Vaya Partners

Individual Rehabilitation Coordination Services

H2017 U5

Service

The purpose of this service is to enhance, restore and/or strengthen the skills needed to promote and sustain independence and stability within the individual's living, learning, social, and work environments. IRCS is a skill building service, not a form of psychotherapy or counseling. The intensity and frequency of services offered should reflect the scope of impairment. Services are generally more intensive and frequent at the beginning of treatment and are expected to decrease as the beneficiary's skills develop. Services are based on medical necessity, person-centered, shall be directly related to the beneficiary's diagnostic and clinical needs and are expected to achieve the specific rehabilitative goals specified in the individual's Person-Centered Plan.

This service was developed in response to COVID-19 state of emergency and intended to be used only during a state of emergency, natural disaster, or situation where member is unable to attend PSR on site due to personal extenuating circumstances. In a situation where the medical necessity for this service is based on member personal experience, documentation must be submitted clearly stating the need and shall be reviewed during the prior authorization process. **During times of state of emergency or natural disaster, Vaya Partners will make providers aware of the availability for this service.**

Treatment Program Philosophy, Goals & Objectives

Similar to Psychosocial Rehabilitation Service, IRCS is based on the principles of recovery, including equipping beneficiaries with skills, emphasizing self-determination, using natural and community supports, providing individualized intervention, emphasizing employment, emphasizing the "here and now", providing early intervention, providing a caring environment, practicing dignity and respect, promoting beneficiary choice and involvement in the process, emphasizing functioning and support in real world environments, and allowing time for interventions to have an effect over the long term. The service is to be used to facilitate cognitive and socialization skills necessary for functioning in a home, work, and/or community environment, focusing on maximum recovery and independence. There should be a supportive, therapeutic relationship between the providers, beneficiary, and family which addresses or implements interventions outlined in the Person-Centered Plan (PCP) in ANY of the following skills development, educational, and pre-vocational activities:

a. Community living, such as housekeeping, shopping, cooking, use of transportation facilities, money management;
b. Personal care such as health care, medication self-management, grooming;
c. Social relationships;
d. Use of leisure time;
e. Educational activities which include assisting the beneficiary in securing needed education services such as adult basic education and special interest courses; or
f. Prevocational and transitional employment activities which focus on the development of positive work habits and participation in activities that would increase the participant's self-worth, purpose and confidence; these activities are not to be job-specific training. g. Identification and addressing of unmet health related resource needs

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Anticipated Outcomes

Afford members life experiences and extended social networks.

- Reduce hospitalizations and/or length of stay when hospitalization is deemed medically necessary.
- Increase quality of life.
- Address and eliminate, when possible, social determinants of health.
- Achieve gains in psychosocial functioning, that when not supported the member is at risk of institutionalization, including:
  - Residential stability;
  - Social autonomy;
  - Role performance;
  - Employment;
  - Social functioning;
  - Member satisfaction

Service Exclusions

This service cannot be provided during the same episode of care as:

- Partial Hospitalization
- Assertive Community Treatment (ACT)

Service Frequency and Intensity

1 unit per week; a total of 52 weeks per individual.

Provider Requirements

The provider delivering this service shall meet the following requirements:

- Provider must meet qualification for participation in NC Medicaid and/or NC Health Choice program, as applicable, and be enrolled in NCTracks.
- 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.
- For any member requiring nursing level assistance, N.C. Board of Nursing regulations and requirements must be followed for tasks that present health and safety risks to the member.
- Provider must verify employee/independent contractor qualifications at the time employee is hired/contracted.
- Providers must provide verification of staff qualifications on at least an annual basis.
- Provider must comply with all terms and conditions of its contract with Vaya Partners, other applicable written agreements, and all applicable federal, state, and local laws, rules, and regulations.

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Staffing Requirements

Title	Qualifications	Credentialing	Clinical Supervision Requirements	Administrative Supervision requirements	Training
Qualified Professional	According to 10A NCAC 27G .0104	N/A	As required by qualifications supervision of qualified professionals	As established by the policies and procedures of the provider	Meet training requirements according to 10A NCAC 27G .0104 and have the knowledge, skills, and abilities required by the population and age to be served.
Associate Professional and Paraprofessional	According to 10A NCAC 27G .0104	N/A	As required by qualifications, supervision of qualified professionals	As established by the policies and procedures of the provider	Meet the training requirements according to 10A NCAC 27G .0104 and have the knowledge, skills, and abilities required by the population and age to be served

Member Eligibility Requirements

To be eligible for Individual Rehabilitation Coordination Services, the member be an adult, ages 18 and older, and must have NC Medicaid based on residence in a county located within Vaya Partners' region, be enrolled in the Vaya Partners Tailored Plan or Medicaid Direct PIHP, and meet the following criteria:

A. The individual has received a comprehensive clinical assessment and has been diagnosed with a serious and persistent mental illness (SPMI), which includes one of the following diagnoses: Bipolar Disorder, Major Depression, a diagnosis within the spectrum of psychotic disorders, and/or substance use disorder (SUD).
B. The individual has a serious and persistent mental illness (SPMI) and/or substance use disorder (SUD) and the symptom-related problems interfere with the individual's functioning and living, working, and/or learning environment.
C. Because of the SPMI or SUD, the individual experiences moderate to severe functional impairment that interferes with three or more of the following areas: daily living, personal relationships, school/work settings, and/or recreational setting.
D. Traditional basic services (e.g., individual/family/group therapy, medication management, etc.) alone are not clinically appropriate to prevent the individual's condition from deteriorating. The level of care provided is determined by the clinician to be the least restrictive and that the benefits to receiving the treatment outweigh any potential harm.
E. Individual meets three or more of the following criteria as documented on the Diagnostic Assessment:
    - Is not functioning at a level that would be expected of typically developing individuals their age;
    - Is at risk of psychiatric hospitalization, homelessness, and/or isolation from social supports due to the individual's SPMI and/or SUD;
    - Exhibits behaviors that require repeated interventions by the mental health, social services, and/or judicial system;
    - Experiences impaired ability to recognize personal and/or environmental dangers and/or significantly inappropriate social behavior.

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F. Individual is expected to benefit from the intervention and identified needs would not be better met by any other formal or informal system or support.
G. A service order for (IRCS) Services must be completed by a physician, licensed psychologist, physician assistant or nurse practitioner according to their scope of practice prior to or on the day that the services are to be provided.

Utilization Management

No Prior authorization required. 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.

Services are based upon a finding of medical necessity, must be directly related to the beneficiary's diagnostic and clinical needs, and are expected 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 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.

A discharge Service Authorization Request (SAR) will not be required when member is discharged from the service.

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

- The procedure, product, or service is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not more than the member's needs;
- The procedure, product, or service can be safely furnished, and no equally effective and more conservative or less costly treatment is available statewide;
- 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
- 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.

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.

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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 NCTracks Provider Claims and Billing Assistance Guide and on the EPSDT provider page.

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.

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 that meets the requirements per APSM 45-2 Records Management and Documentation Manual is required for all dates of service. The note must include the activities performed and the agencies contacted, if applicable.
- Documentation required for this service should be maintained in the provider's medical record for the individual and a full-service note is required for all dates of service. This should include a note of the activities preformed, amount of time spent, agencies contacted, if applicable, and signature and credentials of the individual providing the service.
- If the services are delivered telephonically or through telehealth methods, the documentation must clearly support why this is the most appropriate service delivery method.
- A service order signed by a master's level behavioral health professional fully licensed in the state of North Carolina with at least two years of post-master's degree experience with the population served
- Providers shall make all documentation supporting claims for IRCS reimbursed by Vaya Partners available to Vaya Partners and NCDHHS upon request.

Claims-Related Information

Providers shall comply with the NCTracks 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 Medicaid and NC Health Choice.

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1. Claim Type: Professional (CMS-1500/837P transaction) billed through Vaya Health.
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.
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: H2017 U5
5. Place of Service: Home and/or community
6. Prior Authorization: No prior authorization required.
7. NCTracks Enrollment: Providers must be enrolled through NCTracks and ensure valid NPIs, taxonomies, sites, zip code (+4) and all other provider demographic information provided to Vaya Partners matches the information in NCTracks 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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