North Carolina Mobile Outreach, Response, Engagement, and Stabilization

TITLE:	**MORES - North Carolina Mobile Outreach, Response, Engagement, and Stabilization**		
Type:		**Code:**	
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SERVICE DESCRIPTION

MORES service is for children, adolescents, and young adults. The terms children and youth are used interchangeably throughout this document to capture the age range of 3-21 years of age.

I. Overview

Mobile Outreach, Response, Engagement, and Stabilization (MORES) is a mobile intervention for children and adolescents ages 3-21 years experiencing escalating emotional or behavioral needs.

MORES Team Responds to Family Defined Crisis. A crisis occurs when:

- One's sense of balance is disrupted
- Coping and problem-solving skills that worked in the past are not working
- Life functioning is disrupted (family, living situation, school and/or community environments)
- *Crisis is defined by the person/family experiencing it*

Interventions can include but are not limited to crisis intervention and de-escalation, counseling, behavioral assistance, skill building, medication management, and/or caregiver and youth engagement/support/stabilization services. The service is intended to prevent placement into more restrictive settings, unnecessary court involvement, and declines in functioning.

MORES is a team-based service and will respond within 45 minutes, 80% of the time, face-to-face when a child is experiencing an emotional or behavioral crisis unless deferred response is requested by the parent/caregiver. The immediate face-to-face response is designed to better address the needs children and families in their homes, schools, and communities. MORES staff includes clinicians, qualified mental health professionals, Family Partners, and access to child/adolescent psychiatry.

MORES team provides mobile response services from 8 a.m. to 11 p.m. seven days a week. The LME/MCO Access to Care Center provides telephonic responses during non- mobile response hours. The duration of a MORES episode of care can be up to eight weeks. This intervention can include continued outreach, response, stabilization, engagement, referral, and linkage to on-going care.

II. Goals

MORES Service is guided by overarching goals for the child and family, the provider, and the overall Child-Serving System.

A. Goals for the Child and Family
1. Stabilize the presenting issue/concern.

II. Goals

A. Goals for the Child and Family
1. Stabilize the presenting issue/concern.
2. Assess and eliminate barriers to accessing behavioral health and other services and supports through active family engagement strategies including use of Family and Youth Support Partners.
3. Linkage to appropriate services and support.
4. Promote/enhance emotional and behavioral functioning.
5. Empower and educate children and families to monitor, manage, and cope with similar situations, as they arise.
6. Establish asset skills during transition times.
7. Strengthen the family and youth's natural support system.

B. Goals for the Provider
1. Provide solution-focused behavioral health services that are highly mobile and responsive to child and family needs and the needs of child welfare, juvenile justice, and schools.
2. Provide appropriate screening, early identification, and assessment of suicide risk, trauma exposure, substance use, exposure to and risk of violence, eating disorders, and other clinical presentations.
3. Include family members and informal supports in all aspects of the planning and treatment process fully possible.
4. Increase community awareness of behavioral health needs by providing education and outreach to children, families, schools, and communities.

C. Goals for the Child-Serving System
1. Ensure that all children and their families have access to crisis, prevention, and intervention services and supports.
2. Exhaust all possible options to maintain youth in their homes and communities and prevent placement in more restrictive care settings such as emergency departments, inpatient hospitalization, higher levels of behavioral health residential care, and detention/jail.

III. Practice Model

The MORES episode of care can be divided into two phases: 1) response and screening/assessment 2) ongoing outreach, stabilization, engagement, and transition to appropriate services and supports. Each phase is comprised of many clinical and supportive activities. MORES Team provides services to children and families with a variety of presenting concerns and in a variety of contexts; thus, there is not a "typical"

Specialist will collect the minimal amount of information needed over the phone to deploy MORES Team, which will allow MORES to respond quickly to the situation.

2. First MORES Response

Mobile and deferred mobile responses are generally provided by one MORES clinician, but a team of two clinicians is recommended when worker safety is a significant concern, in which case the MORES team may also consider teaming with a police officer to respond to the crisis. The MORES clinician may also bring in the MORES Family Partner during the initial call. Each MORES response option is described

below:

a) Mobile Initial Response. MORES clinician provides the initial mobile response, which involves a face-to-face response to the caller's home, school, an emergency department, or another community location.

b) Deferred Mobile Initial Response. MORES clinicians may provide a deferred mobile response only when requested by the caller or the family. Deferred mobile responses occur when the family requests that a MORES clinician respond later. MORES clinicians should provide the deferred mobile responses in less than 4 hours, but no more than 24 hours after receiving the initial call.

Follow-up services that occur after the first response should include collateral contacts to arrange services and supports as well as telephonic, and face-to-face contact with the child and family in the home, school, or community. Generally, family preference is the only factor that can determine whether follow-up care is provided somewhere other than the family's home or in the community.

3. Acuity Levels:

During the initial phone contact, in the first few face-to-face sessions, and throughout the episode of care, the MORES clinician will continue to assess the child's acuity level based on relevant clinical features such as presenting problem, risk of harm to self or others, mental status, diagnosis, risk level, overall level of functioning, behavioral history, and other characteristics. The subsequent delivery of MORES services depends, in part, on the assessed acuity level but also takes into consideration family needs and preferences as well as clinical judgment. The phase of intervention, intensity, and duration of care changes accordingly as youth and families experience changes in acuity level, needs, and preferences.

MORES has three levels of acuity: high, intermediate, and low. Each acuity level corresponds with recommended intensity and duration of MORES care, described below:

a) *High Acuity*: Youth and families with high acuity receive face-to-face contact every 24 to 48 hours with the MORES clinician in the home or community, psychiatric consultation as needed and additional phone contact as needed. The purpose of frequency of contact when a family is in high acuity is to stabilize the immediate situation, complete a MORES plan, and reduce risk factors to prevent emergency room visits, inpatient hospitalization and incarceration when MORES can provide a safe and effective alternative. If there is not a safe and effective alternative, clinicians will refer a child for inpatient evaluation.

   The recommended intensity and duration of follow-up care is extensive for children presenting at high acuity. It is important to note, however, that children typically do not remain at this high level of acuity for more than a day or two. If a child is assessed to be at high acuity for longer than two days, MORES is likely not the most appropriate level of care and a referral to a higher level of care (including an emergency department referral) is probably indicated.

b) *Intermediate Acuity*: Youth and families with intermediate acuity receive face-to- face contact every 48 to 72 hours (or 3-4 times a week) in the home or community, phone contact 3-4 days a week, and psychiatric consultation as needed. This level of contact is generally appropriate for children and families that are not in an active crisis so the purpose is to maintain stabilization and begin planning for discharge which may include linkage and transition to ongoing services and supports. In this phase of stabilization, family engagement

c) *Low Acuity*: Youth and families with low acuity receive, at minimum, one face-to-face contact per week in the home or community, two phone contacts per week, and psychiatric consultation as needed. The purpose of this contact is to maintain progress toward the reactive and proactive crisis plans. Generally, youth and families with low acuity will be moving toward discharge from MORES services which may include linkage and transition to ongoing services and supports. The MORES clinician will stay connected with the family until they are firmly established and engaged with the services and supports to meet their needs.

In addition, given the high demand for MORES services, MORES Team balances the need for immediate crisis response/stabilization with the need for follow-up stabilization services. It is appropriate for MORES providers to prioritize crisis stabilization of children presenting with high acuity over follow-up care sessions with children at lower levels of acuity.

4. Standardized Screening/Assessment Measures

Responding to the initial call, stabilizing the initial crisis, and screening/assessing acuity are the primary focus of the Screening/Assessment phase; however, as the presenting crisis begins to stabilize, MORES clinicians use standardized assessment measures to gather more clinical information, a strength and needs assessment to determine immediate needs(s), and develop a care plan. MORES Team responds to a variety of situations involving children and families with diverse needs and presenting concerns which requires that MORES clinicians be familiar with various clinical screening and assessment tools.

MORES Screening & Assessment Form

This screening and assessment form was designed specifically for MORES and combines narrative and checklist methods to develop a formulation of the child and family at intake. Factors considered include presenting crisis, brief crisis history, psychiatric and substance use history, treatment history, general physical history, family and social history, developmental history, environmental history, diagnostic information and impression, recommendations, and disposition.

Acuity assessment

The MORES acuity assessment is not a structured assessment document. It is a set of guidelines to help structure clinical judgment around making a risk determination of high, medium, or low. The measure helps clinicians to consider the presence and severity of factors such as suicidality, homicidally, self- injurious behavior, aggressiveness, psychosis, treatment history, and other factors.

Emergency Involuntary Commitment. Effective October 1, 2010, Section 7a-78 of the General Statutes was amended to include subsection (f) pertaining to the issuance of emergency certificates (ECs) by certain EMPS clinicians. EMPS clinicians with the required degree and training can issue ECs authorizing transport to an emergency department for evaluation and possible inpatient hospitalization. The EC process requires EMPS clinicians to assess whether youth present an imminent risk of harm to self or others or are "gravely disabled" due to the presence of a psychiatric condition.

Child and Adolescent Needs and Strengths (CANS) – completed after the initial response.

The CANS is a Multi-Purpose tool developed to support planning and level of care decision making, facilitate quality improvement, and monitor for outcomes. Developed from a communication perspective to link the assessment process to individualized service plans. The CANS enable the MORES team to gather information based on the youth and parent/caregiver's strengths (assets/areas of life where doing well, has an interest, and/or ability), and needs (areas where a youth and family/caregiver needs help/serious intervention). This tool helps the MORES team and the youth and family/caregiver to know where intensive or immediate action is most needed and where the youth has assets that can be a major part of the service/care plan.

The Global Appraisal of Individual Needs – Short Screen (GAIN-SS).[3]

The GAIN-SS is a brief (3-5 minute) screening instrument for mental health (internalizing and externalizing) and substance abuse disorders rated on a four-point frequency scale. The measure is intended to be brief and to allow clinicians to identify youth in need of further assessment and intervention for these disorders.

3 Dennis, M.L., Chan, Y-. F., & Funk, R.R. (2006). Development and validation of the GAIN Short Screener (GAIN-SS) for psychopathology and crime/violence among adolescents and adults. *The American Journal on Addictions, 15*, 80-91

Summary of Tasks for Screening/Assessment Phase:

1) Receive all calls and warm transfers from Access to Care Center and informing their families of their estimated arrival times.

2) Provide appropriate initial mobile response to child and family: assessing acuity and needs, de-escalating crisis, stabilizing immediate situation.
3) Maintain children in their homes and communities when MORES and community-based care is a safe and effective alternative to emergency departments, inpatient hospitalization, and detention/jail.
4) Administer other screening and assessment measures as appropriate to determine needs
5) Assess and address barriers to accessing needs services and supports
6) Begin completing the MORES Standardized screening
7) Communicate with family and original referrer
8) Enter all relevant data into MORES spreadsheet or other database required by the LME/MCO.

B. Ongoing Stabilization, Engagement, and Transition (Phase Two)

Some MORES episodes of care end following an initial call or initial response within Phase I; however, many children and families may require follow-up care for up to eight weeks. The Ongoing Stabilization, Engagement, and Transition phase entails the delivery of ongoing clinical services for the remainder of the episode of care.

It is important to note that many of the activities in the Assessment phase can be, and are, repeated in the Ongoing Stabilization, Engagement, and Transition phase. Service delivery activities during an episode of care rarely proceed in a predictable or linear manner. For example, the needs of the youth and families are continuously assessed, and clinicians frequently review and update the MORES plans. Each of these activities may in turn affect the interventions that are implemented.

The emphasis of this phase is on meeting child and family needs in a way that stabilizes the current situation and prevents further crises from occurring, in alignment with the youth and family, provider, and child-serving system goals identified above.

The list below identifies many clinical activities that may be implemented during this phase; however, the list is not intended to be exhaustive, nor will youth and families typically receive all of these services within a single episode of MORES care. In addition, activities below may occur in a different order than what is presented and will occur when clinically indicated.

1. <u>Actively engage family and youth in planning, assessment, and problem solving</u>

The MORES provider will engage families and children youth in service planning, problem-solving, and on-going assessment of acuity and will involve MORES Family and Youth Support Partners to support this work.

2. <u>Review Results of Assessment</u>

The results of the assessment will be shared with the family and youth as soon as possible. Sharing this information helps empower families to join as active partners in the care planning and delivery process. This should include an overall case conceptualization and recommendations.

3. Develop a MORES Plan

The clinician will work with the youth and family to jointly develop strength-based goals that are solution focused and integrated into a MORES plan. The MORES plan should address stabilization, recommended service, and follow-up care.

4. Address Factors Contributing to or Maintaining the Crisis

The MORES clinician addresses the factors contributing to or maintaining the presenting concern. Often, this involves identifying unmet needs and underlying concerns such as parent-child conflict, in-school behavior problems, anxiety, depression, academic issues, failure to take prescribed psychotropic medication, symptoms related to trauma exposure, social or peer problems, and many other presenting concerns. The MORES clinicians should engage in strengths discovery in order to ensure that strengths are incorporated into the stabilization plan and subsequent service delivery. In addition, the MORES clinician will work with the child, family, and referrer to develop coping strategies and solutions that address these underlying factors.

5. Address Trauma Exposure and Symptoms of Traumatic Stress

Children who have experienced a trauma may be at increased risk for an acute decline in their baseline functioning or in jeopardy of a change in their current living environment. MORES providers shall provide psychoeducation and review with children and families the traumatic events to which children have been exposed. Administration of the CANS may be helpful in this process. MORES clinicians are trained to screen and refer for trauma-informed care throughout the duration of the intervention.

6. Provide Ongoing Acuity/Risk Assessment

Acuity level, along with other factors, informs service delivery and decision-making. As a result, ongoing acuity assessment is an important part of service delivery. As changes occur in the acuity assessment, there are accompanying changes in the expected intensity and duration of MORES services.

7. Refer for Psychiatric Evaluation

If the clinician and family believe it to be clinically necessary, child will be referred for a psychiatric evaluation. MORES clinicians will collaborate with the MORES psychiatrist or the child's existing psychiatrist.

8. Provide Case Management

MORES clinicians provide case management in order to assist families in identifying their current strengths and needs. MORES clinicians assist with developing transition assets and strategies to address those needs using an array of community-based services, supports, and system collaborations. MORES case management includes, but is not limited to, attending/facilitating Child and Family Team meetings, connecting or re-connecting to formal and informal services and supports in the community, and ensuring systems collaboration. It may also include reviewing insurance and/or entitlement eligibility and linking families to resources and natural supports in the community to meet basic needs that may be a barrier to receiving the appropriate level of treatment. MORES clinicians also provide psychoeducation about psychological conditions, information about navigating the mental health system, reducing stigma, and overcoming obstacles their child is facing.

9. Enhance Motivation to Participate in Ongoing Care

MORES team will work with youth and families related to engagement in services and following through with their ongoing care plan, post-MORES services. This can be accomplished using techniques from Motivational Interviewing and Strengths Based Case Management. In this effort, MORES team may also review with the child and family the gains and successes that were achieved during participation in MORES.

10. Communicate with the Original Referrer

With appropriate consent from the family communication with the original referrer is very important for sharing care plan strategies and generalizing stabilization gains to other settings. This communication helps build a positive reputation for collaboration with community partners. Communication and collaboration with family members/caregivers is required.

11. Facilitate Transition to Ongoing Services and Supports

MORES staff will actively help families to transition to post-MORES services and supports. Transition planning occurs throughout the episode of care. Families are supported in accessing natural supports to address identified challenges.

MORES staff will assist youth and families in developing assets that help manage and persevere during transition times.

Summary of Tasks for Stabilization and Transition Phase

1. Actively engage youth and family/caregiver in planning, assessment, and problem solving.
2. Provide follow-up services in the home or other community locations.
3. Family liaison and advocate.
4. Regular re-assessment of needs and modifying interventions accordingly.
5. Interpreting assessment and incorporating findings into stabilization plan.
6. Accurately identifying and intervening with factors that contribute to and/or maintain behavioral crises.
7. Identifying unmet needs and strengths and incorporating into the stabilization plan.
8. Delivering trauma-informed care.
9. Coordinating care with psychiatrists – both MORES staff and external psychiatrists, as well as schools, emergency departments, primary care physicians, child welfare, and juvenile court.
10. Utilize Motivational Interviewing strategies and a Strengths Based Case Management Approach.
11. Active monitoring of progress towards outcomes.
12. Resource referrals.
13. Service delivery oversight.
14. Ongoing communication with family/caregiver.
15. Collateral contacts.
16. Transition planning – facilitating transition to ongoing services and supports and staying engaged until family is firmly engaged with the new services and supports.

PROVIDER REQUIREMENTS

I. Outreach requirements

a. Priority will be given to key stakeholders and high-volume referrers to local Emergency Departments, including but not limited to:

i. Local Schools
ii. Law Enforcement
iii. Department of Social Services
iv. Foster Care Providers
v. Department of Public Safety - Juvenile Justice
vi. Pediatricians/Physicians
vii. Local Hospital Emergency Departments
viii. Emergency Medical Services

b. Minimum of 24 formal outreach activities per year.

STAFFING REQUIREMENTS

Responsibilities of the Team Lead

- Proven experience in crisis intervention and stabilization.
- Five or more years working with individuals and families across various disciplines (mental health, substance use, intellectual/developmental disabilities).
- Supervise and evaluate the team's performance in all aspects of their positions.
- Lead team coaching per week to monitor adherence to the MORES principles and program protocols.
- Provide individual supervision at least monthly, preferably weekly, and author the staff supervision plans.
- Provide training of theory and application of MORES services and assist in a variety of ways to ensure the success of the program.
- Provide ongoing supervision to the MORES team.

The MORES Clinician:

- Must meet requirements as a qualified professional.
- Must complete MORES training curriculum.
- Pass background check, the child and adult abuse registry checks, and motor vehicle screens.
- Must be a Licensed clinician.
- Have training and knowledge in dual diagnosis (MHSU and IDD).
- Have received training in CALOCUS/LOCUS and CANS. Knowledge in: Functional limitations and health problems that may occur in clients with SED, dual diagnosis (MHSU and IDD) or clients with other disabilities, as well as strategies to reduce limitations and health problems.
- Eligibility for intellectual/developmental disabilities

- Safety and crisis planning; behavioral health service array including PRTF and other child/adolescent behavioral health residential placement criteria; federal, state, and local resources
- Using strengths and needs assessments (including environmental, psychosocial, health, and functional factors) to develop a Service Plan.
- System of Care Values and Wraparound principles.
- Family driven and youth guided care including the client's and family/caregiver's right to make decisions about all aspects of their child's care; family support and services.
- Linkage and connection.
- Coordination of supports and services.
- The principles of human behavior and interpersonal relationships; and general principles of record documentation.
- Skills in:
    - Engagement of youth and family/caregiver.
    - Negotiating with clients, family/caregivers, and service providers.
    - De-escalation – observing, interrupting, and shifting dynamics, education, and skill introduction.
    - Assessment – strengths, triggers, communication, contexts (medical, mental health, trauma, development, patterns of behavior, collateral outreach, etc.
    - Planning – safety, crisis and transition, alternative strategies, plan oversight/progress monitoring.
    - Identifying, developing, or providing services to clients with serious emotional disturbance, and
    - Identifying services within the established services system and uncovering natural supports to meet the client's needs.
    - Motivational interviewing behavior change strategies.
- Ability to:
    - Report findings of the assessment or onsite visit, either in writing or an alternative format for clients who have visual impairments.
    - Demonstrate a positive regard for clients and their families.
    - Be persistent and remain objective.
    - Work independently, performing position duties under general supervision.
    - Communicate effectively, orally and in writing; and develop rapport and communicate with persons from diverse cultural backgrounds.

Family Support Partners:

- Must have lived experience as a primary caregiver for a child who has/had mental health, substance use disorders, or intellectual/developmental disability.
- Experience in navigating any of the child and family-serving systems and teaching family members who are involved with the child and family serving system.
- 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 and two year of experience working with children/adolescents/transition age

youth; or high school diploma or GED and a minimum of four years of experience working with children/adolescents/transition age youth.

- Holds National Certification in Family Partner or is actively working on completing certification and is on track to complete Family Partner certification within (two years) of hire date. Family Partner 101 is part of National Certification Trainings for North Carolina. http://www.ffcmh.org/certification

TRAINING REQUIREMENTS

First 90 days					
Training	**Date**	**Location**	**Date**	**Location**	**Trainers**
CPI/NVCI	Agencies	will	provide		provider
Crisis Response Protocol	Agencies	will	provide		provider
MORES Assessment Tool/Service Definition			one week after contract signed		Tim Lentz, Janet Reading/Liza
Mental Health 101/Domestic Violence/Trauma Informed Care/CRM	11/9/18	Hickory Basement	11/15/2018	Gastonia Auditorium	Brandy Lineburger, Susan Sullivan, Jeanne
Youth Mental Health First Aid	11/6/18	Hickory Basement	11/20/2018	Gastonia Auditorium	Jeanne Patterson, Kim Rhoades, Stephanie Fundeburk
Family Partner 101	completed	completed			NC Families United
Navigating the system/ Overview of I/DD	consider web ex				various
Introduction to Motivational Interviewing					Partners TA
Within 6- 12 months					
Adolescent Development/ Substance Use Disorder					Liza, and Tammy Godfrey
Family Dynamics/Cultural Competency	Agency	will	provide		
CFT 1	10/22-23/18	Partners Auditorium			Jeanne, Casey
CFT 2					StephanieKim, Casey
WRAP Training					
Overview of Postive Behavior Support					Teri Putnam, DPI

MORES Team Training & Competency:

Language Used:

Success of MORES Team includes use of language consistent with system of care principles.

System of Care (SOC) Language	NOT SOC Language
Children, youth, young adult	Clients, Case, Consumer
Parents, caregivers	Mom and Dad
Treatment	Placement
Engagement	Not Motivated
Transition	Close, Terminate
Missing	Runaway
Therapeutic Leave	Home visits

MORES Plan:

The MORES Service plan shall be Proactive and include the following elements:

- Youth and family/caregiver vision
- Functional strengths of the youth and family
- Target behaviors and primary presenting needs
- Strength-based strategies
- Barriers to implementing strategies
- Additional unmet needs
- Youth diagnosis if available
- Listed medication if applicable
- Services to be requested/referred (if any)
- Resource/Support people and their roles

The MORES team shall establish consensus with youth and family/caregiver on the plan.

UTILIZATION MANAGEMENT

There is no prior authorization for this service. Pass Thru for first to four weeks.

Service Authorization Request (SAR) required for five to 8 weeks.

Unit of Service: 1 week = 1 unit

Anticipated Units of Service per Person: Up to 8 weeks

For beneficiaries enrolled with LME/MCO, the crisis management provider shall contact the LME/MCO to determine if the beneficiary is enrolled with a provider that should and can provide or be involved with the response. Mobile Outreach, Response, Engagement and

Stabilization shall be used to divert individuals from inpatient psychiatric and detoxification services. Interventions can include but are not limited to crisis intervention and de-escalation, counseling, behavioral assistance, skill building, medication management, and/or caregiver and youth engagement/support/stabilization services. The service is intended to prevent placement into more restrictive settings, unnecessary court involvement, and declines in functioning.

SERVICE ORDERS

Service Order not required.

CONTINUED STAY CRITERIA

The beneficiary is eligible to continue this service up to eight weeks if the crisis has not been resolved or his or her crisis situation has not been stabilized, which may include placement in a facility-based crisis unit or other appropriate residential placement.

DISCHARGE CRITERIA

Discharge Criteria:

Any of the following criteria is sufficient for discharge from this level of care.

1. Child's goals for the MORES service have been met, barriers to service engagement have been addressed, and youth/family has started and engaged services with appropriate service provider.
2. The assessment indicates that the youth needs a higher or lower intensity of service and the youth has started and is engaged with this higher or lower level of services.
3. The caregiver/family has withdrawn consent for treatment and there is no court order requiring such treatment.

DOCUMENTATION REQUIREMENTS

The minimum standard is a daily full service note that includes the following:

a. Beneficiary's name
b. Beneficiary's Medicaid number
c. Date of service
d. Purpose of contact
e. Description of provider's interventions
f. Time spent performing the interventions
g. Effectiveness of the intervention
h. Signature of the staff providing the service

Additionally, completed MORES Standardized Screening Tool and MORES Service Plan

A daily full service note or grid that meets the criteria specified in the DMH/DD/SAS Records Management and Documentation Manual (APSM 45-2) is required. The DMH/DD/SAS Records Management and Documentation Manual can be found at: http://www.ncdhhs.gov/mhddsas/statspublications/Manuals/rmdmanual-final.pdf.

SERVICE EXCLUSIONS

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:

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

EPSDT and Prior Approval Requirements

1) 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.
2) IMPORTANT ADDITIONAL INFORMATION about EPSDT and prior approval is found in the *NC Tracks Provider Claims and Billing Assistance Guide,* and on the EPSDT provider page. The Web addresses are specified below.

NC Tracks Provider Claims and Billing Assistance Guide:
https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html
EPSDT provider page: http://www.ncdhhs.gov/dma/epsdt/
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.