIH service definition and all criteria for the chosen therapies, practices, and models must be followed. Where there is any incongruence between the service definition and the chosen therapy, practice, or model, the more stringent clinical requirements must be met; however, at a minimum, all the requirements of the service definition must be met.

IIH services are delivered to children and adolescents, primarily in their living environments, with a family focus, and include but are not limited to the following interventions as clinically indicated:

- Individual and family therapy
- Substance abuse treatment interventions
- Developing and implementing a home-based behavioral support plan with the youth and his or her caregivers
- Psychoeducation, which imparts information to the recipients, families, caregivers, and/or other individuals involved with the recipient's care about the recipient's diagnosis, condition, and treatment..
- Intensive case management
  - assessment
  - planning
  - linkage and referral to paid and natural supports
  - monitoring and follow up
- Arranges for psychological and psychiatric evaluations
- Crisis management

The IIH Team shall provide "first responder" crisis response, as indicated in the Person Centered Plan, 24 hours a day, 7 days a week, 365 days a year to recipients of this service.

In partnership with the youth, his or her family, and the legally responsible person, as appropriate, the Licensed or Qualified Professional is responsible for convening the Child and Family Team, which is the vehicle for the person-centered planning process. The Licensed or Qualified Professional is responsible for monitoring and documenting the status of the recipient's progress and the effectiveness of the strategies and interventions outlined in the Person Centered Plan. The Licensed or Qualified Professional consults with identified medical (such as primary care and psychiatric) and non-medical providers [for example, the county department of social services (DSS), school, the Department of Juvenile Justice and Delinquency Prevention (DJJDP)], engages community and natural supports, and includes their input in the person-centered planning process.

For Medicaid-funded IIH services, a signed service order shall be completed by a physician, licensed psychologist, physician assistant, or nurse practitioner according to his or her scope of practice and shall be accompanied by other required documentation as outlined elsewhere in this policy (DMA Clinical

Coverage Policy 8A, *Enhanced Mental Health and Substance Abuse Services*). 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 shall be in place *prior to* or on the day that the service is initially provided in order to bill Medicaid for the service. The service order shall be based on a comprehensive clinical assessment of the recipient's needs. For State-funded services, it is recommended that a service order be completed prior to or on the day that the service is initially provided.

Provider Requirements

IIH services shall be delivered by practitioners employed by mental health or substance abuse provider organizations that

- have been certified as a Critical Access Behavioral Health Agency (CABHA) effective July 1, 2010;
- meet the provider qualification policies, procedures, and standards established by DMA;
- meet the provider qualification policies, procedures, and standards established by the Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS); and
- fulfill the requirements of 10A NCAC 27G.

These policies and procedures set forth the administrative, financial, clinical, quality improvement, and information services infrastructure necessary to provide services. Provider organizations shall demonstrate that they meet these standards by being endorsed by the Local Management Entity (LME). As part of the endorsement, the Provider must notify the LME of the therapies, practices, or models that the provider has chosen to implement. Additionally, within one year of enrollment as a provider with DMA, the organization shall achieve national accreditation with at least one of the designated accrediting agencies. (Providers who were enrolled prior to July 1, 2008, shall have achieved national accreditation within three years of their enrollment date.) The organization shall be established as a legally constituted entity capable of meeting all of the requirements of the Provider Endorsement, Medicaid Enrollment Agreement, Medicaid Bulletins, and service implementation standards.

For Medicaid services, the organization is responsible for obtaining prior authorization from Medicaid's approved vendor for medically necessary services identified in the Person Centered Plan. For State-funded services, the organization is responsible for obtaining prior authorization from the LME. The IIH service provider organization shall comply with all applicable federal and state requirements. This includes, but is not limited to, DHHS statutes, rules, policies, and Implementation Updates; Medicaid Bulletins; and other published instruction.

Staffing Requirements

All treatment shall be focused on, and for the benefit of, the eligible recipient of IIH services. The service model requires that IIH staff provide 24-hour-a-day coverage, 7 days a week, 365 days a year. This service model is delivered by an IIH team comprised of one full-time equivalent (FTE) team leader and at least two additional full-time equivalent positions as follows:

- one FTE team leader who is a Licensed Professional who has the knowledge, skills, and abilities required by the population and age to be served (may be filled by no more than two individuals). A provisionally licensed or board-eligible Qualified Professional actively seeking licensure may serve as the team leader conditional upon being fully licensed within 30 months from the effective date of this policy. For provisionally licensed team leaders hired after the effective date of this policy, the 30-month timeline begins at date of hire.

Note: The service definitions for Intensive In-Home Services and Community Support Team have been revised effective July 1, 2010. Other service definitions are currently undergoing revision. Please check the DMA policy index page (http://www.ncdhhs.gov/dma/mp/) frequently to see updates as they become available.

Multisystemic Therapy (MST): Medicaid Billable Service

Service Definition and Required Components

Multisystemic Therapy (MST) is a program designed for youth generally between the ages 7 through 17 who have antisocial, aggressive/violent behaviors, are at risk of out-of-home placement due to delinquency and/or; adjudicated youth returning from out-of-home placement and/or; chronic or violent juvenile offenders, and/or youth with serious emotional disturbances or abusing substances and their families. MST provides an intensive model of treatment based on empirical data and evidence-based interventions that target specific behaviors with individualized behavioral interventions. The purpose of this program is to keep youth in the home by delivering an intensive therapy to the family within the home. Services are provided through a team approach to youth and their families. Services include: an initial assessment to identify the focus of the MST intervention; individual therapeutic interventions with the youth and family; peer intervention; case management; and crisis stabilization. Specialized therapeutic and rehabilitative interventions are available to address special areas such as substance abuse, sexual abuse, sex offending, and domestic violence. Services are available in-home, at school, and in other community settings. The duration of MST intervention is 3 to 5 months. MST involves families and other systems such as the school, probation officers, extended families, and community connections.

MST services are delivered in a team approach designed to address the identified needs of children and adolescents with significant behavioral problems who are transitioning from out of home placements or are at risk of out-of-home placement and need intensive interventions to remain stable in the community. This population has access to a variety of interventions 24 hours a day, 7 days a week, by staff that will maintain contact and intervene as one organizational unit.

This team approach is structured face-to-face therapeutic interventions to provide support and guidance in all areas of functional domains: adaptive, communication, psychosocial, problem solving, behavior management, etc. The service promotes the family’s capacity to monitor and manage the youth’s behavior.

A service order for MST must be completed by a physician, licensed psychologist, physician’s assistant or nurse practitioner according to their scope of practice prior to or on the day that the services are to be provided.

Provider Requirements

MST services must be delivered by practitioners employed by a mental health/substance abuse provider organization that meets the provider qualification policies, procedures, and standards established by DMH and the requirements of 10A NCAC 27G. These policies and procedures set forth the administrative, financial, clinical, quality improvement, and information services infrastructure necessary to provide services. Provider organizations must demonstrate that they meet these standards by being endorsed by

the LME. Within three years of enrollment as a provider, the organization must have achieved national accreditation. The organization must be established as a legally recognized entity in the United States and qualified/registered to do business as a corporate entity in the State of North Carolina.

MST providers must have the ability to deliver services in various environments, such as homes, schools, detention centers and jails (state funds only), homeless shelters, street locations, etc.
Organizations that provide MST must provide "first responder" crisis response on a 24/7/365 basis to consumers who are receiving this service

Staffing Requirements
This service model includes at a minimum a master's level QP who is the team supervisor and three QP staff who provide available 24-hour coverage, 7 days a week. Staff is required to participate in MST introductory training and quarterly training on topics directly related to the needs of MST youth and their family on an ongoing basis. All staff on the MST team shall receive a minimum of 1 hour of group supervision and 1 hour of telephone consultation per week. MST team member–to–family ratio shall not exceed 1:5 for each member.

Service Type/Setting
MST is a direct and indirect periodic service where the MST worker provides direct intervention and also arranges, coordinates, and monitors services on behalf of the recipient. This service is provided in any location. MST services are provided in a range of community settings such as recipient's home, school, homeless shelters, libraries, etc. MST also includes telephone time with the individual recipient and collateral contact with persons who assist the recipient in meeting their goals specified in their Person Centered Plan.

Note: For all services, federal Medicaid regulations will deny Medicaid payment for services delivered to inmates of public correctional institutions or for patients in facilities with more than 16 beds that are classified as Institutions of Mental Diseases.

Clinical Requirements
For registered recipients, a minimum of 12 contacts must occur within the first month. For the second and third months of MST, an average of 6 contacts must occur each month. It is the expectation that service frequency will be titrated over the last 2 months.

Units will be billed in 15-minute increments.

Program services are primarily delivered face-to-face with the consumer and/or their family and in locations outside the agency's facility. The aggregate services that have been delivered by the agency will be assessed annually for each provider agency using the following quality assurance benchmarks:

- A minimum of 50% of the contacts occur face-to-face with the youth and/or family. The remaining units may either be phone or collateral contacts; and
- A minimum of 60% of staff time must be spent working outside of the agency's facility, with or on behalf of consumers.