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1.0 Description of the Procedure, Product, or Service

Comprehensive Case Management (CCM) for Adult Mental Health/Adult Substance Use (AMH/ASU) is a 24/7 service for adults with either a primary mental health (MH) or primary substance use (SU) disorder, or co-occurring MH/SU/IDD/ TBI diagnosis, in addition to other designated eligibility criteria, that would benefit from time-limited case management assistance to access necessary behavioral health, physical health, health-related, and social services. The individual will receive their first CCM visit in the community to begin the hands-on case management services within 24 hours of receiving the referral. CCM will be provided for a maximum of 6 months in a fiscal year.

CCM teams should be staffed with professionals that are highly skilled case managers who are well informed of the resources in their community and how to access them. CCM teams should have up-to-date and in-depth knowledge of primary care providers, specialty health care providers, community transportation resources, medication resources, mental health providers, substance use providers, food pantries and resources, supported housing services, legal services, benefits counseling, and other community-based services. A CCM team should be able to complete in depth case management assessments, complete a person-centered Case Management Plan and then put the Plan to action to ensure individuals have been linked to appropriate services and supports consistent with their goals and preferences.

It is critical that the CCM team is integrated into the behavioral health system, including but not limited to, Emergency Departments (EDs), inpatient community hospitals, Mobile Crisis Management (MCM) Teams, Facility Based Crisis (FBC), State Psychiatric Hospitals, Alcohol and Drug Abuse Treatment Centers (ADATCs), and Behavioral Health Urgent Care (BHUC) facilities. The CCM team assumes responsibility for developing a Case Management Service Plan that focuses solely on the case management functions that will be provided to address the individual's service and support needs.

An effective CCM team should be well connected with a wide range of community resources and supports which enable them to quickly link individuals to critical services and supports to prevent or reduce crisis. With appropriate consent, the case manager is required to coordinate and communicate with the individual's relevant, natural community supports, primary care physician, mental health and/or substance use service provider, obstetrician, and gynecologist (OBGYN), and other supports.

1.1 Comprehensive Case Management (CCM) for Adult Mental Health (AMH)/ Adult Substance Use (ASU)

Comprehensive Case Management for AMH/ASU is a service designed to ensure individuals meeting eligibility criteria for this service have access to intensive case management services that can prevent behavioral health crises, emergency department admissions and involuntary commitments when appropriate community supports could stabilize the individual, and ensure that individuals have intensive, time-limited case management supports that link to appropriate community-based levels of care and supports. CCM for AMH/ASU will assist individuals in gaining access to necessary care: medical, behavioral, social, and other services appropriate to their needs. CCM for AMH/ASU is individualized, person-centered, comprehensive, strengths-based, recovery-oriented, and outcome-focused. The functions of case management include:

1. Case Management Assessment
2. Case Management Service Plan

3. Person centered service planning;
4. Referral and linkage to services and supports
5. Coordination and collaboration with natural supports
6. Psychoeducation;
7. Monitoring and follow-up; and
8. Program Specific Information
9. Transition Planning

1.1.1 Comprehensive Clinical Assessment

A Comprehensive Clinical Assessment (CCA) or Diagnostic Assessment (DA) is completed by a licensed clinician that meets the criteria included in 10A NCAC 27G. 0104 (12). The CCA or DA demonstrates medical necessity and must be completed prior to the provision of this service and is billed separately. 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 and state requirements, it may qualify as a current CCA.

Relevant diagnostic information must be obtained and documented in the individual's Case Management Service Plan.

If the individual has substance use disorder, the ASAM criteria (http://www.asam.org/quality-practice/guidelines-and-consensus-documents/the-asam-criteria) shall be included as part of the disposition. Information from the CCA or DA should be used to develop the CCM for AMH/SU Case Management Plan.

1.1.2 Case Management Assessment

A comprehensive and culturally appropriate case management assessment documents an individual's service needs, strengths, resources, preferences, and goals to develop a Case Management Service Plan. The case manager gathers information regarding all aspects of the individual's goals and preferences, including medical, physical, and functional, psychosocial, behavioral, financial, social, cultural, environmental, legal, and vocational or educational areas. The case management assessment integrates all current assessments including the comprehensive clinical assessment and medical assessments, as well as assessments and information from the primary care physician, including an OBGYN, as relevant. The case management assessment includes early identification of conditions and needs for prevention and amelioration. The case management assessment involves consultation with other natural and paid supports such as family members, medical and behavioral health providers, and educators to form a complete assessment. The case management assessment includes periodic reassessment to determine whether an individual'sneeds or preferences have changed.

1.1.3 Case Management Service Plans

According to 10A NCAC 27G .0205, the case management service plan shall be developed based on the assessment, and in partnership with the individual or legally responsible person or both, within 30 days of admission for individuals who are expected to receive services beyond 30 days. The case management service plan shall include at least the following elements, also according to 10A NCAC 27G .0205:

- Client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement;
- Strategies;
- Staff responsible;
- A schedule for review of the plan after three months in consultation with the individual or legally responsible person, or both, to review goals and strategies to promote effective treatment;
- Basis for evaluation or assessment of outcome achievement; and written consent or agreement by the client or responsible party, or a written statement by the provider stating why such consent could not be obtained

Refer to the DMHDDSAS Records Management and Documentation Manual (http://www.ncdhhs.gov/mhddsas/providers/recordsmanagement/resources.htm) for specific information.

1.1.4 Referral and Linkage

Referral and linkage activities connect an individual with medical, behavioral, social, and other programs, services, and supports to prevent possible crisis service usage, crisis events or possible involuntary commitment, and decrease the potential for recurring crisis service intervention. Referral and linkage activities include:

a. Assist the individual in applying for eligible benefits (Medicaid, housing, food stamps, WIC etc.) including assisting pregnant women with applying for Medicaid for Pregnant Women;
b. Coordinating the delivery of services to reduce fragmentation of care and maximize mutually agreed upon outcomes;
c. Facilitating access to (including ensuring transportation is not a barrier) and connecting the individual to services and supports identified in the Case Management Service Plan;
d. Making referrals to providers for needed services and scheduling appointments with the individual;
e. Assisting the individual as there are transitions through levels of care;
f. Educating the individual on mental health and substance use crisis services available in the community, and how to access them;
g. Facilitating communication and collaboration among all service providers and the individual;
h. Assisting the individual in establishing and maintaining a primary care physician; and
i. Assisting the pregnant individual in establishing obstetrician and prenatal care, as necessary.

1.1.5 Psychoeducation

Psychoeducation related to relapse prevention, symptom management and recovery resources:

a. Psychoeducation for the individual, families, caregivers, or other individuals/natural supports involved with the individual about their diagnosis symptoms, and treatment;
b. Psychoeducation regarding symptom reduction and self-management of any prescribed medications and medical needs management;
c. Psychoeducation to assist in building a natural support system.

1.1.6 Monitoring and Follow-Up

Monitoring and follow up includes activities and contacts that are necessary to ensure that the Case Management Service Plan is effectively implemented and addresses the needs of the individual. Monitoring activities may involve the individual, their supports, providers, and others involved in care delivery. Monitoring activities help determine whether:

a. services are being provided in accordance with the individual's Case Management Service Plan;
b. services in the Case Management Service Plan are of sufficient duration, frequency, and intensity to help the individual achieve their desired goals;
c. there are changes in the needs or status of the individual; and
d. the individual is making progress toward their goals.

1.2 Program Specific Information

1.2.1 CCM Team Meeting

The CCM team meeting is the central hub of communication. This meeting allows for the sharing of recent assessment information and planning for the day's activities. The CCM team shall meet once a week to allow staff to systematically update information, briefly discuss the status of individuals receiving services, problem-solve emerging issues, identify progress towards desired goals and plan approaches to address and prevent crises. This critical clinical supervision and organizational meeting is also used to plan upcoming service contacts. There must be a reliable communication mechanism in place to relay important information to team members not present during that day or shift. This meeting can be facilitated using a HIPAA compliant web platform.

1.2.2 Service Duration and Intensity

The CCM team serves as linkage to medical, behavioral health, co-occurring IDD/TBI, pharmacy, and basic needs (housing, food, transportation, employment/income, legal, insurance, etc.). Therefore, individuals should be receiving a minimum of two (2) hours of interventions per week in the community when CCM is initiated. Service frequency and intensity is only expected to decrease as individuals are linked to community-based services and natural supports identified in the Case Management Service Plan.

It is expected that additional in person, telehealth, and telephonic communications are made with the individual's natural supports, and other providers on their behalf (e.g., inpatient hospital staff, landlord, and residential staff) with valid consent.

1.2.3 Expected Outcomes

An individual:

a. has been successfully linked to the clinically appropriate mental health, substance use disorder, IDD/TBI and/or other services & supports identified in the Case Management Plan;

b. has increased utilization of natural, community and recovery supports;

c. has experienced a decrease in or has not accessed mental health and/or substance use crisis services;

d. becomes increasingly independent in managing symptom and wellness management (e.g.,effectively engaging in care, attending appointments, using medications as prescribed, etc.).

2.0 Eligibility Criteria

An individual who is 18 or older is eligible for this service when ALL the following are met:

A- The individual is diagnosed with a mental health or substance use disorder (as defined by the Diagnostic and Statistical Manual of Mental Disorders, fifth edition (DSM-5), or any subsequent editions of this reference material), other than a sole diagnosis of an intellectual developmental disability (I/DD) and/or traumatic brain injury (TBI);
AND

B- The individual requires coordination between two or more agencies, including medical or non-medical providers, or the individual has not been successfully linked with community-based services to address their mental health and/or substance use symptoms;
AND

C- The individual meets ANY ONE of the following:

1. the individual has had 3 or more behavioral health crisis events in the past 3 months. Crisis events may include psychiatric inpatient admissions, FBC admissions, withdrawal management events, emergency department admissions for a psychiatric reason, mobile crisis events, or BHUC events;
2. the individual has a serious complicating medical co-morbidity (including pregnancy);
3. the individual is placed at an inappropriate level of care or at risk of being discharged from current placement due to complex needs;
4. the individual has complex behaviors requiring additional supervision than is typically available and/or highly specialized interventions;
5. has a legal history affecting ability to live in congregate settings and/or in proximity to children;
6. the individual is being released from a correctional setting and is not eligible to receive another care management service. This service can be initiated 30 days before release to incarcerated individuals.

Continued Stay Criteria

The individual is eligible to continue receiving CCM services, after the initial authorization period, if the individual meets any of the following:

a. The individual is making progress towards, but has not fully met the current goals of the case management Service Plan; or

b. The individual has met current goals and additional goals are indicated; or

c. The individual is not making significant progress towards Plan goals following reassessment and another service is indicated but additional time is needed to connect to that service.

2.1 Discharge Criteria

a. The individual has received CCM services for six months;
   or
b. The individual has successfully been linked with long-term community-based recovery supports;
   or
c. The individual or their legally responsible guardian no longer wishes to receive CCM support and has refused CCM services after reasonable attempts have been made to engage him/her in services
   or
d. The individual is clearly in need of a higher level of care and has been connected to the service
   or
e. The individual has been unavailable for 60 days or more.

3.0 Requirements for and Limitations on Coverage

3.1 Specific Requirements

Service authorization is required within 14 days of service initiation. Reimbursement for CCM is limited to 10 units per day. Services, based upon a finding of medical necessity, shall be directly related to the individual's diagnostic, clinical, and case management needs, and are expected to achieve the goals specified in the individual's Case Management Plan.

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 individual's physician, therapist, or other licensed practitioner.Typically, a medically necessary service shall be generally recognized as an accepted method of medical practice or treatment.

CCM is a short-term service. Individuals will receive up to 90 consecutive days for the authorization period. CCM shall not last longer than six months.

3.2 Service Limitations

Individuals that are receiving the following services are not eligible for CCM:

- Assertive Community Treatment
- Community Support Team
- Critical Time Intervention
- Substance Abuse Intensive Outpatient Program
- Substance Abuse Comprehensive Outpatient Treatment
- Substance Abuse Non-Medical Community Residential Treatment
- Group living low, moderate, or high
- Supervised living low and moderate
- Family living low and moderate
- Partial Hospitalization
- Psychosocial Rehabilitation
- Transition Management Services

Provider(s) shall report the appropriate code(s) used which determines the billing unit(s). Units are billed in 15-minute increments. LME-MCOs and provider agencies shall monitor utilization of service by conducting record reviews and internal audits of units of service billed. LME-MCOs shall assess their network providers' adherence to service guidelines to assure quality services for individuals. The case management functions shall be any of the four: (assessment, service planning, linking, monitoring). The amount of weekly case management activity shall be determined by the level of acuity and the needs of the individual based on the comprehensive clinical assessment and the Case Management Service Plan. Weekly in person case management activities are only expected to decrease over the length of the service as the individual is linked to community-based services and natural supports. It is the expectation that the level of case management activity including in person contacts shall be commensurate with the complexity of MH/SU needs of the individual.

Telehealth can only be utilized if an in-person visit is unavailable at that time. This should be documented in the service record. Telehealth in accordance with the DMHDDSAS State Funded Telehealth and Virtual Communication Services Policy.

Individuals receiving services under a Standard Plan or NC Medicaid Direct are not eligible to receive this service.

3.3 Service Orders

A signed service order must be completed by the Licensed Team Lead.

Each service order must be signed and dated by the authorizing professional and must indicate the date on which the service was ordered. A service order must be in place by the 30th day. The service order must be based on an assessment of the individual's needs.

Service orders are valid for one year from the Date of Plan entered on the Case Management Service Plan.

4.0 Documentation Requirements

The service record documents the nature and course of an individual's progress in treatment. All CCM related activities should be documented including collateral contacts. Providers must ensure that their documentation is consistent with the requirements contained in this policy and the *DMH/DD/SAS Records Management and Documentation Manual*.

4.1 Responsibility for Documentation

The case manager who provides the service is responsible for accurately documenting the services billed. The case manager must sign the written entry. The signature must include credentials.

4.2 Contents of a Service Note

Refer to *DMH/DD/SAS Records Management and Documentation Manual* for a complete listing of documentation requirements.

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

- Individual's name
- Individual's identification or CNDS number
- Service Record Number
- Service provided
- Date of service
- Place of service
- Type of contact (in person, telephone call, collateral)
- Purpose of the contact
- Description of the case management activity (-ies)
- Amount of time spent performing the intervention. Documentation of the intervention must accurately reflect treatment for the duration of the time indicated
- Duration of service, amount of time spent performing the intervention
- Description of the results or outcome of the case management activity (-ies), any progress noted, and next steps, when applicable
- Signature and credentials of the staff member(s) providing the service

A documented discharge plan shall be discussed with the individual and must be included in the service record.

5.0 Provider Qualifications and Occupational Licensing Entity Regulations

CCM shall be delivered by practitioners employed by mental health or substance abuse provider organizations that:

a: meet the provider qualification policies, procedures, and standards established by theDivision of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS);
and
b: 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. The organization shall be established as a legally constituted entity capable of meeting all requirements of the Provider Endorsement, Enrollment Agreement, Communication Bulletins, and service implementation standards.

6.0 Staffing Requirements

CCM must be provided by a team of three full-time equivalent positions (3 FTEs)

- 1.0 FTE CCM Licensed Team Lead,
- 1.0 FTE CCM Case Manager, and
- 1.0 FTE Certified Peer Support Specialist.

Staffing ratio cannot exceed 1:20 individuals on a caseload for the CCM Case Manager and Certified Peer SupportSpecialist (CPSS), and a caseload size of 1:10 for the Team Lead. This service is for a 3-person team with a team case load of 1:50.

	Staff FTE (minimum and maximum), minimum FTEto the CCM team	**Staff Licensing/Training/Certification Requirements**
CCM Licensed TeamLead This position is to beoccupied by only oneperson	• One full-time, dedicated, licensed team leader	• Licensed Psychologist, Licensed Psychological Associate, Licensed Clinical Social Worker/Associate, Licensed Clinical Mental Health Counselor/Associate, Licensed ClinicalAddictions Specialist/Associate, or Licensed Marriage and Family Therapist/Associate
CCM Case Manager	• Must be a minimum 1.0FTE dedicated to the CCM team	• Must meet the NC Qualified Professional(QP) requirements • At least two years of experience with thepopulation to be served

CCM Peer Support Specialist	• Must be a minimum 1.0FTE. Position can be split between not more than 2 CPSS	• Must have completed all requirements to obtainthe NC CPSS credential prior to employment on the CCM team. • At least one year of experience with thepopulation to be served

The CCM Licensed Team Lead must be 1.0 FTE dedicated to the CCM team, have at least two years of experience with the population to be served. They are responsible for providing clinical oversight to the team, providing supervision to the team, facilitating the CCM Team meetings, facilitating any meetings with community partners, as well as completing the case management assessment.

The CCM Case Manager will facilitate the development of a case management service plan that addresses unmet needs and social determinants of health, provide community-based case management that refer and link individuals to services and resources identified in the case management service plan, follow up with community providers to ensure the individual has been linked to and is receiving support.

For each year of employment, each CCM team member shall receive an additional three hours of training in an area that is commensurate with their area of expertise. This additional training may be in the form of locally provided training, virtual workshops and regional or national conferences. Broader topics of additional training may include:

- Family Psychoeducation
- Recovery Oriented Approaches
- Recovery Planning
- Benefits Counseling
- DHHS approved Individual Placement and Support/Supported Employment
- Psychiatric Rehabilitation
- Limited English Proficiency (LEP), blind or visually impaired, deaf, and hard of hearing accommodations
- NAMI psychoeducational trainings
- Psychiatric Advanced Directives
- SOAR (SSI/SSDI outreach, access, and recovery)
- Stepping Stones to Recovery
- Permanent Supportive Housing, such as the SAMHSA evidenced based practices toolkit, Housing First: Pathways Model to End Homelessness for People with Mental Illness and Addiction, and other evidenced based models
- Trauma Informed Care
- Wellness and Integrated Health Care
- Critical Time Intervention
- Wellness Management and Recovery Interventions (includes WRAP,

IMR/WMR)
- Supervising NC Certified Peer Support Specialists
- DHHS Approved Tenancy Support/Permanent Supported Housing
- Pregnancy & SUD
- Motivational Interviewing

7.0 Additional Requirements

7.1 Compliance

Provider(s) shall comply with the following in effect at the time the service is rendered:

All applicable agreements, federal, state, and local laws and regulations including the Health Insurance Portability and Accountability Act (HIPAA), 42 CFR Part 2 and record retention requirements; and all DMHDDSAS's clinical service definition policies, guidelines, policies, provider manuals, implementation updates, and DHHS, DHHS division(s) or fiscal contractor(s).

Attachment A: Claims-Related Information for CCM

Provider(s) shall comply with the *NC Tracks Provider Claims and Billing Assistance Guide*, communication bulletins, fee schedules, and any other relevant documents for specific coverage and reimbursement for state funds:

A. Claim Type

Professional (CMS-1500/837P transaction)

B. International Classification of Diseases, Tenth Revision, Clinical Modification (ICD- 10-CM) Codes

Provider(s) shall report the ICD-10-CM diagnosis code(s) to the highest level of specificity that supports medical necessity. Provider(s) shall use the current ICD-10-CM edition and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for code description as it is no longer documented in the policy.

C. Code(s)

Provider(s) shall select the most specific billing code that accurately and completely describes the procedure, product or service provided. Provider(s) shall use the Current Procedural Terminology (CPT), Health Care Procedure Coding System (HCPCS), ICD-10-CM procedure codes, and UB-04 Data Specifications Manual (for a complete listing of valid revenue codes) and any subsequent editions in effect at the time of service.

Provider(s) shall refer to the applicable edition for the code description.

HCPCS Code(s)	Billing Unit
YM130	1 unit = 15 minutes

Unlisted Procedure or Service

CPT: The provider(s) shall refer to and comply with the Instructions for Use of the CPT Codebook, Unlisted Procedure or Service, and Special Report as documented in the current CPT in effect at the time of service.

HCPCS: The provider(s) shall refer to and comply with the Instructions for Use of H codes, National Level II codes, Unlisted Procedure or Service and Special Report as documented in the current H Code edition in effect at the time of service.

D. Modifiers

Provider(s) shall follow applicable modifier guidelines.

Telehealth Claims: Modifier GT must be appended to the CPT or HCPCS code to indicate that a service has been provided via interactive audio-visual communication.

Telephonic Claims: Modifier KX must be appended to the CPT or HCPCS code to indicate that a telephonic communication was made with the individual's natural supports, and other providers on their behalf.

E. Billing Units

Provider(s) shall report the appropriate code(s) used which determines the billing unit(s). Units are billed in 15-minute increments.

F. Place of Service

CCM providers must deliver services face-to-face in various environments, including homes, school, courts, homeless shelters, and other community settings.