

NC Division of Mental Health, Developmental Disabilities, and Substance Abuse Services

Requirements for Service Provision

I. MEDICAID CONSUMER	DIAGNOSTIC ASSESSMENT (DA) T1023	CLINICAL INTAKE/EVALUATION/ASSESSMENT: 90801, H0001, OR H0031	COMMUNITY SUPPORT (CS) OR TARGETED CASE MANAGEMENT (TCM)*	PERSON-CENTERED PLAN (PCP) INCLUDING CRISIS PLAN**
<p><u>NEW MEDICAID CONSUMER (for 1st 30 Days) ENHANCED BENEFIT SERVICES</u></p> <ul style="list-style-type: none"> Meets Medical Necessity Criteria for Enhanced Benefit Services 	<p>REQUIRED***. Provide service within 30 days of service initiation</p>	<p>Not Required. Provide as necessary for evaluation of special consumer needs & submit to VO.</p>	<p>REQUIRED. Provide service for up to 30 days from services initiation.</p>	<p>REQUIRED. Complete and submit electronically to VO within 30 days of service initiation.</p>
<p><u>NEW MEDICAID CONSUMER BASIC BENEFIT SERVICES ONLY</u></p> <ul style="list-style-type: none"> Meets Medical Necessity Criteria for Basic Benefit Services Only 	<p>Not Required.</p>	<p>Not Required.</p>	<p>Not Required.</p>	<p>Not Required.</p>
<p><u>CURRENT MEDICAID CONSUMER ENHANCED BENEFIT SERVICES</u></p> <ul style="list-style-type: none"> Meets Medical Necessity Criteria for Enhanced Benefit Services and services received are GREATER THAN Outpatient (OP) and/or Medication Management (MM) Only 	<p>Not Required. Provide only when necessary to clarify diagnosis or consider a second opinion, or if consumer is not making progress in treatment and additional assessment is needed to inform a revision in treatment plan.</p>		<p>REQUIRED. Provide continued services with authorization as medically necessary.</p>	<p>REQUIRED. Complete and submit electronically to VO at time of annual update.</p>
<p><u>CURRENT MEDICAID CONSUMER ENHANCED BENEFIT SERVICES – OP/MM ONLY</u></p> <ul style="list-style-type: none"> Meets Medical Necessity Criteria for Enhanced Benefit Services and services received are LIMITED TO Outpatient (OP) and/or Medication Management (MM) Only. 	<p>Not Required. Service is optional as needed.</p>	<p>Not Required. Service is optional as needed.</p>	<p>Not Required. Service is optional as needed.</p>	<p>Not Required. Plan is optional as needed.</p>
<p><u>CURRENT MEDICAID CONSUMER BASIC BENEFIT SERVICES ONLY</u></p> <ul style="list-style-type: none"> Meets Medical Necessity Criteria for Basic Benefit Services Only and services received are LIMITED TO Outpatient (OP) and/or Medication Management (MM) Only. 	<p>Not Required.</p>	<p>Not Required.</p>	<p>Not Required.</p>	<p>Not Required.</p>

* Community Support (CS), Targeted Case Management (TCM), or any other Enhanced Benefit Service that includes case management services.

** Time spent developing the Person Centered Plan and the level of detail included in the Plan should be commensurate with the services to be delivered.

*** Not required for consumers discharged from any inpatient hospital or state-operated ADATCs and Developmental Centers if a substantially equivalent assessment was completed during the inpatient stay.

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Requirements for Service Provision

II. STATE ONLY CONSUMER	DIAGNOSTIC ASSESSMENT (DA) T1023	CLINICAL INTAKE/ EVALUATION/ ASSESSMENT: 90801, H0001, OR H0031	COMMUNITY SUPPORT (CS) OR TARGETED CASE MANAGEMENT (TCM)*	PERSON-CENTERED PLAN (PCP) INCLUDING CRISIS PLAN
<p><u>NEW STATE ONLY CONSUMER ENHANCED BENEFIT SERVICES</u></p> <ul style="list-style-type: none"> Meets DMHDDSAS Target Population Eligibility 	<p align="center">REQUIRED***.</p> <p>Provide one of these services as authorized by LME.</p>	<p align="center">HIGHLY RECOMMENDED.</p> <p>Provide, subject to availability of funds, as medically necessary and as authorized by LME.</p>	<p align="center">REQUIRED.</p> <p>Complete and submit to LME within 30 days of initiation of services.</p>	
<p><u>CURRENT STATE ONLY CONSUMER ENHANCED BENEFIT SERVICES</u></p> <ul style="list-style-type: none"> Meets Medical Necessity Criteria for Enhanced Benefit Services and services received are GREATER THAN Outpatient (OP) and/or Medication Management (MM) Only 	<p align="center">Not Required.</p> <p>Provide only as medically necessary and authorized by LME for clarification of diagnosis or revision in treatment plan.</p>	<p align="center">HIGHLY RECOMMENDED.</p> <p>Provide, subject to availability of funds, as medically necessary and as authorized by LME.</p>	<p align="center">REQUIRED.</p> <p>Complete and submit to LME at time of annual update or at request for reauthorization.</p>	
<p><u>CURRENT STATE ONLY CONSUMER ENHANCED BENEFIT SERVICES – OP/MM ONLY</u></p> <ul style="list-style-type: none"> Meets Medical Necessity Criteria for Enhanced Benefit Services and services received are LIMITED TO Outpatient (OP) and/or Medication Management (MM) Only. 	<p align="center">Not Required.</p> <p>Provide only as medically necessary and authorized by LME for clarification of diagnosis or revision in treatment plan.</p>	<p align="center">Not Required.</p> <p>Provide only as medically necessary and as authorized by LME.</p>	<p align="center">Not Required.</p> <p>Plan is optional as needed.</p>	
<p><u>NEW STATE ONLY CONSUMER CORE SERVICES ONLY</u></p> <ul style="list-style-type: none"> Does Not Meet DMHDDSAS Target Population Eligibility Services received are Assessment Only, Crisis/Emergency Services, or Consultation, Education and Prevention Services 	<p align="center">Not Required.</p>	<p align="center">Not Required.</p>	<p align="center">Not Required.</p>	

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 ** Time spent developing the Person Centered Plan and the level of detail included in the Plan should be commensurate with the services to be delivered.
 *** Not required for consumers discharged from any inpatient hospital or state-operated ADATCs and Developmental Centers if a substantially equivalent assessment was completed during the inpatient stay.