

## Community Support – Individual

HIPAA Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate
Community Support Individual	Practitioner Level 4, In-Clinic	H2015	U4	U6			\$20.30
	Practitioner Level 5, In-Clinic	H2015	U5	U6			\$15.13
	Practitioner Level 4, Out-of-Clinic	H2015	U4	U7			\$24.36
	Practitioner Level 5, Out-of-Clinic	H2015	U5	U7			\$18.15
	Practitioner Level 4, In-Clinic, Collateral Contact	H2015	UK	U4	U6		\$20.30
	Practitioner Level 5, In-Clinic, Collateral Contact	H2015	UK	U5	U6		\$15.13
	Practitioner Level 4, Out-of-Clinic, Collateral Contact	H2015	UK	U4	U7		\$24.36
	Practitioner Level 5, Out-of-Clinic, Collateral Contact	H2015	UK	U5	U7		\$18.15

**Definition of Service:** Community Support services consist of rehabilitative, environmental support and resources coordination considered essential to assist a youth and family in gaining access to necessary services and in creating environments that promote resiliency and support the emotional and functional growth and development of the youth. The service activities of Community Support include:

- Assistance to the youth and family/responsible caregivers in the facilitation and coordination of the Individual Resiliency Plan (IRP) including providing skills support in the youth/family's self-articulation of personal goals and objectives;
- Planning in a proactive manner to assist the youth and family in managing or preventing crisis situations;
- Individualized interventions, which shall have as objectives:
  - 1) Identification, with the youth, of strengths which may aid him/her in achieving resilience, as well as barriers that impede the development of skills necessary for age-appropriate functioning in school, with peers, and with family;
  - 2) Support to facilitate enhanced natural and age-appropriate supports (including support/assistance with defining what wellness means to the youth in order to assist them with resiliency-based goal setting and attainment);
  - 3) Assistance in the development of interpersonal, community coping and functional skills (including adaptation to home, school and healthy social environments);
  - 4) Encouraging the development and eventual succession of natural supports in living, learning, working, other social environments;
  - 5) Assistance in the acquisition of skills for the youth to self-recognize emotional triggers and to self-manage behaviors related to the youth's identified emotional disturbance;
  - 6) Assistance with personal development, school performance, work performance, and functioning in social and family environment through teaching skills/strategies to ameliorate the effect of behavioral health symptoms;
  - 7) Assistance in enhancing social and coping skills that ameliorate life stresses resulting from the youth's emotional disturbance;

- 8) Service and resource coordination to assist the youth and family in gaining access to necessary rehabilitative, medical, social and other services and supports;
- 9) Assistance to youth and other supporting natural resources with illness understanding and self-management;
- 10) Any necessary monitoring and follow-up to determine if the services accessed have adequately met the youth's needs;
- 11) Identification, with the youth/family, of risk indicators related to substance related disorder relapse, and strategies to prevent relapse.

This service is provided to youth in order to promote stability and build towards age-appropriate functioning in their daily environment. Stability is measured by a decreased number of hospitalizations, by decreased frequency and duration of crisis episodes and by increased and/or stable participation in school and community activities. Supports based on the youth's needs are used to promote resiliency while understanding the effects of the emotional disturbance and/or substance use/abuse and to promote functioning at an age-appropriate level. The Community Support staff will serve as the primary coordinator of behavioral health services and will provide linkage to community; general entitlements; and psychiatric, substance use/abuse, medical services, crisis prevention and intervention services.

<b>Target Population</b>	Children and Adolescents with one of the following: Mental Health Diagnosis Substance-Related Disorder Co-Occurring Substance-Related Disorder and Mental Health Diagnosis Co-Occurring Mental Health Diagnosis and Mental Retardation/Developmental Disabilities Co-Occurring Substance-Related Disorder and Mental Retardation/Developmental Disabilities
<b>Benefit Information</b>	Available to Core Customers. Requires a MICP Registration or a MICP New Episode.
<b>Utilization Criteria</b>	<u>Available to those with CAFAS scores:</u> 10-50: Resiliency Maintenance 60-90: Low Intensity Community-Based Services 100-130: High Intensity Community-Based Services 140-180: Medically Monitored Community Residential 190-240: Medically Managed Community Residential 190-240: Medically Managed Inpatient Residential
<b>Ordering Practitioner</b>	Physician, Psychologist, Physician's Assistant, Advanced Practice Registered Nurse (Clinical Nurse Specialist or Nurse Practitioner), LPC, LMFT, LCSW
<b>Unit Value</b>	15 minutes
<b>Initial Authorization*</b>	600 units
<b>Re-Authorization*</b>	600 units
<b>Maximum Daily Units*</b>	48 units
<b>Authorization Period*</b>	180 days
<b>UAS: Budget and Expense Categories</b>	<u>Core Services Provider</u> 226 – C&A Mental Health 826 – C&A Addictive Diseases

Admission Criteria	<ol style="list-style-type: none"> <li>1. Individual must meet target population criteria as indicated above; <b>and one or more of the following:</b></li> <li>2. Individual may need assistance with developing, maintaining, or enhancing social supports or other community coping skills; <b>or</b></li> <li>3. Individual may need assistance with daily living skills including coordination to gain access to necessary rehabilitative and medical services</li> </ol>
Continuing Stay Criteria	<ol style="list-style-type: none"> <li>1. Individual continues to meet admission criteria; <b>and</b></li> <li>2. Individual demonstrates documented progress or maintenance of community skills relative to goals identified in the Individualized Resiliency Plan.</li> </ol>
Discharge Criteria	<ol style="list-style-type: none"> <li>1. An adequate continuing care plan has been established; <b>and one or more of the following:</b></li> <li>2. Goals of Individualized Resiliency Plan have been substantially met; <b>or</b></li> <li>3. Individual/family requests discharge and the individual is not imminently in danger of harm to self or others; <b>or</b></li> <li>4. Transfer to another service is warranted by change in the individual's condition.</li> </ol>
Service Exclusions	<ol style="list-style-type: none"> <li>1. Intensive Family Intervention and CSI may be provided concurrently during transition between these services for support and continuity of care for a maximum of four units of CSI per month. If services are provided concurrently, CSI should not be duplication of IFI services. This service must be adequately justified in the Individualized Resiliency Plan.</li> <li>2. Assistance to the youth and family/responsible caregivers in the facilitation and coordination of the Individual Resiliency Plan (IRP) including providing skills support in the youth/family's self-articulation of personal goals and objectives can be billed as CSI; however, the actual plan development must be billed and provided in accordance with the service guideline for Service Plan Development.</li> <li>3. The billable activities of Community Support do not include: <ul style="list-style-type: none"> <li>• Transportation</li> <li>• Observation/Monitoring</li> <li>• Tutoring/Homework Completion</li> <li>• Diversionary Activities (i.e. activities/time during which a therapeutic intervention tied to a goal on the individual's treatment plan is not occurring)</li> </ul> </li> </ol>
Clinical Exclusions	<ol style="list-style-type: none"> <li>1. There is a significant lack of community coping skills such that a more intensive service is needed.</li> <li>2. Individuals with the following conditions are excluded from admission unless there is clearly documented evidence of a psychiatric condition overlaying the primary diagnosis: <ul style="list-style-type: none"> <li>• mental retardation</li> <li>• autism</li> <li>• organic mental disorder, or</li> <li>• traumatic brain injury</li> </ul> </li> </ol>

*\*(unless authorized as a part of a specific "package" which changes the authorization parameters)*

## Additional Service Criteria:

### A. Required Components

1. Community Support services must include a variety of interventions in order to assist the consumer in developing:
  - Symptom self-monitoring and self-management of symptoms
  - Strategies and supportive interventions for avoiding out-of-home placement for youth and building stronger family support skills and knowledge of the youth or youth's strengths and limitations
  - Relapse prevention strategies and plans
2. Community Support services focus on building and maintaining a therapeutic relationship with the youth and facilitating treatment and resiliency goals.
3. The organization must have policies and procedures for protecting the safety of staff that engage in these community-based service delivery activities.
4. Contact must be made with youth receiving Community Support services a minimum of twice each month. At least one of these contacts must be face-to-face and the second may be either face-to-face or telephone contact (denoted by the UK modifier) depending on the youth's support needs and documented preferences of the family.
5. At least 50% of CSI service units must be delivered face-to-face with the identified youth receiving the service and at least 80% of all face-to-face service units must be delivered in non-clinic settings over the authorization period (these units are specific to single individual consumer records and are not aggregate across an agency/program or multiple payors).
6. In the absence of the required monthly face-to-face contact **and** if at least two unsuccessful attempts to make face-to-face contact have been tried and documented, the provider may bill for a maximum of two telephone contacts in that specified month(denoted by the UK modifier).
7. Unsuccessful attempts to make contact with the consumer are not billable.
8. When this service is provided to youth and their families, the child/adolescent consumer of service must clearly remain the target of service.
9. Any diagnosis given to a youth must come from persons identified in O.C.G.A Practice Acts as qualified to provide a diagnosis. These practitioners include a licensed psychologist, a physician or a PA or APRN (NP and CNS-PMH) working in conjunction with a physician with an approved job description or protocol.
10. When the primary focus of Community Support Services for youth is medication maintenance, the following allowances apply:
  - a. These youth are not counted in the offsite service requirement or the consumer-to-staff ratio; and
  - b. These youth are not counted in the monthly face-to-face contact requirement; however, face-to-face contact is required every 3 months and monthly calls are an allowed billable service.
11. CSI is an individual intervention and may **not** be provided or billed for more than one consumer during the same time period.
12. "Out-of-Clinic" may only be billed when:
  - Travel by the practitioner is to a non-contiguous location; and/or
  - Travel by the practitioner is to a facility not owned, leased, controlled or named as a service site by the agency who is billing the service(excepting visits to Shelter Plus sites); and/or

- Travel is to a facility owned, leased or controlled by the agency billing the service, but no more than 6 individuals are being served in the course of that day by a single practitioner in non-group services; and/or
  - Travel is to a facility owned, leased, controlled or named as a service site by the agency, but no more than 24 individuals are being served in groups at that site in the course of a day.
- If the service does not qualify to be billed as "out of clinic," then the "in-clinic" rate may still be billed.

## **B. Staffing Requirements**

1. The following practitioners may provide Community Support services:
  - Practitioner Level 1: Physician/Psychiatrist (reimbursed at Level 4 rate)
  - Practitioner Level 2: Psychologist, APRN, PA (reimbursed at Level 4 rate)
  - Practitioner Level 3: LCSW, LPC, LMFT, RN (reimbursed at Level 4 rate)
  - Practitioner Level 4: LMSW; LAPC; LAMFT; Psychologist/LCSW/LPC/LMFT's supervisee/trainee with at least a Bachelor's degree in one of the helping professions such as social work, community counseling, counseling, psychology, or criminology, functioning within the scope of the practice acts of the state; MAC, CAC-II, CADC, CCADC, GCADC (II, III); PP, CPRP, CAC-I or Addiction Counselor Trainees with at least a Bachelor's degree in one of the helping professions such as social work, community counseling, counseling, psychology, or criminology
2. Under the documented supervision (organizational charts, supervisory notation, etc.) of one of the licensed/credentialed professionals above, the following staff may also provide Community Support:
  - Certified Peer Specialists
  - Paraprofessional staff
  - Certified Psychiatric Rehabilitation Professional
  - Certified Addiction Counselor-I
  - Registered Alcohol and Drug Technician (I,II, or III)
  - Addiction Counselor Trainee
3. Community Support - Individual practitioners may have the recommended consumer-to-staff ratio of 30 consumers per staff member and must maintain a maximum ratio of 50 consumers per staff member. Youth who receive only medication maintenance are not counted in the staff ratio calculation.

## **C. Clinical Operations**

1. Community Support services provided to youth must include coordination with family and significant others and with other systems of care such as the school system, juvenile justice system, and child welfare and child protective services when appropriate to treatment and educational needs. This coordination is an essential component of Community Support and can be billed for up to 70 percent of the contacts when directly related to the support and enhancement of the youth's resilience. When this type of intervention is delivered, it shall be designated with a UK modifier.

2. Community Support providers must have the ability to deliver services in various environments, such as homes, schools, homeless shelters, or street locations. The provider should keep in mind that families may prefer to meet staff at a community location other than their homes or other conspicuous locations (e.g. their school), especially if staff drive a vehicle that is clearly marked as a state or agency vehicle, or if staff must identify themselves and their purpose to gain access to the youth in a way that may potentially embarrass the individual or breach the youth's privacy/confidentiality. Staff should be sensitive to and respectful of youth and family privacy/confidentiality rights and preferences in this regard to the greatest extent possible (e.g. if staff must meet with a youth during their school time, choosing inconspicuous times and locations to promote privacy).
3. If services are performed in school setting during school hours:
  - a. Documentation must indicate that intervention is most effective when provided during school hours.
  - b. IRP should indicate how the intervention has been coordinated among family system, school, and provider.
4. The organization must have policies that govern the provision of services in natural settings and can document that it respects youth and/or families' right to privacy and confidentiality when services are provided in these settings.
5. The organization must have established procedures/protocols for handling emergency and crisis situations that describe methods for supporting youth as they transition to and from psychiatric hospitalization.
6. Each provider must have policies and procedures for the provision of individual-specific outreach services, including means by which these services and youth are targeted for such efforts.
7. The organization must have a Community Support Organizational Plan that addresses the following:
  - a. Description of the particular rehabilitation, resiliency and natural support development models utilized, types of intervention practiced, and typical daily schedule for staff
  - b. Description of the staffing pattern and how staff are deployed to assure that the required staff-to-consumer ratios are maintained, including how unplanned staff absences, illnesses, or emergencies are accommodated, how case mix is managed, access, etc.
  - c. Description of the hours of operations as related to access and availability to the youth served; and
  - d. Description of how the plan for services is modified or adjusted to meet the needs specified in every Individualized Resiliency Plan
8. Utilization (frequency and intensity) of CSI should be directly related to the CAFAS and to the other functional elements of the youth's assessment. In addition, when clinical/functional needs are great, there should be complementary therapeutic services by licensed/credential professionals paired with the provision of CSI (individual, group, family, etc.).

#### **D. Service Accessibility**

1. Agencies that provide Community Support services must regularly provide individuals served with Georgia Crisis & Access Line contact information (1-800-715-4225 and 1-800-255-0056 for TTY, and 1-800-255-0135 -Voice) for appropriate crisis intervention services.
2. Specific to the "Medication Maintenance Track," consumers who require more than 4 contacts per quarter for two consecutive quarters (as based upon clinical need) are expected to be re-

- evaluated with the CAFAS for enhanced access to CSI and/or other services. The designation of the CSI "medication maintenance track" should be lifted and exceptions stated above in A.10. are no longer applied.
3. Community Support--Individual may **not** be provided in an Institution for Mental Diseases (IMD, e.g. state or private psychiatric hospital, psychiatric residential treatment facility or crisis stabilization program with greater than 16 beds), jail, youth development center (YDC) or prison system.
  4. This service may not be provided and billed for youth who are involuntarily detained in Regional Youth Detention Centers (RYDCs) awaiting criminal proceedings, penal dispositions, or other involuntary detention proceedings. The only exception to this is that Core Services may be provided and billed to Medicaid and the DBHDD's C&A fee-for-service system in situations in which the Department of Juvenile Justice is voluntarily housing the youth in the RYDC until other living arrangements appropriate to the individual's needs are available (i.e. no court order requires detention in RYDC).

**E. Additional Medicaid Requirements**

Currently, there are no additional Medicaid requirements to be added to the requirements above when billing Medicaid for this service.

**F. Reporting & Billing Requirements**

1. When a billable collateral contact is provided, the H2015UK reporting mechanism shall be utilized. A collateral contact is classified as any contact that is not face-to-face with the individual.
2. All other applicable Medicaid, MICP, and other DBHDD reporting requirements must be followed.

**G. Documentation Requirements**

Providers must document services in accordance with the specifications for documentation requirements specified in Part II, Section V of the Provider Manual.