North Carolina Utilization Management Guideline for Medicaid

Subject: ILOS – High Fidelity Wraparound
Status: Active
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Description

The High-Fidelity Wraparound (HFW) service is an intensive, team-based, and person-centered approach designed to provide coordinated and integrated care for children and youth with complex emotional, behavioral, or mental health needs. This approach is utilized in lieu of potential escalations to higher levels of care due to members' behavioral, emotional, and mental health needs. It targets young individuals involved with multiple systems, such as mental health and juvenile justice, and those at risk of placement in residential or institutional settings.

HFW is a structured, family- and youth-driven service model that provides intensive care coordination for:

- Youth ages 3–17 with Serious Emotional Disturbance (SED)
- Young adults ages 18–21 with Serious Mental Illness (SMI)

The goal is to facilitate collaborative care planning and service delivery that integrates physical and behavioral health, social determinants of health, and natural supports.

Each HFW team ensures that care is:

- Strengths-based
- Individualized
- Culturally and linguistically competent
- Family- and youth-driven

Team Composition and Caseloads

- HFW Facilitator:
  Works full-time with 10–12 families. Serves as the single point of accountability ensuring coordination of all services and supports.

- Family Partner / Youth Partner:
  Each may serve up to 15 families/youth across multiple HFW teams. Partners promote engagement, provide lived-experience support, and empower families/youth. They may be part-time.

- Coach/Supervisor:

  Oversees up to 4 facilitators, 2 family peer support partners, and 1 youth peer support partner, covering up to 48 youth/families.

Core Functions of HFW

- Facilitates care planning and coordination across systems.
- Provides family peer support to enhance engagement and service completion.
- Builds a Child and Family Team (CFT) that develops and monitors a strengths-based plan of care.
- Ensures services, activities, and natural supports are accessible and coordinated.
- Aligns with the System of Care philosophy—promoting collaboration across agencies and community-based supports.

The Four Phases of the HFW Process

1. Engagement and Team Preparation (2–4 weeks)

- The Facilitator, with support from the Family and Youth Partners, begins by establishing trust through a strengths-based, non-judgmental approach.
- Activities include:
  - Crisis stabilization
  - Orientation to the HFW process
  - Identification of family/youth strengths, culture, and vision (goals) for the future

This phase builds the foundation for collaborative planning.

2. Plan Development Phase (1–2 weeks)

- Focuses on developing the individualized Plan of Care based on:
    - Treatments and strategies previously found to be successful
    - Identification of key individuals in the youth's and family's life (including extended family and community resources)
- The team identifies:
    - Barriers to effective treatment
    - Crisis stabilization strategies to prevent disruptions
- The Family Partner provides continuous caregiver support throughout this phase.

3. Plan Implementation Phase (2–12 months)

- The longest and most intensive phase.
- Focus: Executing and monitoring the Plan of Care while building family self-sufficiency.
- The HFW staff:
    - Work with families to develop transition assets and natural supports
    - Transfer responsibility for sustaining progress to the family
    - Regularly meet with families to review progress toward goals
    - Monitor completion of action steps, crisis strategies, and achievement of outcomes

Transition planning begins early in this phase. Formal HFW concludes when the team—guided primarily by the family—agrees that priority needs and outcomes have been met.

4. Transition Phase (Typically one meeting)

- The formal wrap-up phase.
- Most transition work has already been completed during implementation.

- The final meeting:
    - Celebrates achievements
    - Reviews and finalizes the transition plan
    - Ensures continuity of supports beyond HFW

Clinical Indications

Utilization Management

- High Fidelity Wraparound length of stay is 9-12 months or 9 -12 monthly units; 1 unit is equal to 1 month.
- Notification Service Authorization Request by Healthy Blue Care Together/CFSP is required within 1 week of service initiation.
- Initial pass-through authorization is for 9 months, and it is expected that Phase 1 (Engagement/Team Preparation) and Phase 2 (Plan Development) will be completed, and Phase 3 (Plan Implementation) will be initiated.
- After that, each reauthorization will be for no more than 60 days (2 Units)

Prior authorization is not required for 9 months of services. Reauthorizations are up to 60 days.

- A Comprehensive Clinical Assessment (CCA) or addendum that demonstrates medical necessity shall be completed prior to provision of this service. If an equivalent assessment is available, reflects the current level of functioning and contains all the required elements outlined in community practice standards as well as in all applicable federal and state requirements, it may be used as part of the current comprehensive clinical assessment or addendum.

- A signed service order shall be completed by a licensed clinician, physician, licensed psychologist, physician's assistant, or nurse practitioner 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 should be in place prior to or on the first day that the service is provided. The service order is valid for one year from the date of the original service order. Service orders may not be backdated. The service order shall be based on a comprehensive clinical assessment of the member's needs.
- A Notification Service Authorization Request by Healthy Blue Care Together (HBCT) is required within 1 week of service initiation. No clinical documentation is required to be submitted to HBCT during the 9-month passthrough.
- A complete Service Authorization Request (SAR), updated Person-Centered Plan, Comprehensive Clinical Assessment, service order, and crisis plan must be submitted with continued authorization requests. Services are based upon a finding of medical necessity, must be directly related to the member's diagnostic and clinical needs and are expected to achieve the specific rehabilitative goals detailed in the member's Person-Centered Plan.

Eligibility Criteria:

Medicaid eligible children and adolescents ages 3 up to 21 who also meet the following criteria:

The member is eligible for this service when all the following are met:

- Have a primary mental health or substance use disorder diagnosis as defined by the DSM-5, or any subsequent editions of this reference material, may have a co-occurring diagnosis of intellectual and developmental disability, OR
- Have a primary I/DD diagnosis as defined by DSM-5, or any subsequent editions of this reference material, and a co-occurring diagnosis of mental health or substance use disorder; AND
- Based on the current comprehensive clinical assessment (completed within the past year), this service was indicated and there are no other more appropriate services; AND
- Youth's symptoms and behaviors are unmanageable at home, school or community settings; AND

- Youth requires coordination between two or more service agencies, including medical or non-medical providers; **AND must meet at least one of the criteria below**:
  - Is at risk of placement into a therapeutic residential setting, Level II group or Level II family setting or individuals in these settings needing intensive support to transition home (note for these individuals a shortened length of stay in level II would be expected).
  - Youth could be stepping down from PRTF, Level IV, III or II group and Level II family to other least restrictive community-based setting.
  - Has a recent history of multiple inpatient psychiatric hospitalizations (in the past year) or one stay that exceeded 14 days.
  - Directly transitioning or has been discharged in the past six months from Juvenile Justice related facilities (Assessment Center, Youth Development Center, Detention, Eckerd, etc.).
  - Child Welfare involvement including congregate care.
  - Older adolescents whose family situation is such that they are moving toward independence; **AND**
  - There is no evidence to support that alternative interventions would be equally or more effective, based on North Carolina community practice standards (Best Practice Guidelines of the American Academy of Child and Adolescent Psychiatry, American Psychiatric Association, American Society of Addiction Medicine).

Continued Stay Criteria

- A youth is eligible to continue this service if the desired outcome or level of functioning has not been restored, improved or sustained over the time frame outlined in the beneficiary's PCP; or the beneficiary continues to be at risk for out-of-home residential treatment based on current clinical assessment, history and the tenuous nature of the functional gains **AND** one of the following applies:
- The youth has achieved current PCP goals, and additional goals are indicated as evidenced by documented symptoms.
- The youth 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.

- The youth 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 premorbid level of functioning, are possible, OR

- The youth is not making progress or demonstrates regression, in meeting goals through the interventions outlined in the PCP. The beneficiary's diagnosis should be re-assessed to identify any unrecognized co-occurring disorders, and interventions or treatment recommendations shall be revised based on the findings. This includes consideration of alternative or additional services.

Discharge Criteria

A youth meets the criteria for discharge if any of the following apply:

- The youth has achieved goals and is no longer in need of High- Fidelity Wraparound services.
- The youth's level of functioning has improved with respect to the goals outlined in the PCP, inclusive of a transition plan to step down to a lower level of care.
- The youth is not making progress or is regressing, and all reasonable strategies and interventions have been exhausted, indicating a need for more intensive services.
- The youth or legally responsible person no longer wishes to receive services.
- The youth, based on presentation and failure to show improvement despite modifications in the PCP, requires a more appropriate best practice treatment modality based on North Carolina community practice standards (for example, National Institute of Drug Abuse, American Psychiatric Association).

Service Exclusions:

- Services may overlap with Child ACT for 30 days.

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

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

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

- Basic Outpatient Services

- ~~In-Home Therapy Services (IHTS)~~
- Intensive In-Home Services (IIHS)
- Intercept
- Transitional Youth Services
- Day Treatment
- Substance Abuse Intensive Outpatient (SAIOP)
- Substance Abuse Comprehensive Outpatient Treatment (SACOT)
- High Fidelity Wraparound may occur on a short-term basis with child residential treatment services to assist in facilitation of discharge planning. The timeframe would be based on acuity of need and clinical justification. The provider is required to fulfill all care management duties, including coordinating with physical health providers, except for delivering interventions related to Prevention and Population Health Programs.

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, Qualified Professional 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, 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 NCTracks 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:
nctracks.nc.gov/content/public/providers/provider-manuals.html

EPSDT provider page: ncdhhs.gov/dma/epsdt/

Service Documentation Requirements

Services shall be documented in accordance with this section and the DMH/DD/SUS Records Management and Documentation Manual (RMDM) updated July 8, 2025 prior to seeking reimbursement. The services require a full service note, which includes all items listed under Contents of a Service Note, Chapter 6 of the RMDM.

Providers shall make all documentation supporting claims for services reimbursed. For each service contact or intervention, a comprehensive service note is required, containing: the member's name, service record number, Medicaid ID if applicable, service details, date, place, type of contact, purpose, provider interventions, time spent, effectiveness description, and signature with credentials of the provider.

Documentation of all discharge planning and transition activities with the youth, family, caregiver, and child and family team must start at admission, and a completed LME/MCO Consumer Admission and Discharge Form must be submitted.

Treatment Plan: Each individual receiving HFW services is required to have a Person-Centered Plan (PCP) that is fully completed prior to or on the first date of service. The PCP must meet all 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.

Monitoring Activities

Healthy Blue Care Together will monitor level of care and outcomes tracking with use of the CANS periodically and at discharge. It is expected that this service will be effective and result in positive outcomes when a lower score is reported. This would indicate a plan for a successful transition back to basic services and outpatient services. Completion of NC TOPPS to track outcomes for individual children. Aggregate data is reviewed to support provider in delivery of service.

Provider Level Monitoring Activities

The NC HFW Training Program monitors and tracks staff training and certification development.

Program Requirements

Service Goals and Objectives/Treatment Philosophies:

High-Fidelity Wraparound (HFW) aims to enhance placement stability, improve behavioral, emotional, and social functioning, and support family well-being, potentially preventing escalations to higher levels of care due to complex needs.

High-Fidelity Wraparound (HFW):

This intensive, team-based service provides coordinated, family-driven care for youth/young adults with complex needs, including dual diagnoses and involvement with multiple systems (e.g., mental health, child welfare, justice systems). HFW targets youth at risk of institutional placement or those with crisis history. Suitability for HFW is assessed case-by-case, typically for those with primary mental health diagnoses and mild-to-moderate intellectual or developmental disabilities.

The National HFW Initiative outlines the philosophy as using a structured, creative team planning process, resulting in more effective, holistic plans compared to traditional methods. These plans address the needs of caregivers and siblings and cover various life areas. HFW focuses on developing problem-solving, coping skills, and self-efficacy, and integrating youth into the community by strengthening the family's support network, aiming for family self-sufficiency in

planning and advocacy.

Anticipated Outcomes:

Expected clinical outcomes include:

- Reduced frequency of crisis episodes (use of ED, Mobile Crisis, and Facility-Based Crisis).
- Fewer inpatient hospitalizations related to mental health or substance use.
- Enhanced family assets, as indicated by the Transitional Readiness Scale/Score.
- Decrease in residential treatment days.

Staffing Requirements

Provider Organization Requirements

- Providers must meet qualifications for participation in NC Medicaid program and be enrolled in NCTracks.
- Provider must be credentialed and enrolled as a network provider with the Partners Health Management Provider Network, in good standing and contracted to deliver the service.

Program and Staff Supervision

- **Coach/Supervisor**– master's level Qualified Professional (QP) or bachelor level QP credentialed as a HFW facilitator. Must complete HFW Facilitation training curriculum and be certified as a HFW Coach (or in the process of being certified as a HFW Coach). The certification process should take no longer than 12 months from the date of completing HFW Foundations Training in accordance with model expectations. Training and knowledge in dual diagnosis (MHSU and IDD). Have received trauma informed care training. Have received training in CANS. Safety and crisis planning. Motivational interviewing behavior change strategies.

- **Facilitator-** bachelor's QP. Must complete HFW Facilitation training curriculum and be certified as Wraparound Facilitator (or in the process of being certified as a HFW Facilitator). The certification process should take no longer than 12 months from the date of completing HFW Foundations Training in accordance with model expectations. Training and knowledge in dual diagnosis (MHSU and IDD). Have received trauma informed care training. Have received training in CANS. Safety and crisis planning. Motivational interviewing behavior change strategies.

- **Youth Partner**- bachelor's degree in a human services field from an accredited university and one year of experience working with the target population; or associate's degree in a human service field from an accredited school; or high school diploma or GED and a minimum of two years of experience working with children/adolescents/ transition age youth. Must have lived experience having a mental health/ substance use disorder or intellectual/developmental disability. When part of a Wraparound Team, Youth Support Partner is certified in the role of Youth Support Partner in High Fidelity Wraparound or is in process of completing certification process take no longer than 12 months from date of completing HFW Foundations Training in accordance with model expectations.

- **Family Support Partner**- bachelor's degree in a human services field from an accredited university and one year of experience working with the target population; or associate's degree in a human service field from an accredited school and two years 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 Must have lived experience as a primary caregiver for a child who has/had mental health or substance use disorder or an intellectual/developmental disability.

Coach supervises and evaluates the primary facilitator's performance in all aspects of their position. Facilitator, Family and Youth Support Partners receive monthly supervision by the Coach.

Service Type/Setting:

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

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

The HFW Team Tasks and Responsibilities:

HFW Facilitator

Assessment for HFW criteria:

- Works with family to integrate information from multiple sources into the strengths, needs, and culture discovery.
- Assists the family to identify appropriate members of the Child & Family Team (CFT).
- Collects background information and plans from other agencies. The assessment process determines the needs and wants of the youth for any medical, educational, social, therapeutic, or other services/supports. Further assessments are arranged as needed and/or wanted.
- Facilitates the CFT to develop an integrated mission to support the family. Development of an Individual HFW Plan.

Development of an Individual HFW Plan

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

Referral and related activities:

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

HFW Plan.

- Collaborates with the other service providers and state agencies (if involved) on behalf of the youth and family.

Monitoring and follow-up activities:

- Facilitates reviews of the HFW Plan to reflect the changing needs of the youth and family.
- Completes the required tools as scheduled to track progress.
- Monitors and documents the status of the youth and family's progress and effectiveness of the strategies and interventions outlined in the Plan of Care.
- Attends a minimum of one hour of group supervision and one hour of consultation per week to monitor adherence to the HFW principles.

Family Partner:

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

Youth/Young Adult Peer Partner

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

The Youth Partner:

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

The Coach/Supervisor

- Provides supervision, ongoing consultation and crisis support.
- Helps HFW Team understand the topics of training and develop an understanding of how to apply what they have learned through the structured professional development plan.
- Track certification of each team member and use professional development plan to assist each team member in mastering the core competencies of their role.
- Review cases regularly guided by HRW principles Coach/Supervisor also may carry small caseloads of up to two (2) families. Access to psychiatric consultation for HFW staff: Formal consultation is not required, although children/youth participating in HFW have access to all services available under the NC Medicaid benefit plan. A psychiatrist/APRN actively engaged in treatment with a child/youth should be invited to participate in each team meeting.

Coding			
Procedure Code	**Service Description**	**Rate**	**Billing Frequency**

~~H0032 U5~~ H0032 U5 U1	~~HFW~~ Encounter	1 unit=1 month (Minimum of 4 contacts each month)	~~Monthly~~

Discussion/General Information

The Ten Principles of the HFW Process

1. Family "voice and choice" - Family and youth/child perspectives are intentionally elicited and prioritized during all phases of the HFW process. Planning is grounded in family members' perspectives, and the team strives to provide options and choices such that the plan reflects family values and preferences.
2. Team based - The HFW team consists of individuals agreed upon by the family and committed to them through informal, formal and community support and service relationships. The "professional" members include the Team Facilitator, Parent Partner and Young Adult Peer (as appropriate).
3. Natural supports - The team actively seeks out and encourages the full participation of team members drawn from family members' networks of interpersonal and community relationships. The HFW plan of care reflects activities and interventions that draw on sources of natural support.
4. Collaboration - Team members work cooperatively and share responsibility for developing, implementing, monitoring and evaluating a single HFW plan of care. The plan of care reflects a blending of team members' perspectives, mandates and resources. The plan guides and coordinates each team member's work towards meeting the team's goals.
5. Community-based - The HFW team implements service and support strategies that take place in the most inclusive, most responsive, most accessible and least restrictive settings possible; and that safely promote child and family integration into home and community life.
6. Culturally competent - The HFW process demonstrates respect for and builds on the values, preferences, beliefs, culture and identity of the child/youth and family and their community.
7. Individualized - To achieve the goals laid out in the HFW plan, the team develops and implements a customized set of strategies, supports and services.
8. Strengths based - The HFW process and the HFW plan identify, build on and enhance the capabilities, knowledge, skills and assets of the child and family, their community and other team members.

9. Persistence or Unconditional Support - Despite challenges, the team persists in working toward the goals included in the HFW plan of care until the team reaches agreement that a formal HFW process is no longer required.
10. Outcome based - The team ties the goals and strategies of the HFW plan of care to observable or measurable indicators of success, monitors progress in terms of these indicators and revises the plan accordingly.

In the HFW process, a dedicated Team Facilitator (QP) works together with the family and youth (if developmentally appropriate) to identify the strengths, needs and potentially effective strategies, resulting in a single, coordinated, individualized plan of care. It is in the facilitation of this planning process that the HFW guiding principles are operationalized.

The HFW plan of care typically includes formal services that are balanced with natural supports such as interpersonal support and assistance provided by friends, family and other people drawn from the family's social networks. The additional principles of collaboration, cultural competence, strengths based and outcome based are all achieved and actualized through the team process with team members working cooperatively and sharing responsibility for a single plan of care, even when multiple providers and services are involved. The principle of unconditional support is achieved through HFW teams not giving up on, blaming or rejecting the youth or family, even in the face of significant needs and challenges.

Definitions

In Lieu of Services (ILOS): Services or settings that are not covered under the North Carolina Medicaid State Plan but are a medically appropriate, cost-effective alternative to a State Plan covered service.

Acronyms

ILOS: In Lieu of Services

References

Government Agency, Medical Society, and Other Authoritative Publications:
Centers for Medicare & Medicaid Services. (n.d.). *In Lieu of Services and Settings (ILOS).* Federal guidance pursuant to 42 C.F.R. § 438.3(e)(2) and 42 C.F.R. § 438.6.NC

University of North Carolina at Greensboro, Center for Youth, Family, and Community Partnerships. (n.d.). *North Carolina High Fidelity Wraparound Training Program*. University of North Carolina at Greensboro.

NC Medicaid/DHHS Clinical Coverage Policy 8A — Enhanced Mental Health and Substance Abuse Services (Amended Jan 1, 2025).

NC Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS), the requirements of 10A N.C.A.C 27G and NC G.S. 122C

DMH/DD/SAS Records Management and Documentation Manual 45-2 (RMDM) Items 1 through 12, under Contents of a Service Note, Chapter 7 of the RMDM.

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].

Websites for Additional Information

nchfwtp.uncg.edu/what-is-hfw/
nchfwtp.uncg.edu
nwi.pdx.edu/wraparound-basics/#whatareimplementation

NC Tracks Provider Claims and Billing Assistance Guide:
nctracks.nc.gov/content/public/providers/provider-manuals.html

EPSDT provider page: ncdhhs.gov/dma/epsdt

History

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Draft	11/24/2025	Revised
Approved	02/10/2026	Approved by Medical Operation Committee (MOC)