

**Proposed Addition to:
Clinical Coverage Policy, Attachment D-2**

DRAFT 071309

**NORTH CAROLINA DIVISION OF MH/DD/SAS
SERVICE STANDARDS**

Therapeutic Family Services (TFS)

Service Definition and Required Components

Therapeutic Family Services (TFS) provides services and supports for a child with a principal diagnosis of mental illness or serious emotional and behavioral disorders or substance-related disorders, and who may also have co-occurring disorders including developmental disabilities. TFS are not for a child with a sole developmental disability. This service is available for children to age 18, or if eligible for Medicaid to age 21, and to age 19 for Health Choice. TFS must be delivered by a child placing agency licensed (LCPA) by the N.C. Division of Social Services as established in GS 131-D, 10A NCAC 70E, 10A NCAC 70F, and 10A NCAC 70G. TFS provides a structured, supervised therapeutic milieu in a family environment with one or two foster parent(s). This TFS family is licensed by the Division of Social Services (DSS) and provides TFS under the direction of and supervision of a LCPA. The TFS family facilitates and strengthens the development of skill acquisition and use of interventions and supports that address therapeutic treatment, prevention, recovery, and behavior change consistent with age and development for each child served. TFS services are necessary to assist the child in improving and maintaining functioning across life domains. Skill acquisition in this setting will promote permanency placement for the child with his/her parents, relatives, a guardianship arrangement, an adoptive placement with the TFS family or another adoptive family, or an independent living arrangement.

TFS services are strength-based, support developmentally and functionally appropriate positive behavioral interventions, and work to sustain and improve resiliency factors in the child necessary for recovery. This service is built on the TFS family promoting trust by engaging the child and affirming each child's sense of self and regulation of emotions in relation to self and others.

Services and supports provided by the Therapeutic Family Services family include:

- Interventions to build on each child's strengths for healthy developmental growth across life domains.
- Interventions to increase the child's knowledge of self in relation to others and improve healthy role development and social skills in order to function successfully within the family setting, the community, and the schools.
- On-going structured behavioral interventions that include, but are not limited to, clear and consistent communication; limit setting within the structure of daily living, and opportunity for healthy peer interaction, positive role modeling in all social contexts, problem solving, emotional regulation, anger management and conflict resolution.
- Interventions to develop healthy independent living skills.
- Interventions to improve and support the child's understanding of their health, mental health and substance related disorder.
- Interventions to improve functioning in life domains and self-management skills in coordination with the child's medical and behavioral health providers.

**Proposed Addition to:
Clinical Coverage Policy, Attachment D-2**

DRAFT 071309

In addition, a child with complex treatment needs may require specialized interventions to remain in the TFS family setting, school and community. Such complex needs may include medical conditions, developmental delays, sexually reactive behaviors, trauma disorders, co-occurring disorders, and/or aggressive and/or violent behaviors. To promote stability of the child in the TFS family setting, additional medically necessary services may be provided as brief interventions in order to maintain the current level of care during periods of disruption or regression that may result in a higher level of restrictive care. Additional services and supports that are determined to be medically necessary may include outpatient behavioral health or other community based services. The licensed child placing agency (LCPA), TFS parent(s) and clinical home provider are responsible for coordinating access to needed additional medically necessary services and supports.

The LCPA, TFS family and the clinical home provider shall ensure the provision of the “first responder” crisis response 24 hours a day, 7 days a week, and 365 days a year in accordance with the Person Centered Plan. A crisis plan will be developed as a part of the PCP.

The LCPA Qualified Professional (QP), the TFS family, in partnership with the child, his or her family, the legally responsible person or agency if applicable, and the clinical home provider will participate in the Child and Family Team, which is the vehicle for the person-centered planning process. The clinical home provider is responsible for monitoring and documenting the status of the child’s progress and the effectiveness of the strategies and interventions outlined in the Person Centered Plan. The clinical home provider consults with the LCPA QP, the TFS family, the 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.

A transition and permanency plan will be included and addressed in the Person Centered Plan (PCP) and coordinated with the local department of social services Family Services Agreement (DSS 5240), if applicable. The TFS family’s involvement is identified in the PCP and coordinated with the local department of social services Family Services Agreement (DSS 5240), if applicable. The role of the child’s parent(s)/guardian and their involvement in treatment shall be documented on the PCP.

For Medicaid-funded TFS 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 8 D-2, *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 child’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.

**Proposed Addition to:
Clinical Coverage Policy, Attachment D-2**

DRAFT 071309

Provider Requirements

TFS services shall be delivered by a Licensed Child Placing Agency that:

- meets the provider qualification policies, procedures, and standards established by DMA;
- meets the provider qualification policies, procedures, and standards established by the Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS) in GS 122C;
- is licensed by the N.C. Division of Social Services as established in GS 131-D, 10A NCAC 70E, 10A NCAC 70F, and 10A NCAC 70G;
- fulfills the requirements of 10A NCAC 27G; and
- employs at a minimum one full-time Licensed Professional per LCPA for TFS.

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.

The full-time Licensed Professional (LP) with related child experience is required to provide clinical expertise and oversight of the TFS services. The licensed professional(s) will provide or make provisions for the following:

- Assure clinically appropriate assessments, person centered planning and therapeutic interventions are delivered within the specific service definition;
- Assure clinically appropriate services are delivered to eligible children within the service definition (right person, right treatment, right intensity, frequency and duration);
- Assure that staff operate within their appropriate scope of practice for service delivered;
- Coordinate with quality assurance and quality improvement functions of the agency;
- Assure that clinical supervision is provided to staff (QP, TFS family) delivering the specific service; and
- Monitor professional/ethical conduct of direct service staff (includes, but not limited to, confidentiality, client's rights, appropriate boundaries, etc.).

The agency licensed professional must be employed by the first date of service delivery.

The provider agency assumes responsibility to employ the number of licensed professionals necessary to carry out the above clinical oversight functions for all TFS families.

Some services require a licensed professional as part of the staffing requirement. In those services, the licensed professional may serve as the agency licensed professional. If the LCPA also provides an enhanced service (Clinical Coverage Policy 8A) that does not require a licensed

**Proposed Addition to:
Clinical Coverage Policy, Attachment D-2**

DRAFT 071309

professional as part of the staffing requirement such as Community Support, Community Support Team, MST, or Intensive In-Home (if the Team Leader is provisionally licensed), the agency must employ an additional full-time licensed professional(s) to carry out the above listed functions.

For Medicaid services, the clinical home provider 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 clinical home provider is responsible for obtaining authorization from the LME. The TFS 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.

It is the responsibility of the LCPA, in coordination with the TFS family, to engage and collaborate with the child's parent/guardian in the child's treatment as demonstrated at a minimum by participating in the Child and Family Team meetings, family therapy, and engage in related child therapies as required as well as in transition planning.

Staffing Requirements

The LCPA staffing requirements for the delivery and supervision of TFS in addition to and in accordance with NCDSS GS 131-D, 10A NCAC 70F and 10A NCAC 70G include:

- An Executive Director ~~is~~ as required in accordance with 10A NCAC 70F and 10A NCAC 70G.
- At a minimum one full-time Licensed Professional is required for each LCPA for the clinical oversight and supervision for TFS as outlined in provider requirements.
- One full time equivalent (FTE) Master's level Qualified Professional (QP) with two years of related experience in a human services field, a licensed professional is preferred. No more than two staff can fill each FTE position. This Master's level QP shall serve as the Clinical Supervisor of no more than five QPs who supervise the TFS families. This clinical supervision will be structured and appropriate to meet the specific mental health and/or substance related disorder treatment needs as defined in the PCP for each child receiving TFS services.
- One full time equivalent (FTE) QP with knowledge, skills and abilities appropriate to the meet the mental health and/or substance abuse treatment needs of each child in the TFS family. No more than two staff can fill each FTE position. The QP to child ratio is 1:10. The QP is responsible for coaching, modeling, supporting and monitoring the TFS family in implementing the therapeutic interventions, and monitoring the safety and well being of the child in accordance with each child's PCP. The Qualified Professional shall review all documentation entered by the TFS parent(s) in the service record at least weekly to ensure that the child is receiving the appropriate interventions, services, and level of care to meet each child's needs and strengths. Upon each review, the QP shall document the results of the review in the child's service record.

**Proposed Addition to:
Clinical Coverage Policy, Attachment D-2**

DRAFT 071309

- One or two foster parent(s) serving as the Therapeutic Family Services family in accordance with 10A NCAC 70E. The TFS family provides services to the child under the direction and clinical supervision of the LCPA.

The LCPA is responsible for providing and/or arranging for all training of the TFS parents. TFS training requirements for pre-service and ongoing annual training for TFS parents providing TFS are specified in 10A NCAC 70E. TFS parent(s) shall receive child-specific training determined necessary to meet the needs of the child being placed in the TFS family as outlined in the PCP. In particular, pre-service and ongoing training will include appropriate positive behavioral supports and interventions and understanding of the emotional/behavioral challenges and substance related disorders of a child receiving TFS.

Specific Service Provision especially for child who are sexually reactive (survivor, perpetrator) when increased supportive therapeutic interventions by the TFS parent(s) need to be implemented: In addition to the requirements listed above, when the child requires treatment for a trauma disorder related to a sexual abuse history; this specific treatment will be identified in his/her PCP. Special training of the Therapeutic Family Services parent(s) is required in these situations and the Therapeutic Family Services parent(s) is supervised by a qualified professional with child trauma disorder and sexually reactive specific treatment experience and expertise, such as having clinical membership in the Association for Treatment of Sexual Abusers (ATSA). The LCPA will provide the appropriate clinical supervision to the QPs responsible for the supervision of the TFS parent(s). Supervision of the TFS family will be structured and provided according to the defined treatment needs of each child's PCP and rule requirements.

Substance Related Disorder Specific Service Provision when increased supportive therapeutic interventions by the TFS parent(s) need to be implemented: The LCPA, TFS and clinical home provider will ensure that the child receives substance abuse treatment based on the appropriate American Society of Addiction Medicine (ASAM) level of care. The TFS parent(s) will work in coordination with the substance abuse provider to reinforce recovery interventions identified in the treatment process. LCPA will provide the appropriate clinical supervision to the QPs responsible for the supervision of the TFS parent(s). Supervision of the TFS family will be structured and provided according to the defined treatment needs of each child and rule requirements.

Service Type/Setting

TFS services are provided in a family environment with one or two foster parents serving as Therapeutic Family Services parent(s). TFS services must be delivered by a child placing agency licensed by the N.C. Division of Social Services and shall follow the minimum requirements in GS 131-D, 10A NCAC 70E, 10A NCAC 70F, and 10A NCAC 70G.

TFS is a direct and indirect, 24-hour rehabilitative service in which the LCPA and TFS parent(s) provide medically necessary services and interventions that address the diagnostic and clinical needs of the child. This service is mainly provided in the home; however reinforcement of skill acquisition and enhancement also occurs in the community, school, vocational, and in other natural environments.

**Proposed Addition to:
Clinical Coverage Policy, Attachment D-2**

DRAFT 071309

Program Requirements

LCPAs and Therapeutic Family Services families shall meet the capacity requirements as outlined in 10A NCAC 70E .1001.

TFS parents shall be actively engaged with the child and involved in educational, vocational, and social activities. TFS parents will be actively engaged and present during times when the child's needs are the most significant and when the child is not involved in another structured activity. The Therapeutic Family Services parent(s) will make every reasonable effort to be available at all times telephonically to the child. TFS parent(s) are not required to be awake during sleep time.

The LCPA is responsible for ensuring that the TFS parent(s) will have full knowledge of each child's permanency plan prior to service provision. The TFS parent(s) will develop knowledge, skills, and abilities required to address the behavioral, developmental, medical, mental health and substance abuse needs of each child served according to age and developmental functioning. The TFS parent(s) participates in the child and family team and the development, implementation and ongoing revisions of the PCP. Each child's parent/guardian (if available and appropriate) is expected to be engaged in the planning and treatment process. The child's parent/guardian shall agree to participate in the child's ongoing treatment as a necessary element of TFS. The child's parent/guardian shall participate in the child's treatment as demonstrated at a minimum by participating in the Child and Family Team meetings, family therapy, and engaging in related child therapies as required.

Matching the child with the TFS family will occur through brief transitional visits or overnight visits to assure compatibility between the child, the Therapeutic Family Services family and the home and community environment. The number of overnight visits and day visits will be specified in the PCP, coordinated with the county department of social services Family Services Agreement (DSS 5240), if applicable, and be appropriate to the transition needs of the child and the Therapeutic Family Services family. Prior to child placement, the placement match is evaluated by the child and the Child and Family Team for compatibility. Compatibility criteria will include consideration of the cultural diversity and gender specific needs of the child, and be identified in the PCP and coordinated with the county department of social services Family Services Agreement (DSS 5240), if applicable.

Transition and permanency planning are essential for each child and will occur as a part of the PCP and the DSS Family Services Agreement (DSS 5240), if applicable, in preparation of the child returning to his/her parents, guardians or with the Therapeutic Family Services family/potential adoptive family, or to independent living. This plan will be an outcome stated in the PCP and DSS Family Services Agreement (DSS 5240), if applicable, with interventions that directly support successful transition and permanency planning.

Eligibility Criteria

- A. There is an Axis I or II MH/SA diagnosis (as defined by the DSM-IV-TR or its successors), other than a sole diagnosis of developmental disability.

AND

**Proposed Addition to:
Clinical Coverage Policy, Attachment D-2**

DRAFT 071309

- B. For children with a substance abuse diagnosis, the American Society of Addiction Medicine Patient Placement Criteria (ASAM-PPC) are met for Level III.1.

AND

- C. Moderate to severe difficulty functioning in the naturally available family as evidenced by any four or more of the following:
1. moderate or severe conflict in the current setting, **OR**
 2. pervasive inability to accept age/developmentally appropriate direction and supervision, in significant areas, from caretakers or family members, **OR**
 3. severely limited familial involvement and support, **OR**
 4. impaired ability to form trusting relationships with caretakers, **OR**
 5. limited ability to consider the effect of inappropriate personal conduct in relationship to self and/or others, **OR**
 6. frequent and severely disruptive verbal aggression, **OR**
 7. frequent and moderate property damage and/or occasional, moderate aggression toward self and/or others, **OR**
 8. frequent and disruptive difficulty in maintaining appropriate conduct in community setting, including sexually reactive behaviors.

AND

- D. There is no evidence to support that alternative interventions would be equally or more effective, based on North Carolina community practice standards (Best Practice Guidelines of the American Academy of Child and Adolescent Psychiatry, American Psychiatric Association, American Society of Addiction Medicine, Association for Treatment of Sexual Abusers).

Entrance Process

A comprehensive clinical assessment which 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 in all applicable federal, state, and DHHS requirements, it may be utilized as a part of the current comprehensive clinical assessment. Relevant diagnostic information must be obtained and included in the Person Centered Plan.

Prior authorization is required on the first date of this service.

**Proposed Addition to:
Clinical Coverage Policy, Attachment D-2**

DRAFT 071309

For Medicaid-funded Therapeutic Family Services, prior authorization by the Medicaid-approved vendor is required. In order to request the initial authorization, the Person Centered Plan with signatures and the required authorization request form must be submitted to the Medicaid-approved vendor. In addition, a completed LME Consumer Admission and Discharge Form must be submitted to the Local Management Entity.

For State-funded Therapeutic Family Services, prior authorization by the Local Management Entity is required. In order to request the initial authorization, a Person Centered Plan with signatures, the required authorization request form, and the LME Consumer Admission and Discharge Form must be submitted to the LME.

Medicaid or State funds may cover up to 60 days for the initial authorization period based on medical necessity.

Continued Service Criteria

The desired outcome or level of functioning has not been restored, improved, or sustained over the time frame outlined in the child's Person Centered Plan based on current clinical assessment, history, and the tenuous nature of the functional gains.

AND

One of the following applies:

- A. The child has achieved current Person Centered Plan goals, and additional goals are indicated as evidenced by documented symptoms.
- B. The child 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 child 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 child's pre-morbid level of functioning, are possible.
- D. The child fails to make progress, or demonstrates regression, in meeting goals through the interventions outlined in the Person Centered Plan. The child's diagnosis should be reassessed to identify any unrecognized co-occurring disorders, and interventions or treatment recommendations should be revised based on the findings. This includes consideration of alternative or additional services.

Discharge Criteria

Any one of the following applies:

- A. The child has achieved goals and is no longer in need of TFS services.
- B. The child's level of functioning has improved with respect to the goals outlined in the Person Centered Plan, inclusive of a transition plan to step down to a lower level of care.
- C. The child is not making progress or is regressing, and all reasonable strategies and interventions have been exhausted, indicating a need for more intensive services.

**Proposed Addition to:
Clinical Coverage Policy, Attachment D-2**

DRAFT 071309

- D. The child or legally responsible person no longer wishes to receive TFS services.
- E. The child, based on presentation and failure to show improvement despite modifications in the Person Centered Plan, requires a more appropriate best practice treatment modality based on North Carolina community practice standards (for example, National Institute of Drug Abuse, American Psychiatric Association).

In addition, a completed LME Consumer Admission and Discharge Form shall be submitted to the LME.

Note: Any denial, reduction, suspension, or termination of service requires notification to the child, legally responsible person, or both about the child's appeal rights in accordance with the Department's child notices procedure.

Expected Clinical Outcomes

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

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

- Develop and utilize of behaviors and effective communication skills that enable the child to return to prior living arrangement or into independent living.
- Develop anger management, emotional regulation, conflict resolution and problem solving skills.
- Increase the child's understanding of his/her health, mental health and substance related disorders
- Engage in the recovery process
- Increase self-management skills to improve functioning in home, school and community.
- Improve and sustain developmentally appropriate functioning in specified life domains.
- Increase positive peer interactions and social role-taking in the family and in the community.
- Increase skills, functioning and healthy interactions within the family structure
- Increase understanding of the negative effects of substance dependence and/or psychiatric symptoms
- Use of available natural and social supports

Documentation Requirements

Refer to DMA Clinical Coverage Policies and the DMH/DD/SAS *Records Management and Documentation Manual* for a complete listing of documentation requirements. In addition, compliance with documentation requirements outlined in 10A NCAC 70G .0505 and .0506 is required.

Daily documentation of this service by the TFS parent(s) is required. This documentation may be entered on a full service note or service grid, written and signed by the person(s) who provided the service.

**Proposed Addition to:
Clinical Coverage Policy, Attachment D-2**

DRAFT 071309

The Qualified Professional shall review all documentation entered by the TFS parent(s) in the service record at least weekly to ensure that the child is receiving the appropriate interventions, services, and level of care to meet each child's needs and strengths. Upon each review, the QP shall document the results of the review in the child's service record.

All direct services provided by the Qualified Professional to the child must also be documented in the service record. A service grid or full service note may be used by the Qualified Professional for this purpose.

All critical events, significant events, or changes in status in the course of treatment shall be clearly documented on a full service note in the child's service record a by the Therapeutic Family Services parent(s), or the Qualified Professional, as appropriate.

For any child with sexually reactive perpetrator behaviors who is receiving this service, documentation must include a service note or service grid, describing all appropriate evidenced informed treatment and interventions as supported and carried out through the therapeutic milieu related to the specific sexually reactive treatment goals as outlined in the PCP. This documentation must be written and signed by the person providing this specific treatment and interventions.

Utilization Management

Services are based upon a finding of medical necessity, must be directly related to the child's diagnostic and clinical needs, and are expected to achieve the specific rehabilitative goals specified in the child's Person Centered Plan. Medical necessity is determined by North Carolina community practice standards as verified by independent Medicaid consultants for Medicaid-funded services, or the Local Management Entity for state-funded services.

Medically necessary services are authorized in the most cost efficient mode, as long as the treatment that is made available is similarly efficacious to services requested by the child's physician, therapist, or other licensed practitioner. Typically, a medically necessary service must be generally recognized as an accepted method of medical practice or treatment. Each case is reviewed individually to determine if the requested service meets the criteria outlined under Early Periodic Screening, Diagnosis and Treatment (EPSDT).

For Medicaid, authorization by the Medicaid-approved vendor is required according to published policy. For State-funded TFS services, authorization is required by the Local Management Entity prior to the first visit.

The Medicaid-approved vendor or the Local Management Entity will evaluate the request to determine if medical necessity supports more or less intensive services.

Medicaid or State funds may cover up to 60 days for the initial authorization period based on the medical necessity documented in the child's Person Centered Plan, the authorization request form, and supporting documentation. Reauthorization request must be submitted prior to the expiration of the initial authorization. Medicaid or State-funded services covers up to 120 days

**Proposed Addition to:
Clinical Coverage Policy, Attachment D-2**

DRAFT 071309

for reauthorization based on the medical necessity documented in the required Person Centered Plan, the authorization request form, and supporting documentation.

If continued Therapeutic Family Services are needed at the end of the initial authorization period, the Person Centered Plan and a new request for authorization reflecting the appropriate level of care and service must be submitted to the Medicaid-approved vendor for Medicaid services, or to the Local Management Entity for State-funded services. This should occur prior to the expiration of the authorization.

Units/cost for services is to be determined.

Service Limitations and Exclusions

A child can receive TFS services from only one LCPA at a time. This service cannot be billed with any other residential treatment or inpatient psychiatric or substance abuse services. In addition, a child with complex treatment needs may require specialized interventions to remain in the TFS family setting, school and community. Such complex needs may include medical conditions, developmental delays, sexually reactive behaviors, trauma disorders, co-occurring disorders, and/or aggressive and/or violent behaviors. To promote stability of the child in the TFS family setting, additional medically necessary services may be provided as brief interventions in order to maintain the current level of care during periods of disruption or regression that may result in a higher level of restrictive care. Additional services and supports that are determined to be medically necessary may include outpatient behavioral health or other community based services. Such services (intensive in home, MST, SAIOP, mobile crisis service, day treatment services) must be identified in the PCP in order to provide the therapies and skill building necessary for the child to remain in the Therapeutic Family Services family, successfully transition, and maintain stability within the community system of care.

Community support (CS) can be billed in accordance with the PCP for children who are receiving TFS services for the purposes of: facilitating transition to the TFS service, coordination with the child and his/her family and the Therapeutic Family Services family during the provision of service and discharge planning.

Educational skills usually taught in primary or secondary school settings or in home schools (e.g., math, reading, writing, etc.) are not reimbursable. Such skills and educational advancement should be coordinated with and provided by the local education agency (LEA).

Room and board are not reimbursable by Medicaid.

This service shall not duplicate any IV-E services.

The TFS parent(s) cannot provide any other Medicaid or state funded services to the same child for whom they provide TFS treatment in his/her TFS family.

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