Vaya Partners

High Fidelity Wraparound

H0032U5

H0032 U5 U1 Encounter

Service

High Fidelity Wraparound is an intensive, team-based, person-centered service that provides coordinated, holistic, family-driven care to meet the complex needs of youth/young adults who are involved with multiple systems (e.g., mental health, child welfare, juvenile/criminal justice, special education), experience serious emotional or behavioral difficulties, are at risk of placement in Psychiatric Residential Treatment Facilities (PRTFs) or other institutional settings, or are aging out of Department of Social Services (DSS) care.

High Fidelity Wraparound (HFW) is a service that:

- Facilitates care planning and coordination of services for youth 3-17 years of age with serious emotional disturbance (SED) or young adults 18-21 years of age with serious mental illness (SMI)
- Provides access to family peer support to promote engagement and completion of services
- Engages youth and families to establish an individualized child and family team that develops and monitors a strengths-based plan of care
- Addresses youth and family needs across domains of physical and behavioral health, social determinants of health, and natural supports

The Wraparound Facilitation Team provides a single point of accountability for ensuring that medically necessary services, pro social activities, and natural supports are considered, accessed, coordinated, and delivered in a strength based, individualized, family/youth-driven, and ethnically, culturally, and linguistically relevant manner. Services and supports, which are guided by the need of the youth and family, are developed through a Wraparound planning process consistent with System of Care philosophy and values. The planning process results in an individualized, family-driven, and youth-guided flexible Wraparound plan that is community based and culturally competent. HFW is designed to facilitate a collaborative relationship among a youth with SED, or 18–21-year-old members with SMI, his/her family and involved child-serving systems to support the parent/caregiver in meeting their youth's needs. The wraparound process aims to achieve positive outcomes by providing a structured, creative, and individualized team planning process with four specific phases (engagement, plan development, implementation, and transition). Through the team-based planning and implementation process, wraparound also aims to restore the problem-solving skills, coping skills, and self-efficacy of the young people and family members. The Wraparound planning process ensures that a Wraparound Facilitator organizes and matches care across providers and child-serving systems to enable the youth to be served in their home community. Wraparound utilizes family peer support to engage families in services and to teach families skills in navigating systems and involving natural support.

The National HFW Initiative describes the program philosophy and goals as follows: "The HFW process aims to achieve positive outcomes by providing a structured, creative and individualized team planning process that, compared to traditional treatment planning, results in plans that are more effective and more relevant to the child and family. Additionally, HFW plans are more holistic than traditional care plans in that they are designed to meet the identified needs of caregivers and siblings and to address a range of life areas. Through the team-based planning and implementation process – as well as availability of research-based interventions that can address priority needs of youth and caregivers; HFW also aims to re-develop the problem-solving skills, coping skills, and self-efficacy of the young

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people and family members. Finally, there is an emphasis on integrating the youth into the community and building the family's social support network. Transition age youth define their family members to include other valued adults in the absence of a caregiver. The values of HFW, as expressed in its core principles, are fully consistent with the system of care framework. HFW's philosophy of care begins from the principle of "voice and choice," which stipulates that the perspectives of the family – including the child or youth – must be given primary importance during all phases and activities of HFW. The values associated with HFW further require that the planning process itself, as well as the services and supports provided, should be individualized, family driven, culturally competent, and community based. Additionally, the HFW process should increase the "natural support" available to a family by strengthening interpersonal relationships and utilizing other resources that are available in the family's network of social and community relationships. Finally, the HFW process should be "strengths based," including activities that purposefully help the child and family to recognize, utilize, and build talents, assets, and positive capacities." The HFW philosophy is described through ten principles (Bruns et al. 2008). It is different from traditional service delivery in that the plan of care is not solely based on a diagnosis and/or a list of deficits. HFW is an ecological model, including consideration of the multiple systems in which the youth and family are involved, and the multiple community and informal supports that might be mobilized to successfully support the youth and family in their home and community.

The Ten Principles of the HFW Process

1) *Family "voice and choice"* - Family and youth/child perspectives are intentionally elicited and prioritized during all phases of the HFW process. Planning is grounded in family members' perspectives, and the team strives to provide options and choices such that the plan reflects family values and preferences.

2) *Team based* - The HFW team consists of individuals agreed upon by the family and committed to them through informal, formal, and community support and service relationships. The "professional" members include the Team Facilitator, Parent Partner, and Young Adult Peer (as appropriate).

3) *Natural supports* - The team actively seeks out and encourages the full participation of team members drawn from family members' networks of interpersonal and community relationships. The HFW plan of care reflects activities and interventions that draw on sources of natural support.

4) *Collaboration* - Team members work cooperatively and share responsibility for developing, implementing, monitoring, and evaluating a single HFW plan of care. The plan of care reflects a blending of team members' perspectives, mandates, and resources. The plan guides and coordinates each team member's work towards meeting the team's goals.

5) *Community-based* - The HFW team implements service and support strategies that take place in the most inclusive, most responsive, most accessible, and least restrictive settings possible; and that safely promote child and family integration into home and community life.

6) *Culturally competent* - The HFW process demonstrates respect for and builds on the values, preferences, beliefs, culture, and identity of the child/youth and family, and their community.

7) *Individualized* - To achieve the goals laid out in the HFW plan, the team develops and implements a customized set of strategies, supports, and services.

8) *Strengths based* - The HFW process and the HFW plan identify, build on, and enhance the capabilities, knowledge, skills, and assets of the child and family, their community, and other team members.

9) *Persistence or Unconditional Support* - Despite challenges, the team persists in working toward the goals included in the HFW plan of care until the team reaches agreement that a formal HFW process is no longer required.

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10) *Outcome based* - The team ties the goals and strategies of the HFW plan of care to observable or measurable indicators of success, monitors progress in terms of these indicators, and revises the plan accordingly

The Wraparound Facilitator coordinates the development of a Child and Family Team (CFT) or treatment team comprised of both formal and natural support persons who assist the family and youth in identifying goals and developing a HFW Plan including a Crisis/Safety Plan; convenes CFT meetings; coordinates and communicates with the members of the CFT to ensure the implementation of the HFW Plan; works directly with the youth and family to implement elements of the HFW Plan; coordinates the delivery of available services; monitors and reviews progress toward HFW Plan goals and updates the HFW Plan in concert with the CFT. Each Facilitator may serve 10-12 families. Each Family Partner and Youth Partner may serve up to 15 families and youth across multiple HFW teams. One coach/supervisor for 4 facilitators, 2 family peer support partners, and 1 youth peer support partner for up to 48 youth/families. Youth and Family Support Partners can be part time positions.

Delivery of HFW requires teaming with Family and Youth Partners. In HFW, the HFW Facilitator, Family Partner, and Youth Partner work together with youth with SED and their families while maintaining their discrete functions. The Family Partner works one-on-one and maintains regular frequent contact with the parent(s)/caregiver(s) to provide education and support throughout the care planning process, attends CFT meetings, and may assist the parent(s)/caregiver(s) in articulating the youth's strengths, needs, and goals to the HFW Facilitator and CFT. The Family Partner educates and empowers parents/caregivers about how to effectively navigate the child-serving systems for themselves and about the existence of informal/community resources available to them; and facilitates the caregiver's access to these resources. When implemented fully, the HFW process results in a set of strategies and services provided in the most inclusive and least restrictive settings possible. These strategies are tailored to meet the unique and holistic needs of the youth and family, including supports to family members to reduce stress and to ensure that services are accessed, and treatments completed by the identified youth.

HFW activities are grouped into four phases:

1) In Engagement and Team Preparation (2-4 weeks) the HFW Team Facilitator, along with the Family Partner and Youth Partner, initiates a strengths-based, non-judgmental engagement process that includes crisis stabilization, orientation to the HFW process, and identification of family and youth strengths, culture, and vision (goals) for the future.
2) The Plan Development phase (1-2 weeks) includes a discussion of treatments and strategies that have been successful in the past and identification of individuals who play key roles in the life of the youth and family (including extended family and community resources). Barriers to effective treatment are identified, strategies to stabilize crises that may interfere with treatment planning and follow through are developed, and these are all addressed in the plan. Throughout the process parents/caregivers are provided with support (especially through the Family Partner).
3) During the Plan Implementation phase (2-12 months) of the HFW process, the HFW staff work with the family to build the transition assets that will prepare the family to move forward successfully after HFW ends. This includes transferring responsibility for the process to the family and natural supports. The HFW staff meet with the family frequently to review the status of the plan and identify indicators of progress toward the priority goals. The Facilitator supports the family to manage implementation within other team members to ensure the implementation of the plan of care, monitors completion of action steps, strategies, and successes in meeting needs that lead to the achievement of outcomes. Transition out of formal HFW is intended to occur when the team (with primary guidance from the family) agrees that the identified priority needs have been met.
4) The Transition Phase typically consists of 1 meeting. Most HFW work on transition occurs during the implementation phase.

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Transition out of formal HFW is intended to occur when the team (with primary guidance from the family) agrees that the identified priority needs have been met. The Transition Phase typically consists of 1-4 meetings. The goal of the transition phase is to plan a purposeful transition out of the formal HFW service that supports the youth and family in maintaining the positive outcomes achieved. The cessation of HFW service will be conducted in a manner that celebrates successes and frames transition proactively and positively.

The average length of stay in the total HFW process is 12 months. Maximum stay is 18 months.

HFW Team Tasks and Responsibilities

HFW Facilitator:

Assessment for HFW criteria:

- Reviews multiple tools, including the Child and Adolescent Needs and Strengths (CANS), CALOCUS/LOCUS or the Strengths and Needs Culture Discovery in conjunction with a comprehensive assessment and other clinical information to organize and guide the development of an individual HFW Plan and Crisis/Safety Plan;
- Assists the family to identify appropriate members of the Child & Family Team (CFT);
- Collects background information and plans from other agencies. The assessment process determines the needs and wants of the youth for any medical, educational, social, therapeutic, or other services/supports. Further assessments are arranged as needed or wanted; and
- Facilitates the CFT to identify strengths , needs, and culture of the youth and family in meeting their prioritized needs.

Development of an Individual HFW Plan:

- Convenes and facilitates the CFT meetings and the CFT develops a youth-and family-centered HFW Plan that specifies the goals and actions to address the medical, educational, social, therapeutic, or other services needed or wanted by the youth and family specifying concrete interventions and strategies and identified responsible persons; and
- Ensures the HFW Plan results in the best fit between the family vision, team mission, strengths, needs, and strategies, through a proactive and reactive planning process that is inclusive of a connected crisis plan.

Referral and related activities:

- Works directly with the youth and family to implement elements of the HFW Plan;
- Prepares, monitors, and modifies the HFW Plan in concert with the CFT;
- Identifies, actively assists the youth and family to obtain, and monitors the delivery of available services including medical, educational, social, therapeutic, or other services;
- Assembles child and family teams assesses strengths and needs of the family unit, coordinates meetings, seeks community resources and completes all necessary documentation;
- Develops a transition plan with the CFT when the youth has achieved goals of the HFW Plan; and
- Collaborates with the other service providers and state agencies (if involved) on the behalf of the youth and family.

Monitoring and follow-up activities:

- Facilitates reviews of the HFW Plan to reflect the changing needs of the youth and family;
- Completes the CANS or CALOCUS/LOCUS (as age appropriate) and NC TOPPs as scheduled to track progress;
- Completes the ACORN Tool or other provider selected satisfaction survey tool as scheduled to track/monitor progress & effectiveness;
- Monitors and documents the status of the youth and family's progress and effectiveness of the strategies and interventions outlined in the HFW Plan; and
- Attends weekly coaching to monitor adherence to the HFW principles.

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Family Partner:

- Works one-on-one and maintains weekly contact with the parent(s)/caregiver(s) to provide information and support throughout the care planning process;
- Attends meetings like the Child and Family Teams and Individualized Education Plan (IEP) meetings and may assist the parent(s)/caregiver(s) in articulating the youth's/family's strengths, needs, and goals to the HFW Facilitator and CFT;
- Educates and empowers parents/caregivers about how to effectively navigate the child-serving systems for themselves and about the existence of informal/community resources available to them; and
- Facilitates the parent's/caregiver's access to these resources.

Youth/Young Adult Peer Partner:

- The team encourages the young person to utilize the talents and experiences of others.
- Youth/Young Adult Peer Partner provides mentor support, encourages leadership, and promotes camaraderie.

The Youth Partner:

- Helps re-build relationships and respect with family members, natural supports, community partners, and key stakeholders;
- Develops a working understanding of the young person's desires, goals, interests, and strengths;
- Helps develop trust and mutual respect between the team and the individual, the team also works with the individual to bridge relationships with others, such as family members, teachers, employers, friends;
- Assists the young person with identifying goals and developing an action plan with steps to achieve these goals;
- Helps the young person navigate a system across several domains while focusing on personal effectiveness/wellbeing and life/community functioning;
- Helps redevelop social responsibility and accountability - reteaches the young person problem solving and decision-making skills that enable the young person to manage day to day life problems and opportunities; and
- Builds support network - key element to a young person's identity and independence is his/her support system.

The Youth Partner & HFW team works with the young person to understand the benefits of a support system and identify those individuals and groups that advocate, provide encouragement, and the safety net necessary for success; and enhance Social and Life Skills, assisting the young person to become competent in any skill(s) that are vital to achieving his/her goals. Teaching the individual to become self-sufficient will restore confidence and self-determination.

Anticipated Outcomes

Anticipated system-wide outcomes include but are not limited to the following:

- Reduce costs of care in psychiatric residential treatment facility
- Improve school attendance and performance
- Increase behavioral and emotional strengths
- Improve living situation stability
- Improve caregiver attendance at work
- Reduce suicide attempts
- Decrease contacts with law enforcement

Anticipated clinical outcomes include but are not limited to the following:

- Decrease frequency or intensity of crisis episodes
- Reduce symptomatology
- Increase member and family or caregivers' engagement in the recovery process

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- Improve member functioning in the home, school, and community settings
- Increase ability of the member and family or caregiver to better identify and manage triggers, cues, and symptoms
- Sustain improvement in member's developmentally appropriate functioning as measured by the CANS or CALOCUS/LOCUS
- Reduce hospitalizations and admission and readmissions to residential care
- Increase caregiver and youth ability for self-advocacy and resource gathering
- Increase use of coping skills and social skills that mitigate life stresses resulting from the member's diagnostic and clinical needs
- Reduce symptoms and behaviors that interfere with the member's daily living, such as negative effects of substance use disorder, psychiatric symptoms, or both
- Decrease delinquent behaviors when present
- Increase use of available natural and social supports by the member and family or caregivers
- Improve family assets as defined by the Transitional Readiness Scale/Score

Service Exclusions

Supervision of staff is covered as an indirect cost and therefore must not be counted/billed in the encounter claims submitted.

A member receiving High Fidelity Wraparound will be excluded from Tailored Care Management (TCM). An overlap of 30 days is allowed according to the State duplicative service flexibilities procedure during transitions.

- Services may overlap with Child ACT for 30 days.

Services cannot occur during the same authorization period as the following:

- Multi-systemic Therapy (MST)
- Family Centered Treatment (FCT)
- Assertive Community Treatment Team
- Community Support Team
- Tenancy Support Team
- Substance Use Residential Treatment

Services may occur during the same authorization period as the following if the plan and request clearly demonstrate the roles of each team, and why coordination is needed above and beyond what the below services are expected to do:

- Basic Outpatient Services
- In-Home Therapy Services (IHTS)
- Intensive In-Home Services (IIHS)
- Intercept
- Transitional Youth Services
- Day Treatment
- Substance Abuse Intensive Outpatient (SAIOP)
- Substance Abuse Comprehensive Outpatient Treatment (SACOT)
- High Fidelity Wraparound may occur on a short-term basis with child residential treatment services to assist in facilitation of discharge planning. The timeframe would be based on acuity of need and clinical justification.

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EPSDT SPECIAL PROVISION

Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age

42 U.S.C. § 1396d(r) [1905(r) of the Social Security Act]

Early and Periodic Screening, Diagnostic and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or procedures for Medicaid beneficiary under 21 years of age if the service is medically necessary health care to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination (includes any evaluation by a physician or other licensed practitioner). This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his or her health in the best condition possible, compensate for a health problem, prevent it from worsening or prevent the development of additional health problems.

Medically necessary services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the beneficiary's physician, therapist, or other licensed practitioner; the determination process does not delay the delivery of the needed service; and the determination does not limit the beneficiary's right to a free choice of providers.

EPSDT does not require the state Medicaid agency to provide any service, product, or procedure:

- That is unsafe, ineffective, or experimental or investigational
- That is not medical in nature or not generally recognized as an accepted method of medical practice or treatment

EPSDT and Prior Approval Requirements

If the service, product, or procedure requires prior approval, the fact that the beneficiary is under 21 years of age does NOT eliminate the requirement for prior approval.

Important additional information about EPSDT and prior approval is found in the NC Tracks Provider Claims and Billing Assistance Guide and on NC DHHS: Early Periodic Screening, Diagnostic and Treatment Medicaid Services for Children.

Service limitations on scope, amount, duration, frequency, location of service and other specific criteria described in clinical coverage policies may be exceeded or may not apply as long as the provider's documentation shows that the requested service is medically necessary "to correct or ameliorate a defect, physical or mental illness, or a condition" [health problem]; that is, provider documentation shows how the service, product or procedure meets all EPSDT criteria, including to correct or improve or maintain the beneficiary's health in the best condition possible, compensate for a health problem, prevent it from worsening or prevent the development of additional health problem.

Service Frequency and Intensity

A minimum of four contacts per month. Services are provided in the home and community. Telehealth services can be offered under special circumstances (i.e., pandemic/illness, youth and/or caregiver transitioning to another part of the state where HFW services are available to link to a new HFW team, to support engagement, check-ins when youth and/or the caregiver is traveling outside the immediate service area, etc.). The use of telehealth must be clearly documented, and program fidelity maintained as required by the NC HFW Training Program.

Telehealth is the use of two-way real-time interactive audio and video to provide and support health care services when participants are in different physical locations.

Provider Requirements

The provider delivering this service shall meet the following requirements:

- Provider must meet qualification for participation in NC Medicaid program and be enrolled in NC Tracks.
- Provider must be credentialed and enrolled as a network provider in Vaya Partners' Closed Provider Network, in good standing, and contracted to deliver the service.

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Staffing Requirements

Title	Qualifications	Credentialing Process	Clinical Supervisor Requirements	Administrative Supervision Requirements	Training
Coach/ Supervisor	Master's level Qualified Professional (QP) or Bachelor level QP credentialed as a HFW facilitator. Must complete HFW Facilitation training curriculum and be certified as a HFW Coach (or in the process of being certified as a HFW Coach). The certification process should take no longer than 12 months from date of completing HFW Foundations Training in accordance with model expectations.	Clinicians associated with the program will be credentialed according to standard process	Supervise and evaluate the primary facilitator's performance in all aspects of their position		Be certified as a Wraparound Coach (or in the process of being certified as a Wraparound Coach). The national certification process should take no longer than 12 months from date of hire.
Facilitator	Qualified Professional (QP); meets the requirements specified for QP status according to 10A NCAC 27G.0104	NA	Minimum of monthly individual supervision by Wraparound Coach/ Supervisor		• Must complete Wraparound Facilitation training curriculum and be certified as Wraparound Facilitator (or be in process of completing training and certification). Certification should be completed within 12 months of hire. • Pass background check, the child and adult abuse registry checks, and motor vehicle screens • Receive monthly supervision by the Wraparound Coach/Supervisor. • Trained in Child and Adolescent Needs and Strengths (CANS) (two hours) and Child and Adolescent Level of Care Utilization System (CALOCUS) (two hours)

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Title	Qualifications	Credentialing Process	Clinical Supervisor Requirements	Administrative Supervision Requirements	Training
					within 90 days • Receive Motivational Interviewing (six hours) training within 90 days • Receive trauma-informed care training (six hours) training within 90 days
Family Support Partner	Bachelor's degree in a human services field from an accredited university and one year of experience working with the target population; or associate degree in a human services field from an accredited school; or high school diploma or GED and a minimum of two years of experience working with children/ ADOLESCENTS/transition age youth	NA	Receive monthly supervision by the Wraparound Coach/ Supervisor		• Holds National Certification in Family Peer Support or is actively working on completing certification and is on track to complete Family Peer Support certification within one year of hire date (http://www.ffcmh.org/certification) • When part of a Wraparound Team, Family Peer Support is certified in the role of Family Peer Support in High Fidelity Wraparound or is in process of completing certification process within one year from hire
Youth Partner	Bachelor's degree in a human services field from an accredited university and one year of experience working with the target population; or associate degree in a human service field from an accredited school; or high school diploma or GED and a minimum of two years of experience working with children/adolescents/ transition age youth	NA	Receive monthly supervision by the Wraparound Coach/ Supervisor		Holds National Certification in Peer Support or is actively working on completing certification and is on track to complete Peer Support certification within one year of hire date

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Member Eligibility Requirements

To be eligible for HFW, the member must have NC Medicaid based on residence in a county located within Vaya Partners' region and be enrolled in the State of North Carolina MH/IDD/SAS Health Plan waiver authorized pursuant to section 1915(b) of the Social Security Act, and meet the following criteria:

- Youth with a mental health or substance use disorder diagnosis (as defined by the DSM-5, or any subsequent editions of this reference material), other than a sole diagnosis of intellectual/ developmental disability; AND
- Based on the current comprehensive clinical assessment functional impairment is demonstrated to indicate this level of service. Less intensive services were considered or previously attempted but were found to be inappropriate or not effective.
- Youth requires coordination between two or more service agencies, including medical or non-medical providers; AND
- Youth has current or history within the last six months of symptoms or behaviors indicating the need for a crisis intervention as evidenced by suicidal or homicidal ideation, physical aggression toward others, self-injurious behavior, serious risk-taking behavior (running away, sexual aggression, sexually reactive behavior, or substance use); AND one of the following:
    - Youth's symptoms and behaviors are unmanageable at home, school, or in other community settings due to the deterioration of the member's mental health or substance use disorder condition and is at imminent risk of out-of-home youth residential treatment or adult residential placement, requiring intensive, coordinated clinical interventions and is at risk of needing PRTF or other long-term out-of-home placements; OR
    - Youth is transitioning from PRTF, level III or II group care, therapeutic foster care, Youth Development Center and returning to community services; OR
    - Has a recent history of multiple inpatient psychiatric hospitalizations (in the past year) or one stay that exceeded 14 days; OR
    - Directly transitioning or has been discharged in the past six months from Juvenile Justice related facilities (Assessment Center, YDC, Detention, Eckerd, etc.); OR
    - Transitional age youth in need of an increase and strengthening of family and community support to transition from DSS care or out-of- home placement to independent living (due to aging out of system); AND
    - 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).

Utilization Management

Utilization management of covered services is a part of the assurance of medically necessary service provision. Authorization, which is an aspect of utilization management, validates approval to provide a medically necessary covered service to eligible beneficiaries

Prior Approval Requirements:

- Wraparound will be a maximum of 18 months.
- Prior authorization is not required for 9 months of services; however, a notification Service Authorization Request (SAR) is required within 1 week of service initiation. Each reauthorization after that will be for no more than 60 days.

Services are based upon a finding of medical necessity, must be directly related to the beneficiary's diagnostic and clinical needs, and are designed to achieve the specific rehabilitative goals detailed in the beneficiary's PCP. Medical necessity is determined by North Carolina community practice standards, as verified by Vaya Partners, which will evaluate the request to determine if medical necessity supports more or less intensive services. Medically necessary

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services are authorized in the most cost-effective mode, as long as the treatment that is made available is similarly efficacious as services requested by the beneficiary's physician, therapist, or other licensed practitioner. Typically, the medically necessary service must be generally recognized as an accepted method of medical practice or treatment.

This service shall be covered when the service is medically necessary and:

a. The procedure, product, or service is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the member's needs;
b. The procedure, product, or service can be safely furnished, and no equally effective and more conservative or less costly treatment is available statewide;
c. The procedure, product, or service is furnished in a manner not primarily intended for the convenience of the member, the member's caretaker, or the provider; and
d. The member meets and continues to meet the eligibility requirements for this service, and treatment goals have not yet been achieved. Services and interventions must be reviewed for effectiveness, and interventions should be modified, if necessary, so that the individual makes greater progress.

Transition or Discharge Criteria

The criteria for transition or discharge of the member from High Fidelity Wraparound includes one or more of the following:

1. The member and provider determine that the services are no longer needed based on the attainment of goals as identified in the Individual Support Plan (ISP) or care plan and a different level of care would adequately address current goals.
2. The member has developed skills to function independently in the community.
3. The member has related to natural supports in the community and no longer requires this formal support service.
4. The member has requested discharge.
5. The member no longer meets criteria for the service.
6. The member has not achieved treatment goals despite documented efforts.
7. The member's Medicaid-eligibility is terminated or is transitioned to a county outside Vaya Partners' catchment area.
8. The member moves out of the catchment area and the provider has successfully transitioned the member to another provider of such services in the member's primary place of residence.

Documentation Requirements

These services shall be properly and contemporaneously documented in accordance with this section and the DMH/DD/SAS Records Management and Documentation Manual 45-2 (RMDM) prior to seeking reimbursement from Vaya Partners.

Regardless of the service type, significant events in an individual's life that require additional activities or interventions shall be documented over and above the minimum frequency requirements.

Providers shall make all documentation supporting claims for services reimbursed by Vaya Partners available to Vaya Partners, NCDHHS, and CMS upon request.

A full service note for each contact or intervention (such as individual counseling, case management, crisis response) for each date of service, written and signed by the person(s) who provided the service is required and must contain the following information:

- Member's name,
- service record number,
- Medicaid identification number if applicable,

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- service provided,
- date of service,
- place of service,
- type of contact (face to face, telephone call, collateral),
- purpose of contact,
- providers interventions,
- time spent providing interventions,
- description of effectiveness of intervention, and
- signature and credentials of the staff member(s) providing the service.

Beginning at the time of admission, all interventions/activities regarding discharge planning and transition with youth, family/caregiver, and child and family team will be documented. A completed LME/MCO Consumer Admission and Discharge Form shall be submitted to Vaya Partners. A documented discharge plan shall be discussed with the individual and included in the service record.

Monitoring activities will occur as outlined in Vaya Partners' monitoring plan to assess compliance with the definition and requirements. Focused Monitoring, Complaint Investigations or post payment reviews will occur when quality concerns are identified.

Vaya Partners will monitor level of care and outcomes tracking with use of the CANS periodically and at discharge. It is expected that this service would be effective and result in positive outcomes when a lower score is reported. This would indicate a plan for successful transition back to basic services outpatient services.

Completion of NC TOPPS to track outcomes for individual children. Aggregate data is reviewed to support provider in delivery of service.

Claims-Related Information

Providers shall comply with the NC Tracks Provider Claims and Billing Assistance Guide, applicable Medicaid bulletins issued by the NC Division of Health Benefits (DHB), applicable NC Medicaid Clinical Coverage Policies, this service definition, Vaya Partners' fee schedule and other requirements and any other relevant documents for specific coverage and reimbursement for NC Medicaid.

1. **Claim Type:** Professional (CMS-1500/837P transaction) billed through Vaya Partners.
2. **International Classification of Diseases, Tenth Revisions, Clinical Modification (ICD-10-CM) and Procedural Coding System (PCS):**
   a. Provider(s) shall report the ICD-10-CM and Procedural Coding to the highest level of specificity that supports medical necessity. Provider(s) shall use the current ICD-10 edition and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for code description.
   b. A mental health and/or substance use diagnosis must be present to bill for this service. (See 42 CFR § 435.110)
3. **Codes and Modifiers:** Provider(s) shall report 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), 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. If no such specific CPT or HCPCS code exists, then the provider(s) shall report the procedure, product or service using the appropriate unlisted procedure or service code.
4. **Billing Units:** Providers bill this service on a unit basis. 1 unit = 1 month.
5. **Place of Service:** member home/community
6. **Prior Authorization:** No prior authorization required.

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7. **NC Tracks Enrollment:** Providers must be enrolled through NC Tracks and ensure valid NPIs, taxonomies, sites, zip code (+4) and all other provider demographic information provided to Vaya Partners matches the information in NC Tracks to bill Vaya Partners and be reimbursed for this service.
8. **Coordination of Benefits:** Providers must file with primary payor(s) prior to submission of claims for payment to Vaya Partners, if applicable.
9. **Reimbursement:** Vaya Partners reimburses providers for clean claims for services rendered in accordance with this Service Definition.

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