Title:	Child Focused Assertive Community Treatment Team – Child ACTT	Code:	H0040 HA U5 Encounters = H0040 HA U5 EN
Type:	Community Based Services – Children with MD co-occurring SUD/IDD	Group Code:	H0040
Effective Date:	July 1, 2019	Units:	1 unit per week; anticipated Units of service per person = 24 units

SERVICE DESCRIPTION

Child Focused Assertive Community Treatment (Child ACTT) is a team-based multidisciplinary approach to serve children in their homes, kinship placement Child Focused Assertive Community Treatment (Child ACTT) is a team-based multi-disciplinary approach to serve children in their homes, kinship placements, DSS foster homes, or may begin during transition from a more restrictive residential setting. Similar to the ACTT service for adults, this service uses a community-based team approach to meet the needs of youth with Serious Emotional Disturbance (SED). This service is used to meet the needs of youth that are high risk for out-of-home residential treatment due to a psychiatric disorder, have a history of multiple hospitalizations or long term hospitalization(s) at a state facility, have a history of multiple episodes of Residential treatment, who are unresponsive to conventional outpatient treatment (outpatient therapy, Intensive In-home services, etc.) after discharge from Residential treatment even when evidenced based models were utilized, and/ or symptoms are at a severity where typically Psychiatric Residential treatment would be recommended, but based on team approach and planning for crisis intervention, Child ACTT would be appropriate to implement.

- The service is designed for male and female beneficiaries with a primary mental health diagnosis. However, individuals diagnosed with Mental Health conditions and co-occurring Moderate or Mild Intellectual disabilities or Autism will be assessed on a case by case basis for participation in Child ACTT.

- A beneficiary who is appropriate does not benefit from receiving services across multiple, disconnected providers, and may become at greater risk of hospitalization, out of home placement, substance use, victimization, and juvenile justice involvement. The beneficiary needs assertive engagement to develop treatment motivation.

- The team provides person-centered services addressing the breadth of a beneficiary's needs, helping him or her achieve their personal goals.
- The team includes the family/caregiver, as they are a critical component of addressing the identified beneficiary's needs and achieving goals. Thus, a fundamental charge is to be the first-line (and generally sole provider) of all the services that a beneficiary needs. Being the single point of responsibility necessitates a higher frequency and intensity of community-based contacts and a very low beneficiary-to-staff ratio.
- Services are flexible; teams offer varying levels of care for all beneficiaries and appropriately adjust service levels given an individual beneficiary's changing needs over time.
- Services address needs in multiple life domains, including family life and social relationships, health, housing, substance use, medication support, financial stability, activities of daily living, educational/vocational success, and wellness self-management/relapse prevention.

- Treatment interventions would include evidenced based treatment with the methodologies being specific to the present needs of the member, so this would vary from member to member:

- Trauma Systems Therapy (underlying agency-wide treatment model)
- Trauma Focused Cognitive Behavioral Therapy (TF-CBT)
- Dialectical Behavior Therapy (DBT)
- Cognitive Behavioral Therapy (CBT)
- Motivational Interviewing (MI)
- Attachment Self-Regulation and Competency (ARC)
- Wellness Recovery Action Plan (WRAP)
- Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS)
- Seven Challenges
- Other models as determined by youth/family needs

Population to Be Served/Service Type/Setting
Children ages 12-18 with a major depressive disorder, psychotic disorders, anxiety disorders, disruptive behavior disorders and bipolar disorder because these illnesses more often cause long term psychiatric disability. Beneficiaries with other psychiatric illnesses are eligible dependent on the level of the long-term disability, co-occurring disorders, and complex trauma. Child ACTT services are primarily provided in the community. A fundamental feature of Child ACTT is that services are taken to the member/family in his or her natural environment, rather than having the member/family come into an office or clinic setting to receive services. Services shall be delivered in various natural environments, such as homes, schools, court, homeless shelters, libraries, street locations, and other community settings. Some supportive coordination activities such as researching community supports are available for the member and family. Obtaining progress updates from other treatment providers may be done from the provider's office setting. Whenever appropriate these activities should be done in the community with the families or discussion that occur during Child and Family team meetings. All encounter claims should accurately reflect the setting in which they were provided. Child ACTT also includes telephone time with the member and the member's family or caregivers, as well as collateral contact with persons who assist the member in meeting the member's goals as specified in the Person-Centered Plan (PCP}. Child ACTT includes participation and ongoing clinical involvement with the Child and Family Team and meetings for the planning, development, implementation, and revision of the member's PCP.
Entrance Process
Children 12-18 years with major depressive disorders, psychotic disorders, anxiety disorders, disruptive behavior disorders and bipolar disorder because these illnesses more often cause long term psychiatric disability. Beneficiaries with other psychiatric illnesses are eligible dependent on the level of the long-term disability, co-occurring disorders, and complex trauma. Beneficiaries with a primary diagnosis of a substance use disorder, intellectual developmental disabilities, traumatic brain injury, or an autism spectrum disorder are not the intended beneficiary group and would be considered for Child ACTT on a case by case basis. Child ACTT teams shall document written admission criteria that reflect the following medical necessity criteria required for admission: a. Has a current Mental Health and Diagnostic and Statistical Manual (DSM) 5 (or its successor) diagnosis consistent with reflecting the need for treatment and the covered treatment must be medically necessary for meeting the specific preventive, diagnostic, therapeutic, and rehabilitative needs of the beneficiary.

AND

b. Has significant functional impairment as demonstrated by **at least one** of the following conditions:

1. Significant difficulty consistently performing the range of routine tasks required for basic child/adolescent functioning in the community (for example, demonstrating safety skills, self- regulation, and basic social interaction) or persistent or recurrent difficulty performing daily living tasks except with significant support or assistance from others such as friends, family, or relatives;
2. Significant difficulty maintaining consistent educational/vocational performance at a self-sustaining level (such as regular attendance, regular participation without expulsion or repeated suspension)

Utilization Management

Unit of Service: 1 Unit per week

Anticipated Units of Service per Person: 24 units

A comprehensive clinical assessment (CCA) that 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 and state requirements, it may be used as a part of the current CCA. Relevant diagnostic information must be obtained and included in the Person-Centered Plan (PCP).

Eligibility Criteria

Children ages 12-18 with a major depressive disorder, psychotic disorders, anxiety disorders, disruptive behavior disorders and bipolar disorder because these illnesses more often cause long term psychiatric disability. Beneficiaries with other psychiatric illnesses are eligible dependent on the level of the long-term disability, co-occurring disorders, and complex trauma.

Child ACTT services are primarily provided in the community. A fundamental feature of Child ACTT is that services are taken to the member/family in his or her natural environment, rather than having the member/family come into an office or clinic setting to receive services. Services shall be delivered in various natural environments, such as homes, schools, court, homeless shelters, libraries, street locations, and other community settings.

Continued Stay Criteria

Medicaid shall cover a continued stay if the desired outcome or level of functioning for the beneficiary or family has not been restored, improved, or sustained over the time frame outlined in the beneficiary's PCP or the beneficiary or family continues to be at risk for relapse based on current clinical assessment, history, or the tenuous nature of the functional gains;

AND

One of the following applies:

a. The beneficiary or family has achieved current PCP goals and additional goals are indicated as evidenced by documented symptoms;

b. The beneficiary or family 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 PCP;

c. The beneficiary or family is making some progress, but the specific interventions in the PCP need to be modified so that greater gains, which are consistent with the beneficiary's pre-morbid or potential level of functioning, are possible;

d. The beneficiary or family fails to make progress or demonstrates regression in meeting goals through the interventions outlined in the PCP. {In this case, the beneficiary's diagnosis must be reassessed to identify any unrecognized co• occurring disorders, and treatment recommendations should be revised based on the findings); or

e. If the beneficiary is functioning effectively with this service and discharge would otherwise be indicated, The Child ACTT team services must be maintained when it can be reasonably anticipated that regression is likely to occur if the service is withdrawn. The decision must be based on either of the following:

1. The beneficiary has a documented history of regression in the absence of Child ACTT team services, or attempts to titrate team services downward have resulted in regression; or
2. There is an epidemiologically sound expectation that symptoms will persist and that ongoing outreach treatment interventions are needed to sustain functional gains.

Discharge Criteria

Beneficiary shall meet at least one of the following:

a. The beneficiary and team determine that ACT-Y services are no longer needed based on the attainment of goals as identified in the person-centered plan and a less intensive level of care would adequately address current goals;

b. The beneficiary moves out of the catchment area and the ACT-Y has facilitated the referral to either a new ACT-Y provider or other appropriate mental health service in the new place of primary private residence and has assisted the beneficiary in the transition process;

c. The beneficiary and, if appropriate, the legally responsible person, choose to withdraw from services and documented attempts by the program to re-engage the beneficiary with the service have not been successful; or

d. The beneficiary and family have not demonstrated significant improvement following reassessment and several adjustments to the treatment plan over at least three months and:

1. Alternative treatment or providers have been identified that are deemed necessary and are expected to result in greater improvement; or
2. The beneficiary's behavior has worsened, such that continued treatment is not anticipated to result in sustainable change; or
3. More intensive levels of care are indicated.

Child ACTT team services may be billed for up to 30 days in accordance with the Person-Centered Plan for beneficiaries who are transitioning to or from Intensive In Home, Day Treatment, Residential levels 2-4, TASK, MST

A discharge SAR should be submitted at the time of discharge.

Service Exclusions/Limitations

This is intended to be a bundled comprehensive service that meets all treatment needs of the member so other services other than previously referenced during a transition period are excluded from Co-Occurrence. Inpatient, Facility Based Crisis, and Emergency Department Services can still be accessed as medically necessary for crisis stabilizations. Early Periodic Screening, Diagnosis and Treatment (EPSDT) will still be considered on as necessary on an individual member basis.

- In lieu of services are not included in the Medicaid State Plan and are provided only when they are expected to be cost effective alternative to state plan services which result in as good as or better outcomes than would the state plan service
- In lieu of services may be provided to individuals who participate in NC Innovations or other home and community-based waiver programs, such as CAP/C and CAP/DA, as long as the alternative services are not duplicative of waiver services
- If a request for authorization of this service is denied, or if an authorization of this service is terminated, suspended, or reduced, then appeal rights will be provided in accordance with applicable law.

Treatment Program Philosophy, Goals, and Objectives

ACTT Youth engages a comprehensive team, which meets daily, to wrap any needed services around the child and family. Each ACTT Youth team includes a licensed team leader, psychiatric care provider, registered nurse, licensed clinician, peer specialist, family advocate, case coordinator, and behaviorl specialist, when needed. During the daily team meetings, any and all needs of the childa nd family, including Social Determinants of Health (SDOH), are addressed. Unlike other services, which provide treatment in solos, child/ACTT youth synthesizes all necessary

treatment providers under one coordinate plan, therefore repairing a previously fragmented delivery system. Through this more synthesized case management approach, children and families are able to navigate the sometimes very different systems of social service, mental health, public health, public instruction, and legal systems wih the ultimate goal of famlies beomcing their own case managers, accesssing their own services, and seeking out supports within their own communities. One additional challenge we seek to solve is how to facilitate the movement of children with complex behavioral health issues and severe disorders with no "home" to which they can return. In many cases placement in forster care or other community based alternatives is not possible for these youth due to their behaviors and past incidents. In order to envision a future in which they are able to escape the cycle of moving through the levels of congregate and institutionalized care, we must create alternatives to current foster care system in North Carolina. Our study will include 5 professional parents who will fill the role of providing a safe place in the community for this specific subset of kids. These individuals may have a working spouse or not, but the professional parent's job will be to be af ull time member of the child's treatme team. Along with the ACTT youth team, they will insure that coordination of care and resources are adequate to create a safe, healing pathway for success. Additionally, for any in home placement it is critical that the professional parent receive on-going and frequent respte so that they may provide the best care possible. We will contract for these services with these unique individuals.

Treatment Elements/Documentation Requirements

Documentation Requirements

Treatment Plan

Each individual receiving Child ACTT services is required to have a Person-Centered Plan (PCP) that is fully complete prior to or on the first date of service. The PCP must meet all of the requirements, including an enhanced crisis plan, as outlined in the NC PCP Instruction Manual. The amount, duration, and frequency of the service must be included in the PCP.

Service Documentation

A full-service note that meets the requirements per APSM 45-2 is required for each contact or intervention (such as individual session, case management, crisis response) for each date of service, written and signed by the person(s) who provided the service, will contain the following information:

- Recipient's name
- Service record number
- Medicaid identification number (as applicable)
- Name of service provided
- Full date of service
- Place of service
- Type of contact (face to face, telephone call, collateral, etc.)
- Purpose of contact as it relates to the goal(s) on the PCP
- Description of the interventions provided
- Time spent providing interventions (i.e. duration)
- Assessment of effectiveness of intervention and/or the recipient's progress towards the goal(s)
- Signature and credentials of the staff member(s) providing the service. Discharge Planning

Discharge Planning

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 documented discharge plan shall be discussed with the individual and included in the service record.
A discharge SAR should be submitted at the time of discharge.

Program Requirements

Child ACTT is a team-based multi-disciplinary approach to serve children in their homes, kinships placements, DSS foster homes, or may begin during transition from a more restrictive residential setting but typically would not exceed 30 days, although may be extended as needed if discharge plans are adjusted. It is the expectation that the majority of services are provided in the home or other community settings, typically 80-90% of the contacts will be in these settings. While the composition of the team is established, the team members providing the direct interventions to the child and family may be varied based on the needs of the individual. The team will have daily meetings to prioritize activities, share information, and discuss individual members. The team will be available to respond 24/7 for crisis de-escalation and assessment, inclusive of availability by phone within 15 minutes and face to face within no more than 2 hours. This will include face-to-face assessment by a clinician, or nurse if this is determined to be needed for the individual. The psychiatric provider will be available minimally by phone 24/7 for consultation and treatment recommendations. The team will assess the overall needs of the family to ensure that all necessary treatment and supports are in place for entire family system. Targeted length of service is 6 months.

Program Size:

a) Small teams: serve a maximum of 40 beneficiaries, with 1 team member per 8 or fewer beneficiaries (must have at least 5 staff if team is full)

b) Mid-Size Teams: serve a maximum of 63 beneficiaries with 1 team member per 9 or fewer beneficiaries (must have at least 7 staff if team is full)

Note: Movement on and off the teams may result in temporary breaches of caseload. Therefore, teams shall be expected to maintain an annual average not to exceed the limits above.

Expected Outcomes

It is expected that beneficiaries will reduce the amount of time spent in residential settings and become more integrated within their own community. In addition, the following outcomes are expected:

a. Beneficiary satisfaction
b. Increased adherence to treatment/service plan
c. Vocational/educational gains
d. Increased stay in their community residence with family or natural supports
e. Increased natural supports
f. Increased engagement in positive supportive activities

Staffing Requirements

All employees must meet the minimum education, experience and licensure criteria established for their position as required in rules or service definitions, whichever is most restrictive.

Child ACTT is delivered by a team comprised of the following positions:

Position	Minimum Staffing	Staff Qualifications
Team Leader: This position is to be occupied by only one person. (Mandatory)	1 FTE	The team leader shall be a licensed mental health professional holding any of the following licenses: licensed psychologist, licensed psychological associate, licensed clinical social worker, licensed professional counselor, licensed marriage and family therapist, licensed psychiatric nurse practitioner, clinical nurse specialist certified as an advanced practitioner psychiatric clinical nurse specialist. The team leader shall have three years of clinical experience with children with serious emotional disturbance, with a minimum of 2 years post graduate school experience.
Psychiatric Care Provider (Mandatory)	.5FTE	Board eligible or certified by the American Board of Psychiatry and Neurology and licensed to practice in NC and meet the credentialing and qualifications as specified in NCAC 27G .0104 (16). Psychiatrist must be a Child and Adolescent psychiatrist. If a psychiatric nurse practitioner is utilized, he/she shall be currently licensed as a NP in NC and meet the requirements as specified in 21 NCAC 36.0800, approval and practice parameters for nurse practitioners, with at least three years full time experience in treating children with serious emotional disturbance. If a physician assistant is utilized on the team, he/she shall be currently licensed as a PA in NC and must meet the requirements as specified in 21 NCAC 32S.0200 with at least three years full time experience treating children with serious emotional disturbance.
Nursing (Mandatory)	1 FTE	A registered nurse(s) RN or advanced practice registered nurse (APRN) has

		a minimum of one-year experience working with children with serious emotional disturbance and a working knowledge of psychiatric medications
Licensed Clinician (Mandatory)	1 FTE	Licensed clinician(s) with at least 1 year of experience working with children with serious emotional disturbance. The licensed clinician shall be a licensed clinician shall be a licensed mental health professional holding any of the following licenses: licensed psychologist, licensed psychological associate, licensed clinical social worker, licensed professional counselor, licensed marriage and family therapist, licensed psychiatric nurse practitioner, clinical nurse specialist certified as an advanced practices psychiatric clinical nurse specialist. An associate level licensed professional must be fully licensed within 30 months from the date of hire.
Substance Abuse Specialist: (may be utilized to make up the additional 2 FTE (small team) or contribute to the additional staffing for a mid-size team.	PRN	The team shall include substance abuse expertise if serving youth with primary SUD diagnosis and this is not within the scope of the team lead or other clinicians on the team; individuals providing substance abuse expertise shall meet qualified professional credentials and qualifications according to 10A NCAC 27G.0104(19), and have a designation of certified clinical supervisor, licensed clinical addition specialist, licensed clinical addiction specialist associate, or certified substance abuse counselor.
Peer Specialist – **Youth** (may be utilized to make up the additional 2 FTE (small team) or contribute to the additional staffing for a mid-size team.	.25 - .5 FTE	The team includes Peer Specialist(s). Minimum age is 18. To ensure that the experience of the peer specialist is commensurate with those served by team for this position, the individual must have "lived experience" and a personal recovery story specific to child/adolescent SED.
Family Advocate – (may be utilized to make up the additional 2 FTE (small team) or	.25 - .5 FTE	Each has Family Advocate(s). To ensure that the experience of the family advocate is commensurate with those served by the team, for

contribute to additional staffing for a mid-size team)		this position, the individual must have "lived experience" and a personal recovery story specific to being a caregiver for an SED child/adolescent.
Case Coordination (may be utilized to make up the additional 2 FTE (small team) or contribute to the additional staffing for a mid-size team)	1 FTE	Team will include case coordination; staff providing this service meet requirements as an associate licensed professional or licensed professional and must have one year of experience with children with serious emotional disturbance. An associate level licensed professional must be fully licensed within 30 months from the date of hire.
Behavioral Specialist (may be utilized to make up the additional 2 FTE (small team) or contribute to the additional staffing for a mid-size team)	.5 FTE	Team will include Behavioral Specialist(s). Must qualify as QP or AP. Must have one year of experience working with children with serious emotional disturbance
Additional Staff additional staff reflecting the expertise and training needed for the targeted clinical population (example., a second substance abuse counselor for teams serving primarily beneficiaries with co-occurring substance use disorders)		Any additional staffing should reflect the intended program size, number of beneficiaries served, and needs of the team. Areas of expertise and training may include, for example: supportive housing, money management, empirically-supported therapy, family liaison, and forensic and legal issues. If teams are targeting a specific clinical population, it is recommended they hire

A team will have a minimum of 5 FTE staff at all times. The team must always maintain a team lead, a nurse, a clinician, and a psychiatric practitioners. The 4th and 5th staff can be a FTE or combination of part time FTEs fulfilling the roles most needed based on the members being served by the team or areas that the existing staff do not have sufficient experience and or expertise in. For example, if the team lead and/or clinician have experience with Substance Use Disorders it may not be necessary to have an additional SUD clinician even if members on the team have this as an identified treatment need. However, if neither of those individuals have this background it may be necessary to have an SUD on the team if the members have this as an identified treatment need. The Case Coordination activities may also be provided by a combination of individuals on the team or may be done by a designated staff member.

The Psychiatric Care Provider is not counted in the minimum FTE but one must always be assigned to a team. Additional staff will be added based on the caseload served by the team or the clinical needs of the members. Not all members being served by the team will interact with all staff, but all will be seen by the Psychiatric Care Provider.

For licensed professionals: Provider will ensure that all licensed staff complete the required MCO credentialing process and maintain their licensure. Provider organization will complete CAQH, and if needed NCTRACKS, NCID, and NPI and submit credentialing application to MCO.

For unlicensed staff: Provider organization completes primary source verification for education and verifies experience. Final determination of paraprofessional, associate professional, or qualified professional must follow all applicable agencies policies and procedures and NC General Statutes. The provider organization is responsible for ensuring staff have the knowledge, skills, and abilities required by the population and age to be served.

All team members shall receive ongoing clinical and administrative supervision from team leadership, with the team leader as the primary clinical supervisor. Supervision will be based on staff licensure. Non-licensed staff members shall receive scheduled supervision bi-weekly, either in individual or group format; no staff shall go without a supervision session in a given month.

As part of the service, a team meeting will occur daily which will also serve as a method for overall supervision of the team facilitated by the team lead or designee in the absence of the team lead.

Staff Training Requirements:

Training	Initial Within 120 days of hire	Annual
Team Leader	Crisis response (3 hours) Person Centered Thinking (12 hours) Introductory Motivational Interviewing (13 hours) System of Care (11 hours) PCP Instructional Elements (3 hours) Alternatives to restrictive interventions (8 hours) Training in at least one model of care with empirical evidence (duration unknown) 50 hours Total (plus any specific training required for the treatment modality being used by the team)	Additional 3 hours of training that fits with expertise; annual training as required by the model of care
Psychiatric Care Provider	Person Centered Thinking (12 hour) Alternatives to restrictive interventions (8 hours) 20 hours Total	Continued education as required for license
Nursing	Alternatives to restrictions Interventions (8 hours) Person Centered Thinking (12 hours) 20 hours total	Continuing education as required for license
Licensed Clinician	Crisis Response (3 hours), Person Centered Thinking (12 hours), Introductory Motivational Interviewing (13 hours), System of Care (11 hours), PCP Instructional Elements (3 hours), Alternatives to Restrictive Interventions (8 hours), training in at least one model of care with empirical evidence. 50 Hours Total (plus any specific training required for the treatment modality being used by the team)	Additional 3 hours of training that fits with expertise; annual training as required by the model of care, alternatives to restrictive interventions refresher

Substance Abuse Specialist	Crisis Response (3 hours), Person Centered Thinking (12 hours), Introductory Motivational Interviewing (13 hours), System of Care (11 hours), PCP Instructional Elements (3 hours), Alternatives to Restrictive Interventions (8 hours), training in at least one model of care with empirical evidence Total 50 Hours (plus any specific training required for the treatment modality being used by the team)	Additional 3 hours of training that fits with expertise; annual training as required by the model of care, Alternatives to restrictive interventions refresher
Peer Support Specialist (Youth)	Peer to peer training providing by NC Families United (32 hours) 32 hours total	Additional 16 hours of peer 2 peer training 6 months after hire
Family Advocate	Family Partner 101 provided by NC Families United (24 hours) 24 hours total	Over first year: Motivational interviewing (8 hours), WRAP (16 hours), Child and Family Teams (11 hours), Trauma Informed Care (4 hours). Two electives (hours unknown)
Case Coordinator	Crisis Response (3 hours), Person Centered Thinking (12 hours), Introductory Motivational Interviewing (13 hours), System of Care (11 hours), PCP Instructional Elements (3 hours), Alternatives to Restrictive Interventions (8 hours), training in at least one model of care with empirical evidence 50 Hours Total {plus any specific training required for the treatment modality being used by the team)	Additional 3 hours of training that fits with expertise; annual training as required by the model of care, Alternatives to Restrictive Intervention Refresher
Behavioral Specialist	Crisis Response (3 hours), Person Centered Thinking (12 hours), Introductory Motivational Interviewing (13 hours), System of Care (11 hours), Alternatives to Restrictive Interventions (8 hours), training in at least one model of care with empirical evidence Total Hours 47 {plus any specific training required for the treatment modality being used by the team model)	Additional 3 hours of training that fits with expertise; annual training as required by the model of care, Alternatives to Restrictive Interventions Refresher

As is typical of an ACTT team, it will be important for the various specialists on the team to ensure cross training of other staff to reinforce strategies, identify unmet needs, etc. For example, the behavioral specialist may be the one developing the specific behavioral strategies but the others members of the team would also be reinforcing these strategies.

Targeted Length of Service
24 units or 5-6 months length of stay

Service Orders
A signed service order must be completed by a Medical Doctor (MD), Doctor of Osteopathic Medicine (DO), Licensed Psychologist, Physician Assistant (PA), or a Nurse Practitioner (NP) according to his or her scope of practice. 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 must be in place prior to or on the day that the service is initially provided in order to bill for the service. The service order is valid for one year from the date of the original service order. Service orders may not be back-dated.