

1 **Peer Support Services (MH/SA)**  
2 **Medicaid Billable Service**  
3

4 **DRAFT** Date: August 19, 2009

5 **Service Definition and Required Components**  
6

7 Peer Support Services (PSS) is a community-based service for adults age eighteen (18) and older who  
8 have a mental illness or a substance abuse disorder. PSS is provided by a Certified Peer Support  
9 Specialist who has self-identified as a person in recovery from mental illness or substance abuse issues  
10 and is committed to his or her own recovery. PSS provides structured, scheduled activities that promote  
11 recovery, self-determination, self-advocacy, and enhancement of community living skills. Peer Support  
12 Service is an individualized, recovery-focused service, based on a relationship of mutuality that allows the  
13 individual an opportunity to learn to manage his or her own recovery. Recovery refers to the process in  
14 which people are able to live, work, learn, and participate fully in their communities. Each person is free  
15 to define recovery in his or her terms. For some individuals, recovery is the ability to live a fulfilling and  
16 productive life despite a disability. For others, recovery implies the reduction or complete remission of  
17 symptoms.

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19 **\*Note:** The age at which an individual is considered an adult is determined by the funding source. State-  
20 funded services begin at age 18; Medicaid-funded services begin at age 21 unless the individual is eligible  
21 through EPSDT.

22  
23 PSS assists in the acquisition, development, and expansion of rehabilitative skills needed to move forward  
24 in recovery. This is built on the unique relationship between the Certified Peer Support Specialist and the  
25 individual, and other persons as requested by the individual. PSS is a supportive relationship between the  
26 Certified Peer Support Specialist and the individual that promotes respect, trust and mutuality and  
27 empowers individuals to make changes and decisions to enhance their recovery. The Peer Support staff  
28 define, model, and mentor recovery values, attitudes, beliefs, and personal actions in order to  
29 encourage wellness and resilience. Activities of Peer Support promote self-directed recovery by  
30 emphasizing the person, rather than the identified mental illness or substance abuse disorder. This is  
31 accomplished by PSS staff assisting the individual:

- 32  
33
- 34 • in exploring his or her possibilities of recovery
  - 35 • in tapping into the individual's strengths related to illness self-management
  - 36 • in emphasizing hope and wellness
  - 37 • develop and work toward achievement of specific personal recovery goals as identified in the Person  
38 Centered Plan.

39 PSS interventions include:

- 40  
41
- 42 1. Assisting the individual in developing a network of contacts for information, and developing  
43 collaborative, helping relationships with others (based on experience of the Peer Support staff and  
44 others who have had similar experiences).
  - 45 2. Assist the individual in developing natural supports.
  - 46 3. Encouraging the individual to participate in PCP planning process by:  
47 • identifying goals that are important to him or her;  
48 • developing his or her specific plans for achieving goals; and  
• developing his or her crisis plan and learning how to use it.

- 1 4. Providing encouragement that pursuing recovery is worth the effort by:
- 2 • Assisting the individual in identifying the personal benefits of engaging in recovery.
- 3 • Assisting the individual in evaluating the advantages and disadvantages of keeping things
- 4 the way they are, and the advantages and disadvantages of changing.
- 5 • Providing positive feedback to build the individual's confidence about pursuing recovery
- 6 goals.
- 7 • Encouraging him or her to identify, talk about and utilize personal strengths.
- 8 5. Assisting the individual in the development of self-advocacy skills to improve and increase
- 9 independence by:
- 10 ○ Providing information about accessing mental health, substance abuse, and other
- 11 community based services and benefits.
- 12 ○ Providing an opportunity for individual to discuss the services they are receiving or
- 13 would like to receive.
- 14 ○ Teaching strategies for effective self-advocacy.
- 15 ○ Improving and supporting the individual's understanding of their mental health or
- 16 substance related disorder, wellness and recovery.
- 17 ○ Assisting the individual in navigating systems including social services, housing, health
- 18 settings, etc.
- 19
- 20 6. Assisting the individual in taking a proactive role in his or her own behavioral and physical
- 21 health care by:
- 22 ○ Teaching the individual strategies to communicate with service providers on health,
- 23 medications, and treatment.
- 24 ○ Providing an opportunity for the individual to talk openly about his or her beliefs and
- 25 experiences concerning the use of medication and participating in treatment.
- 26 ○ Assisting the individual who has decided to take medications to develop strategies for
- 27 taking medication regularly.
- 28 ○ Assisting the individual in understanding the importance of keeping appointments and
- 29 identifying and accessing transportation options.
- 30
- 31 7. Assisting the individual in carrying out his or her own personal strategies for coping with
- 32 having a mental illness or substance abuse issue and moving forward in his or her life by:
- 33 • Exploring with the individual the importance and creation of a wellness identity by
- 34 moving beyond an illness identity.
- 35 • Identifying, building and utilizing relationship skills (e.g., assertiveness, conflict
- 36 resolution, starting a conversation) by modeling and role playing skills needed to live in
- 37 the community.
- 38 • Assisting individuals to identify and plan healthy social interactions in the community.
- 39 • Assisting the individual in identifying triggers and early warning signs of relapse or
- 40 decompensation.
- 41 • Assisting the individual in carrying out his or her relapse prevention plan.
- 42 • Encouraging individual to include family members and other natural supports in
- 43 developing and implementing plans for reducing relapses.
- 44 • Assisting the individual with using his or her crisis plan, using less restrictive hospital
- 45 alternatives and diverting from using the emergency room.

- Assisting the individual in identifying stressors and improving his or her ability to cope with stress effectively.

In partnership with the clinical home provider, primary care physician, the individual, the PSS staff, and the Licensed Professional shall participate in the development and ongoing revision of specific PSS goals, interventions and strategies to address the needs of the individual to be specified in the Person Centered Plan.

For Medicaid-funded PSS 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 an individualized assessment of the individual'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. In the event the individual becomes Medicaid eligible, Medicaid may be able to reimburse retroactively for services covered by the signed service order.

### Provider Requirements

Peer Support Services shall be delivered by practitioners employed by a comprehensive mental health or substance abuse provider organizations that

- meet the provider qualification policies, procedures, and standards established by the 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). 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. 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 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 authorization from the LME. The Peer Support Services provider organization shall comply with all applicable federal and state requirements. This includes but is not limited to North Carolina Department of Health and Human Services (DHHS) statutes, rules, policies, and Implementation Updates; Medicaid Bulletins; and other published instruction.

Each Certified Peer Support Specialist within the PSS provider agency shall hold a valid North Carolina Peer Support Specialist certification approved by the Division of MH/DD/SAS prior to billing for this service.

1 **Staffing Requirements**

2 Peer Support Services consists of the following staff:

- 3 • NC Certified Peer Support Specialist(s) provide the PSS interventions in the service definition.
- 4       ○ The ratio of 1 FTE Certified Peer Support Specialists (no more than two individuals may
- 5       fulfill this role) to individuals shall be no more than 1:10. Each caseload will be
- 6       determined by the level of acuity and the needs of the individuals served.
- 7 • At least one FTE Licensed Professional (no more than two individuals may fulfill this role) shall
- 8       provide program oversight and clinical supervision for this service.

9

10 The Licensed Professional, shall provide the following program oversight and clinical supervision:

- 11 • The Licensed Professional is responsible for monitoring the status of the individual's
- 12       progress and the effectiveness of the PSS strategies and interventions outlined in the Person
- 13       Centered Plan.
- 14 • Assure that staff operate within their appropriate scope of practice for services delivered.
- 15 • Monitor professional/ethical conduct of direct service staff (includes, but not limited to,
- 16       confidentiality, client's rights, appropriate boundaries, etc.).
- 17 • The Licensed Professional is required to provide weekly individual supervision with PSS
- 18       staff.
- 19       ○ The Licensed Professional in coordination with each PSS staff member shall develop an
- 20       individualized supervision plan.
- 21       ○ The individualized supervision plan shall address the competencies necessary to perform
- 22       the Peer Support Specialist functions.
- 23       ○ All supervision activities shall be documented by the Licensed Professional
- 24       ○ Assure clinically appropriate interventions are delivered to individuals of PSS (intensity,
- 25       frequency and duration) in accordance with the Person Centered Plan.
- 26       ○ The Licensed Professional will monitor and ensure the PSS staff assist the individual in
- 27       developing natural supports to reduce the use of paid services.
- 28
- 29 • The Licensed Professional is required to perform at least one face-to-face contact with
- 30       the individual within 30 days of admission to the program and no less frequently than every 60 days
- 31       thereafter for the purpose of monitoring the individual's progress towards meeting goals and the
- 32       effectiveness of the PSS interventions. These face-to-face contacts must be documented in the service
- 33       record.

34

35 The Licensed Professional may supervise no more than eight Certified Peer Support Specialists.

36

37 All Peer Support Services staff including the Licensed Professional shall complete a minimum of 20

38 hours of training specific to the required components of the Peer Support Service definition, including

39 crisis response and person-centered thinking prior to the delivery of this service. The Licensed

40 Professional must complete 40 hours of DHHS approved curriculum of Peer Support Specialist training

41 prior to delivery of this service.

42

43 **Service Type and Setting**

1 PSS is a direct periodic service primarily provided in a range of community settings such as individual's  
2 home, school, homeless shelter, libraries, etc. PSS can also be provided for individuals living in  
3 independent living or supervised living (low or moderate). PSS may not be provided in the PSS staff  
4 member's home. PSS also includes telephone time with the individual and collateral contact with persons  
5 who assist the individual in meeting his/ or her rehabilitation goals specified in the Person Centered Plan.  
6 PSS includes participation and ongoing clinical involvement in activities and meetings for the planning,  
7 development, implementation, and revision of the individual's Person Centered Plan.

8  
9 Services may be offered during evening and weekends to meet specific individual needs.

10  
11 **\*Note:** For all services, federal Medicaid regulations will deny Medicaid payment for services delivered  
12 to inmates of public correctional institutions or to patients in facilities that have more than 16 beds and  
13 that are classified as Institutions of Mental Diseases.

#### 14 **Program Requirements**

15 The PSS staff shall be able to provide multiple contacts a week—daily, if needed—based on the severity  
16 of the individual's mental health and substance abuse needs and as indicated in the Person Centered Plan.  
17 PSS staff shall meet with each individual on their caseload at least weekly.

18  
19 Program services are primarily delivered face-to-face with the individual and in locations outside the  
20 agency's facility. The aggregate services that have been delivered by the endorsed provider site will be  
21 assessed and documented annually by each endorsed provider site using the following quality assurance  
22 benchmarks:

- 23
- 24 • At least 80% of PSS shall be delivered face-to-face by staff with the individual. The
- 25 remaining units may either be by phone or collateral contacts; and
- 26 • At least 70% of staff time shall be spent working outside of the agency's facility, with or
- 27 on behalf of individuals.
- 28

29 PSS is not a first responder service.

30  
31 Units are billed in 15-minute increments.

#### 32 **Eligibility Criteria**

33 The individual is eligible for this service when:

- 34 •
- 35 A. •There is an Axis I or Axis II mental health and/or substance-related diagnosis other than a
- 36 sole diagnosis of a developmental disability,
- 37

38 **And**

- 39
- 40 B. The individual has documented identified needs due to their mental health or substance abuse
- 41 diagnosis in at least three of the following areas:
- 42

- 43 ○ Limited ability to self-manage symptoms and behaviors
- 44 ○ Has recently experienced a crisis episode requiring intervention through Mobile
- 45 Crisis Management, Facility-Based Crisis, hospitalization, or detoxification services

- 1           ○ Limited ability to engage with and maintain mental health or substance abuse
- 2           treatment services that the individual has identified as important to his/her own
- 3           recovery
- 4           ○ Limited ability to develop and utilize self-advocacy skills in order to increase
- 5           independence
- 6           ○ Limited ability to identify and utilize community services and supports without
- 7           assistance
- 8           ○ Limited ability to develop and maintain relationships, including natural supports
- 9           ○ Limited ability to maintain in residence, physical health, community, school, job, or
- 10          volunteer activity.

11  
12 **AND**

- 13  
14       C. There is no evidence to support that alternative interventions would be equally or more
- 15       effective based on North Carolina community practice standards (for example, American
- 16       Society for Addiction Medicine, American Psychiatric Association) as available.

17  
18 **\*Note:** The age at which an individual is considered an “adult” is determined by the funding source. State-

19 funded services begin at age 18; Medicaid-funded services begin at age 21 unless the individual is eligible

20 through EPSDT.

21 **Entrance Process**

22 A comprehensive clinical assessment that demonstrates medical necessity shall be completed prior to

23 provision of this service. If a substantially equivalent assessment is available, reflects the current level of

24 functioning, and contains all the required elements as outlined in community practice standards as well as

25 in all applicable federal and state requirements, it may be utilized as a part of the current comprehensive

26 clinical assessment. Relevant diagnostic information shall be obtained and be included in the Person

27 Centered Plan.

**Comment [DW1]:** Not sure how to approach this - This is not a clinical home however, do not want to mandate a referral from clinical home - all clinical homes has PSS except CS which is going away.

28  
29 Prior authorization is required on the first day of this service.

30  
31 For Medicaid-funded PSS services, prior authorization by the Medicaid-approved vendor is required. To

32 request the initial authorization, submit the Person Centered Plan with signatures and the required

33 authorization request form to the Medicaid-approved vendor. In addition, submit a completed LME

34 Consumer Admission and Discharge Form to the LME.

35  
36 For State-funded PSS services, prior authorization by the LME is required. To request the initial

37 authorization, submit a Person Centered Plan with signatures, the required authorization request form, and

38 the LME Consumer Admission and Discharge Form to the LME.

39  
40 Medicaid- or State-funded services may cover up to 90 days for the initial authorization period based on

41 medical necessity.

42 **Continued Service Criteria**

43 The desired outcome or level of functioning has not been restored, improved, or sustained over the time

44 frame outlined in the individual’s Person Centered Plan; or the individual continues to be at risk for

45 relapse based on current clinical assessment, and history, or the tenuous nature of the functional gains;

1 **AND**

2 One of the following applies:

- 3 A. The individual has achieved current Person Centered Plan goals, and additional goals are  
4 indicated as evidenced by documented symptoms.
- 5 B. The individual is making satisfactory progress toward meeting goals and there is  
6 documentation that supports that continuation of this service will be effective in addressing  
7 the goals outlined in the Person Centered Plan.
- 8 C. The individual is making some progress, but the specific interventions in the Person Centered  
9 Plan need to be modified so that greater gains, which are consistent with the individual's  
10 premorbid level of functioning, are possible.
- 11 D. The individual fails to make progress, demonstrates regression, or both in meeting goals  
12 through the interventions outlined in the Person Centered Plan. The individual's diagnosis  
13 must be reassessed by a Licensed Professional to identify any unrecognized co-occurring  
14 disorders, and treatment recommendations should be revised based on the findings. This  
15 includes the consideration of alternative or additional services.

17 **Discharge Criteria**

18 Any one of the following applies:

- 19 A. The individual's level of functioning has improved with respect to the goals outlined in the  
20 Person Centered Plan.
- 21 B. The individual has developed a network of natural supports and community contacts that  
22 support stable and ongoing recovery and no longer requires PSS.
- 23 C. The individual is not making progress or is regressing and requires more intensive services  
24 than PSS services provide.
- 25 D. The individual or legally responsible person no longer wishes to receive PSS.
- 26 E. The individual, based on presentation and failure to show improvement, despite  
27 modifications in the Person Centered Plan, requires a more appropriate best practice  
28 treatment modality based on North Carolina community practice standards (for example,  
29 National Institute of Drug Abuse, American Psychiatric Association).

30 The expected clinical outcomes for this service are specific to recommendations resulting from clinical  
31 assessments and meeting the identified goals in the individual's Person Centered Plan.

32 **Expected Clinical Outcomes**

33 Expected clinical outcomes include, but are not limited to, the following:  
34

- 35 • The individual has developed a network of natural supports and community contacts
- 36 • The ability of the individual to make his or her own informed decisions.
- 37 • The individual's level of functioning has improved.
- 38 • The individual is empowered to practice personal responsibility.
- 39 • The individual participates and views self as a valued member of the community.
- 40 • The individual is reconnected with family and other natural supports.
- 41 • The individual utilizes less restrictive hospital alternatives and diverting from using the  
42 emergency room.

- 1                   • The individual has a sense of self-determination and self-empowerment for their  
2                   recovery process.

### 3 **Documentation Requirements**

4 Refer to DMA Clinical Coverage Policies and the DMH/DD/SAS *Records Management and*  
5 *Documentation Manual* for a complete listing of documentation requirements.

6  
7 For this service, one of the documentation requirements is a full service note for each contact or  
8 intervention for each date of service, written and signed by the person(s) who provided the service, that  
9 includes the following:

- 10                   • Individual's name  
11                   • Medicaid identification number  
12                   • Service provided (for example, PSS)  
13                   • Date of service  
14                   • Place of service  
15                   • Type of contact (face-to-face, telephone call, collateral)  
16                   • Purpose of the contact  
17                   • Description of the provider's interventions  
18                   • Amount of time spent performing the interventions  
19                   • Description of the effectiveness of the interventions  
20                   • Signature and credentials of the staff member(s) providing the service (for Certified Peer  
21                   Support Specialist, position is required in lieu of credentials with staff signature)  
22

### 23 **Utilization Management**

24 The individual's Person Centered Plan for service must reflect the need for Peer Support Services.

25  
26 Services are based upon a finding of medical necessity, shall be directly related to the individual's  
27 diagnostic and clinical needs, and are expected to achieve the specific rehabilitative goals specified in the  
28 individual's Person Centered Plan. Medical necessity is determined by North Carolina community  
29 practice standards as verified by independent Medicaid consultants, or by the LME for State-funded  
30 services.

31  
32 Medically necessary services are authorized in the most cost-efficient mode, as long as the treatment that  
33 is made available is similarly efficacious as services requested by the individual's physician, therapist, or  
34 other licensed practitioner. Typically, the medically necessary service shall be generally recognized as an  
35 accepted method of medical practice or treatment. Each case is reviewed individually to determine if the  
36 requested service meets the criteria outlined under EPSDT.

37  
38 For Medicaid, authorization by the Medicaid-approved vendor is required according to published policy.

39  
40 For State-funded PSS services, authorization is required by the LME prior to the first visit.

41  
42 The Medicaid-approved vendor or the LME will evaluate the request to determine if medical necessity  
43 supports more or less intensive services.

44  
45 Medicaid or State funds may cover up to 90 days for the initial authorization period, based on the medical  
46 necessity documented in the individual's Person Centered Plan, the authorization request form, and

1 supporting documentation. Reauthorization requests shall be submitted before the initial authorization  
2 expires. Medicaid or State funds may cover up to 90 days for reauthorization, based on the medical  
3 necessity documented in the Person Centered Plan, the authorization request form, and supporting  
4 documentation. PSS is a short term service and may not be authorized for more than 180 days in a 12  
5 month period.  
6

7 A maximum of 16 units of PSS can be provided in a 24-hour period. No more than 32 units of services  
8 per week for the first 30 days of PSS services may be authorized. PSS should be titrated after the first 30  
9 days and no more than 16 units of services per week may be authorized for the duration of the  
10 authorization period. Reauthorizations for PSS shall not exceed 16 units per week.  
11

12 If continued PSS services are needed at the end of the initial authorization period, the Person Centered  
13 Plan and a new request for authorization reflecting the appropriate level of care and service shall be  
14 submitted to the Medicaid-approved vendor for Medicaid services, or to the LME for State-funded  
15 services. This should occur before the authorization expires.

16 Units are billed in 15-minute increments.

### 17 **Service Exclusions and Limitations**

18 An individual may receive PSS from only one PSS provider organization during any active authorization  
19 period.  
20

21 Peer Support may not be provided during the same authorization period as the following:  
22

- 23 • ACTT
  - 24 • Community Support Team
  - 25 • Psychosocial Rehabilitation
- 26

27 PSS staff can not provide services to a family member.  
28

29 PSS may not be provided in the PSS staff member's home.  
30

31 The Licensed Professional may not bill any other procedure codes during the provision of this service.  
32

33 **Note:** For individuals under the age of 21, additional products, services, or procedures may be requested  
34 even if they do not appear in the N.C. State Plan or when coverage is limited to those over 21 years of  
35 age. Service limitations on scope, amount, or frequency described in the coverage policy may not apply if  
36 the product, service, or procedure is medically necessary.