

**Alternative or “in Lieu of” Service Description**  
**Partners Behavioral Health Management**

**1. Service Name and Description:**

**Service Name:** Outpatient Plus (OPT Plus)

**Procedure Code:**

- 90837 U5                      Monthly Rate: \$961.92 billed every 30 days during auth period
- 90837 U5 EN                License Professional Encounters – 1 per face to face therapy session
- H0036 U5 EN                Qualified Professional Encounters billed in 15 min increments

**License:**

**Description:** Outpatient Plus (OPT Plus) is a combination of best practice outpatient therapy services, monitoring, support, and management of care interventions to be provided for individuals with complex clinical needs that traditional outpatient cannot adequately address. OPT Plus is a level of care between OPT and IIH/CST.

OPT Plus is a home and community-based treatment service focused on decreasing psychiatric and behavioral symptoms in order to reduce the need for higher levels of care or increase the likelihood of a successful transition to Outpatient Therapy from higher levels of care. OPT Plus will improve the beneficiary’s ability to navigate systems and improve functioning in familial, social, educational, or occupational life domains. OPT Plus services often involve the participation of family members, significant others, and legally responsible person(s) as applicable, unless contraindicated.

OPT Plus consists of evidence based individual/family/group therapy (mental health and substance use disorder treatment interventions) provided in the home and community (services are office based for group and as transitioning to OPT), combined with activities that assist in the monitoring, support, and management of care to include:

- 1) Coordinating the delivery of services to reduce fragmentation of care and maximize mutually agreed upon outcomes (includes case consultation, team meetings, and assisting with placements);
- 2) Facilitating access to/connecting beneficiary to services and supports identified in the Person Centered Plan (PCP), including assist beneficiary as he/she transitions to other levels of care;
- 3) Making referrals to other providers for needed services/supports, scheduling appointments with the beneficiary, and facilitating communication/collaboration among all service providers and the beneficiary;
- 4) Assisting the beneficiary in establishing and maintaining a medical home with a primary care physician (especially assisting pregnant beneficiaries in establishing obstetrician and prenatal care as necessary);
- 5) Monitoring and follow up including activities and contacts that are necessary to ensure that the PCP is effectively implemented and adequately addresses the needs of the beneficiary; and
- 6) Education related to skills development in addition to the reinforcement/practicing of skills and interventions that are introduced through the therapy sessions.

Given that it is anticipated that the coordination needs will be significant and best integrated with support and skill building interventions, these activities would be more appropriately handled by the staff actively treating the consumer and the family rather than a care coordinator. Interventions can then be provided face to face with schools, juvenile/criminal justice systems, housing, etc. in a

manner beyond the scope of what traditional outpatient or Care Coordination can do. In addition, this service includes skill building and other therapeutic interventions. All service interventions must be face to face or telephonic with beneficiary or collaterals. All therapy (50% of service interventions per week) must be face-to-face.

OPT Plus is provided by nationally accredited organizations/agencies that meet all of the requirements for OPT in DMA Clinical Policy 8C and are enrolled in the LME/MCO network for enhanced services. Services will be provided by Licensed Professionals/Associate Licensed Professionals. In addition, interventions to monitor, support, and manage care can be provided by a QP with the same organization/agency if preferred and clinically appropriate.

**2. Information About Population to be Served:**

Population	Age Ranges	Projected Numbers	Characteristics
MH and/or SUD	4 and older	See Projected Numbers for each LME/MCO separated below	<ul style="list-style-type: none"> <li>▪ Chronic non-engagement in Outpatient therapy related to symptoms of MH/SUD diagnosis</li> <li>▪ Multi-system involvement</li> <li>▪ High Risk/Dual Diagnosis</li> <li>▪ High risk or recent history (past six months) of criminal/juvenile justice involvement</li> <li>▪ Significant difficulty meeting basic survival needs, residing in substandard housing, homelessness, or imminent risk of homelessness</li> <li>▪ Traditional office based therapy is not working, and alternative modalities have been attempted, individual is at risk for higher levels of care, and it is determined this service reduces that risk</li> <li>▪ A greater level of required collateral contact and involvement</li> </ul>
<b>Projected Numbers</b> Partners BHM  Data from 7/1/14 to 6/30/2015		<b>367 child consumers</b> The number of children who received OPT and a crisis service (Mobile Crisis or Inpatient)  <b>1169 adult consumers</b> The number of adults who received OPT and a crisis service (Mobile Crisis or Inpatient)  <b>Total projected: 1536 consumers</b>	

**Eligibility Criteria:**

The beneficiary is eligible for this service when the following criteria are met:

- a. There is a mental health or substance use disorder diagnosis (as defined by the DSM-5, or any subsequent editions of this reference material), other than a sole diagnosis of intellectual and developmental disability; AND
- b. Based on the current comprehensive clinical assessment, this service was indicated and outpatient treatment services were previously attempted, but were found to be inappropriate or not effective as documented in the medical record; AND

- c. The Medicaid beneficiary requires coordination between two or more agencies, including medical or non-medical providers; AND
- Two or more of the following are met:
- d. Current or past history of erratic or non-engagement in treatment based on barriers identified in the service plan
  - e. In need of graduated step down from a higher level of care to Outpatient
  - f. At risk of higher level of care and it is determined that this service will reduce that risk
  - g. Symptoms and behaviors are unmanageable at home, school, or in other community settings due to the deterioration of the beneficiary's mental health or substance use disorder condition, requiring intensive, coordinated clinical interventions with a greater level of required collateral contact and involvement
  - h. Unable to manage his/her symptoms or focus on recovery and relapse prevention planning, (independently or with family/caregiver support), due to unmet basic needs, such as safe and adequate housing or food, or legal, educational, vocational, financial, health care, or transportation assistance for necessary services

**3. Treatment Program Philosophy, Goals and Objectives:**

OPT Plus will be person-centered, resiliency and recovery focused, and with an aim of not only helping individuals maintain stability in areas of functioning and wellness valued by the person, but also helping individuals continue on their own path of recovery through person-centered planning and service delivery. It is expected that the service will be consistent with the LME/MCO clinical guidelines and best practices for the treatment of the beneficiaries' diagnosis.

OPT Plus will serve the needs of two distinct groups: those in need of intensive supports, but at a less enhanced comprehensive level than IIH/CST, and those who need an additional level of care to prepare for step down and successful engagement with Basic Outpatient Services.

OPT Plus is designed to:

- a. Reduce psychiatric or substance use disorder symptoms and promote symptom stability and recovery;
- b. Assist the beneficiary with transition to a community setting and to navigate the skills to live independently in the community;
- c. Prevent the need for enhanced services or provide a step down from enhanced services; and
- d. Ensure linkage to community services and resources.

**4. Expected Outcomes:**

Expected clinical outcomes include the following:

- a. Successful transition to Outpatient Therapy;
- b. Increased use of available natural and social supports by the beneficiary and family/caregivers;
- c. Decrease in the frequency or intensity of crisis episodes;
- d. Beneficiary and family or caregivers' engagement in the recovery process;
- e. Reduction of symptoms and improved functioning in the home, school and community settings;
- f. Ability of the beneficiary and family or caregiver to better identify and manage triggers, cues, and symptoms;
- g. Beneficiary's utilization of increased coping skills and social skills that mitigate life stresses resulting from the beneficiary's diagnostic and clinical needs;
- h. Increased independence in managing his or her own care (e.g., making treatment appointments, attending treatment, taking medications as prescribed, etc.).

**5. Staffing Qualifications, Credentialing Process, and Levels of Supervision (Administrative and Clinical) Required:**

OPT Plus is provided by nationally accredited organizations/agencies that meet all of the requirements for OPT in DMA Clinical Policy 8C, and are enrolled in the LME/MCO network for enhanced services. Services will be provided by Licensed Professionals/Associate Licensed Professionals who are credentialed in the LME/MCO network and are employed by network providers. In addition, interventions to assist in the monitoring, support, and management of care will be provided by a QP with the same organization/agency.

Clinicians would follow the standard credentialing process. QPs must receive supervision as outlined in an individualized supervision plan.

**Licensed Professional (LP) or Associate Licensed Professional**

Fully licensed or associate licensed professional who has the knowledge, skills, and abilities required by the population and age to be served, and will have one year of experience with the population and age to be served.

**Qualified Professional (QP)**

QP who has the knowledge, skills, and abilities required by the population and age to be served to provide case monitoring and support tasks, as well as education related to skill development and reinforcement/practice of those skills with the beneficiaries and families.

The licensed/associate licensed professional will be responsible for all therapy provision. The QP will perform the case monitoring, support, and management functions, as well as education related to skills development in addition to the reinforcement/practicing of skills and interventions that are introduced through the therapy sessions. The QP must coordinate all services under the direction of the treating clinician.

**6. Unit of Service:**

**7. 1 unit of service = 30 days.**

8. Billing Guidance: OPT Plus units may only be billed on day when the therapist has performed a face-to-face service with the beneficiary or a family member. Only one unit may be billed per beneficiary per month. All other contacts including qualified professionals, meetings, travel time, etc. is accounted for in the buildup of the unit rate.

9. **On average, 50% of the contacts are face-to-face therapy.** To calculate the median, the number of face-to-face therapy contacts is divided by the total number of contacts, for each beneficiary over the case period, a maximum of six months.

**Anticipated Units of Service per Person: 3-6**

**Utilization Management:**

- OPT Plus will be a maximum of 180 days.
- The case monitoring, support, and management interventions are expected to taper in volume and frequency during the authorized benefit period. It is expected that the beneficiary will successfully step-down to basic benefits with the treating clinician for continuity of care.
- Prior authorization by the LME-MCO is required before or on the first date of service.

### **Service Exclusions and Limitations**

A beneficiary may receive OPT Plus services from only one service provider organization during any active authorization period for this service. Service delivery to individuals other than the beneficiary may be covered only when the activity is directed exclusively toward the benefit of that beneficiary.

The following are not billable under this service:

- a. Transportation time (this is factored in the rate);
- b. Any habilitation activities;
- c. Any social or recreational activities (or the supervision thereof); or
- d. Clinical and administrative staff supervision, including team meetings (factored in the rate).

OPT Plus services cannot be provided during the same authorization period as the following services:

- a. Individual, group and family therapy;
- b. Intensive In-home;
- c. Multisystemic Therapy;
- d. Day Treatment;
- e. Community Support Team;
- f. Substance Abuse Intensive Outpatient Program (SAIOP);
- g. Substance Abuse Comprehensive Outpatient Therapy (SACOT);
- h. ACTT;
- i. Tenancy Support Team;
- j. Child residential treatment services Level II Program Type through Level IV;
- k. Psychiatric Residential Treatment Facility (PRTF);
- l. Substance Abuse residential services; or
- m. For beneficiaries residing in a nursing home facility.

OPT Plus services may be provided for beneficiaries transitioning out of the following adult mental health residential facilities: independent living; supervised living low or moderate; and group living low, moderate, or high.

OPT Plus services may be provided to help a beneficiary transition to and from a service (facilitating an admission to a service, discharge planning, or both), provide coordination during the provision of a service, and ensure the service provider works directly with the OPT Plus clinician/QP. OPT Plus monitoring, support, and management of care services may be provided and billed in accordance with the authorization for services during the same authorization period, for the following services based on medical necessity:

- a. All detoxification services;
- b. Professional Treatment Services in Facility-Based Crisis Programs;
- c. Partial Hospitalization;
- d. Substance Abuse Medically Monitored Community Residential Treatment; or
- e. Substance Abuse Non-Medically Monitored Community Residential Treatment.

**For Medicaid beneficiaries ages 21 and over** there may be exceptional circumstances when one additional reauthorization up to 60 days can be approved.

### **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 *NCTracks Provider Claims and Billing Assistance Guide*, and on the EPSDT provider page. The Web addresses are specified below.

*NCTracks 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

### **Entrance Process**

The process for a beneficiary to enter this service includes completion of a comprehensive clinical assessment (CCA) that demonstrates medical necessity. The CCA shall 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 part of the current comprehensive clinical assessment. Relevant diagnostic information shall be obtained and included in the PCP. A LOCUS/CALOCUS, ASAM (for individuals with SUD), or CANS (for 3-6 year olds) must be submitted with the initial authorization request. The need for more intensive attention, structure, and contact would indicate a Level 3 (High Intensity Community Based Services) score. For beneficiaries with substance use disorders, they would meet ASAM level 2.1.

A signed service order (on the PCP) shall be completed by a physician, licensed psychologist, physician 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 shall be in place *prior to* or on the day that the service is initially provided in order to bill Medicaid for the service. The service order shall be based on a comprehensive clinical assessment of the beneficiary's needs.

**10. Targeted Length of Service:** Length of stay in this service will be a maximum of 180 days.

For Medicaid beneficiaries ages 21 and over there may be exceptional circumstances when one additional reauthorization up to 60 days can be approved.

**EPSDT**

For Medicaid beneficiaries under age 21, service limitations on scope, amount, duration, frequency, location of service, and other specific criteria described in this definition 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 problems.

**11. Describe why this service is needed and is different than any State Plan or alternative service already defined. If implemented in other states, describe successful outcomes.**

In the Gaps and Needs Assessment at Partners, there are identified gaps in both the child and adult treatment continuums between traditional outpatient therapy and IIH/CST. We often find that children and adults need something more intensive than basic individual and family therapy, but that they do not meet the full criteria for IIH/CST.

Outpatient therapy does not allow for intensive case monitoring, support, and management functions needed by this targeted population with multi-system involvement. These individuals do not have LOCUS/CALOCUS scores that meet special needs population threshold outlined in the waiver, however, the need for more intensive attention, structure, and contact would give them a Level 3 (High Intensity Community Based Services) score. For beneficiaries with substance use disorders, they would meet ASAM level 2.1. Given that it is anticipated that the coordination needs will be significant and best integrated with support and skill building interventions, these activities would be more appropriately handled by the staff actively treating the consumer and the family rather than a care coordinator. Face to face interventions can then be provided by the team with schools, juvenile/criminal justice systems, housing, etc. in a manner beyond the scope of what traditional outpatient even when provided in the home, or Care Coordination can do. This will

make the service delivery more seamless for the beneficiary and family and allow for flexibility in the intensity of case monitoring, support, and management over the course of treatment with the ability to quickly address any issues that arise rather than having to wait for issues to become so severe that the individual meets special population criteria for care coordination.

This service will also fill a gap for those beneficiaries who are ready to step down from higher levels of care, but whose history of erratic engagement in treatment indicate the need for a more robust and graduated step down plan. This service will decrease the length of stay in higher levels of care for this population.

**12. Cost-Benefit Analysis: Document the cost-effectiveness of this alternative service versus the State Plan services available.**

Description of comparable State Plan Service Payment Arrangements (include type, amount, frequency, etc.)

**Partners Behavioral Health Management Data (Paid claims data for FY 14-15)**

Service	Procedure Code	Unit Definition	Units of Service	Cost of Service
IIH	H2022	1 Unit = 1 Day	Avg units per episode = 52	\$258.20/Unit \$13,426.40 per episode
CST	H2015-HT	1 Unit = 15 Mins	Avg units per episode = 170	\$14.50/unit \$2,465.00 per episode

Description of Alternative Service Payment Arrangements (include type, amount, frequency, etc.)

Identified Population	Service	Procedure Code	Unit Definition	Units of Service	Cost of Service
<b>Children and adults</b>	<b>OPT Plus</b> A minimum average of 50% of treatment interventions per week must be therapy services  All service interventions must be face		1 Unit = 30 days of treatment interventions	Anticipated Units of Service per Person: 3-6 units	<b>Therapist/QP Model</b> \$961.92/unit  \$\$2885.76 to \$5771.52 per episode



	to face or telephonic with consumer or collaterals				
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Cost Effectiveness Summary:

When we compare the cost of IHH/CST with the projected cost of OPT Plus, it is clear that there are cost savings from any other higher levels of care (ex. Inpatient and emergency departments, PRTF).

**Description of Process for Reporting Encounter Data (include record type, codes to be used, etc.)**  
 Provider will bill for each unit of service provided. Claims data will reflect fee for service billing. Data will be uploaded to DMA by the MCO.

Encounter Data will be recorded by providers with the minimum standard of a service note for each contact, service event, or intervention.

Providers will collect and report/provide access through sharing of the health record to all encounter data. At a minimum, this would include time spent on family based sessions, individual sessions, and indirect contacts.

**Description of Monitoring Activities :**

The MCO will review claims monthly to monitor patterns and trends in utilization of this service.

The MCO will monitor service utilization through prior authorizations, utilization management, and post payment reviews.

The MCO will measure outcomes minimally through LOCUS/CALOCUS scores, ASAM Levels (for individuals with substance use disorders), CANS and ECSII (for 3-6 year olds). The Provider will be asked to review and update the LOCUS/CALOCUS scores, ASAM Level (when appropriate), CANS and ECSII (when appropriate) monthly. The reviewed/updated scores/levels will be submitted with re-authorization requests. It is expected that this service would be effective and resulting in positive outcomes when a lower scores/levels are reported in the request for re-authorization. This would indicate a successful transition back to basic services (OPT).

Additionally, providers will be asked to use a standardized tool to measure effectiveness of the service. The specific tool, its frequency and use will ultimately be the decision of the LME/MCO.

**Documentation Requirements**

Refer to the DMH/DD/SAS *Records Management and Documentation Manual* for a complete listing of documentation requirements.

The minimum standard is a service note for each contact, service event, or intervention that includes the required elements outlined in the Service Description.

A completed LME-MCO Consumer Admission and Discharge Form shall be submitted to the LME-MCO.

A documented discharge plan shall be discussed with the individual and included in the service record.