

## LME Alternative Service Request for Use of DMHDDSAS State Funds

### For Proposed MH/DD/SAS Service Not Included in Approved Statewide IPRS Service Array

**Note:** Submit completed request form electronically to Wanda Mitchell, Budget and Finance Team, at [Wanda.Mitchell@ncmail.net](mailto:Wanda.Mitchell@ncmail.net), and to Spencer Clark, Chief's Office, Community Policy Management Section, at [Spencer.Clark@ncmail.net](mailto:Spencer.Clark@ncmail.net). Questions about completing and submitting this form may be addressed to Brenda G. Davis, CPM Chief's Office, at [Brenda.G.Davis@ncmail.net](mailto:Brenda.G.Davis@ncmail.net) or (919) 733-4670, or to Spencer Clark at [Spencer.Clark@ncmail.net](mailto:Spencer.Clark@ncmail.net) or (919) 733-4670.

<b>a. Name of LME-</b> Piedmont Behavioral Healthcare (PBH)		<b>b. Date Submitted</b> 7-15-08
<b>c. Name of Proposed LME Alternative Service- Individual Therapy – Interactive Group (YA371)</b>		
<b>d. Type of Funds and Effective Date(s):</b> <i>(Check All that Apply)</i>		
<input checked="" type="checkbox"/> <b>State Funds:</b> Effective 7-01-07 to 6-30-08 <input checked="" type="checkbox"/> <b>State Funds:</b> Effective 7-01-08 to 6-30-09		
<b>e. Submitted by LME Staff (Name &amp; Title)</b> David Jones, MA Director of Clinical Operations	<b>f. E-Mail</b> <a href="mailto:davidj@pamh.com">davidj@pamh.com</a>	<b>g. Phone No.</b> 704-743-2106

**Background and Instructions:**

This form has been developed to permit LMEs to request the establishment in IPRS of Alternative Services to be used to track state funds through a fee-for-service tracking mechanism. An LME that receives state single stream or other state non-UCR funding shall use such funding to purchase or start up services included in the Integrated Payment and Reporting System (IPRS) service array and directed towards the approved IPRS target population(s). If the LME wishes to propose the use of state funds for the provision of an Alternative Service that is not included in the IPRS service array, the LME shall submit an ***LME Alternative Service Request for Use of DMHDDSAS State Funds.***

This form shall be completed to fully describe the proposed Alternative Service for which Division approval is requested in order to develop an IPRS reporting code and an appropriate rate for the Alternative Service.

Please use the following template to describe the LME's proposed Alternative Service definition and address all related issues using the standard format and content categories that have been adopted for new MH/DD/SA Services.

Please note that:

- an individual LME Alternative Service Request form is required to be completed for each proposed Alternative Service;
- a separate Request for Waiver is required to be submitted to the Division for the LME to be authorized by the Secretary to directly provide an approved Alternative Service; and
- the current form is not intended to be utilized in SFY 07-08 for the reporting on the use of county funds by an LME. The Division continues to work with the County Funds Workgroup to establish a mechanism to track and report on the use of county funds through IPRS reporting effective July 1, 2008.

## Requirements for Proposed LME Alternative Service

*(Items in italics are provided below as examples of the types of information to be considered in responding to questions while following the regular Enhanced Benefit Service definition format. Rows may be expanded as necessary to fully respond to questions.)*

**Complete items 1 through 28, as appropriate, for all requests.**

1	<b>Alternative Service Name, Service Definition and Required Components</b> <b>Individual Therapy- Interactive Group (YA371)</b>
2	<b>Rationale for proposed adoption of LME Alternative Service to address issues that cannot be adequately addressed within the current IPRS Service Array</b>  <i>PBH specific service array to best provide for consumer needs within the PBH system of care</i>
3	<b>Description of service need(s) to be addressed exclusively through State funds for which Medicaid funding cannot be appropriately accessed through a current Medicaid approved service definition</b>  Psychotherapy is the treatment for mental illness and behavioral disturbances in which the clinician establishes a professional contract with the client and, through definitive therapeutic communication, attempts to alleviate the emotional disturbances, reverse or change maladaptive patterns of behavior, and encourage personality growth and development. Insight Oriented, Behavior Modifying and / or Supportive Therapy refers to the development of insight or affective understanding, the use of behavior modification techniques, the use of supportive interactions, the use of cognitive discussion of reality, or any combination of the above to provide therapeutic change. Individual psychotherapy, insight oriented, behavior modifying and/or supportive psychotherapy are provided in an office or outpatient facility, face to face with the client.  Insight oriented, behavior modifying and/or supportive psychotherapy refers to the development of insight or affective understanding, the use of behavior modification techniques, the use of supportive interactions, the use of cognitive discussions of reality, or any combination of the above to provide therapeutic change.  Interactive Psychotherapy, which is typically furnished to children. It involves the use of physical aids and non-verbal communication to overcome barriers to therapeutic interaction between the clinician and a client who has not yet developed, or has lost, either the expressive language communication skills to explain his/her symptoms and response to treatment, or the receptive communication skills to understand the clinician if he/she were to use ordinary adult language for communication. Individual psychotherapy, interactive uses play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication in an office or outpatient facility face to face with the client.  <b>Therapeutic Relationship and Interventions</b> There should be a supportive and therapeutic relationship between the provider and service recipient or primary caregiver which addresses and/or implements the interventions outlined in the service plan in any one of the following: <ul style="list-style-type: none"><li>A. Mental health therapy,</li><li>B. Medication administration and monitoring,</li><li>C. Behavioral counseling,</li><li>D. Counseling for substance abuse issues including methadone treatment and outpatient detoxification services,</li><li>E. Education about mental health and/or substance abuse issues, and</li><li>F. Other covered services for recipients with only a primary developmental disability diagnosis which are limited to physical therapy, speech therapy, or occupational therapy.</li></ul>

4	<p><b>Please indicate the LME's Consumer and Family Advisory Committee (CFAC) review and recommendation of the proposed LME Alternative Service: (Check one)</b></p> <p><input checked="" type="checkbox"/> <b>Recommends</b>    <input type="checkbox"/> <b>Does Not Recommend</b>    <input type="checkbox"/> <b>Neutral (No CFAC Opinion)</b></p>										
5	<p><b>Projected Annual Number of Persons to be Served with State Funds by LME through this Alternative Service</b></p>										
6	<p><b>Estimated Annual Amount of State Funds to be Expended by LME for this Alternative Service</b></p>										
7	<p><b>Eligible IPRS Target Population(s) for Alternative Service: (Check all that apply)</b></p> <p><u>Assessment Only:</u>    <input type="checkbox"/> <i>All</i>   <input type="checkbox"/> <i>CMAO</i>   <input type="checkbox"/> <i>AMAO</i>   <input type="checkbox"/> <i>CDAO</i>   <input type="checkbox"/> <i>ADAO</i>   <input type="checkbox"/> <i>CSAO</i>   <input type="checkbox"/> <i>ASAO</i></p> <p><u>Crisis Services:</u>    <input type="checkbox"/> <i>All</i>   <input type="checkbox"/> <i>CMCS</i>   <input type="checkbox"/> <i>AMCS</i>   <input type="checkbox"/> <i>CDCS</i>   <input type="checkbox"/> <i>ADCS</i>   <input type="checkbox"/> <i>CSCS</i>   <input type="checkbox"/> <i>ASCS</i></p> <p><u>Child MH:</u>            <input checked="" type="checkbox"/> <i>All</i>   <input type="checkbox"/> <i>CMSED</i>   <input type="checkbox"/> <i>CMMED</i>   <input type="checkbox"/> <i>CMDEF</i>   <input type="checkbox"/> <i>CMPAT</i>   <input type="checkbox"/> <i>CMECD</i></p> <p><u>Adult MH:</u>            <input checked="" type="checkbox"/> <i>All</i>   <input type="checkbox"/> <i>AMSPM</i>   <input type="checkbox"/> <i>AMSMI</i>   <input type="checkbox"/> <i>AMDEF</i>   <input type="checkbox"/> <i>AMPAT</i>   <input type="checkbox"/> <i>AMSRE</i></p> <p><u>Child DD:</u>            <input checked="" type="checkbox"/> <i>CDSN</i></p> <p><u>Adult DD:</u>            <input checked="" type="checkbox"/> <i>All</i>   <input type="checkbox"/> <i>ADSN</i>   <input type="checkbox"/> <i>ADMRI</i></p> <p><u>Child SA:</u>            <input checked="" type="checkbox"/> <i>All</i>   <input type="checkbox"/> <i>CSSAD</i>   <input type="checkbox"/> <i>CSMAJ</i>   <input type="checkbox"/> <i>CSWOM</i>   <input type="checkbox"/> <i>CSCJO</i>   <input type="checkbox"/> <i>CSDWI</i>   <input type="checkbox"/> <i>CSIP</i>  <input type="checkbox"/> <i>CSSP</i></p> <p><u>Adult SA:</u>            <input checked="" type="checkbox"/> <i>All</i>   <input type="checkbox"/> <i>ASCDR</i>   <input type="checkbox"/> <i>ASHMT</i>   <input type="checkbox"/> <i>ASWOM</i>   <input type="checkbox"/> <i>ASDSS</i>   <input type="checkbox"/> <i>ASCJO</i>   <input type="checkbox"/> <i>ASDWI</i>  <input type="checkbox"/> <i>ASDHH</i>   <input type="checkbox"/> <i>ASHOM</i>   <input type="checkbox"/> <i>ASTER</i></p> <p><u>Comm. Enhance.:</u>    <input type="checkbox"/> <i>All</i>   <input type="checkbox"/> <i>CMCEP</i>   <input type="checkbox"/> <i>AMCEP</i>   <input type="checkbox"/> <i>CDCEP</i>   <input type="checkbox"/> <i>ADCEP</i>   <input type="checkbox"/> <i>ASCEP</i>   <input type="checkbox"/> <i>CSCEP</i></p> <p><u>Non-Client:</u>            <input type="checkbox"/> <i>CDF</i></p>										
8	<p><b>Definition of Reimbursable Unit of Service: (Check one)</b></p> <p><input checked="" type="checkbox"/> <b>Service Event</b>    <input type="checkbox"/> <b>15 Minutes</b>            <input type="checkbox"/> <b>Hourly</b>    <input type="checkbox"/> <b>Daily</b>    <input type="checkbox"/> <b>Monthly</b></p> <p><input type="checkbox"/> <b>Other: Explain</b> _____</p>										
9	<p><b>Proposed IPRS <u>Average</u> Unit Rate for LME Alternative Service</b></p> <p><i>Since this proposed unit rate is for Division funds, the LME can have different rates for the same service within different providers. What is the proposed <u>average</u> IPRS Unit Rate for which the LME proposes to reimburse the provider(s) for this service?</i></p> <table border="1" data-bbox="240 1528 1511 1602"> <tr> <td>LP</td> <td>LCSW</td> <td>CNS</td> <td>NP</td> <td>LPA</td> </tr> <tr> <td>\$32.52</td> <td>\$24.39</td> <td>\$27.64</td> <td>\$27.64</td> <td>\$24.39</td> </tr> </table>	LP	LCSW	CNS	NP	LPA	\$32.52	\$24.39	\$27.64	\$27.64	\$24.39
LP	LCSW	CNS	NP	LPA							
\$32.52	\$24.39	\$27.64	\$27.64	\$24.39							
10	<p><b>Explanation of LME Methodology for Determination of Proposed IPRS <u>Average</u> Unit Rate for Service</b> <i>Comparable to like services</i></p>										
11	<p><b>Provider Organization Requirements</b></p> <p>Outpatient services are provided by Qualified Professional, and/or a Professional who is eligible to bill CPT codes based on their licensure and/or certification.</p>										

12	<p><b>Staffing Requirements by Age/Disability</b>  <i>(Type of required staff licensure, certification, QP, AP, or paraprofessional standard)</i></p> <p><i>Same as Above (Question 11)</i></p>
13	<p><b>Program and Staff Supervision Requirements</b></p>
14	<p><b>Requisite Staff Training</b>  <i>Same as Above (Question 11)</i></p>
15	<p><b>Service Type/Setting</b></p> <ul style="list-style-type: none"> <li>• <b>Location(s) of services</b></li> <li>• <b>Excluded service location(s)</b></li> </ul> <p>This is a periodic, professional level service that may be offered on an individual or group basis. Outpatient-Group services may be reimbursed up to 2 hours and 45 minutes. This service is Medicaid billable.</p>
16	<p><b>Program Requirements</b></p> <ul style="list-style-type: none"> <li>• <b>Individual or group service</b></li> <li>• <b>Required client to staff ratio (if applicable)</b></li> <li>• <b>Maximum consumer caseload size for FTE staff (if applicable)</b></li> <li>• <b>Maximum group size (if applicable)</b></li> <li>• <b>Required minimum frequency of contacts (if applicable)</b></li> <li>• <b>Required minimum face-to-face contacts (if applicable)</b></li> </ul> <p>Outpatient services are provided by Qualified Professional, and/or a Professional who is eligible to bill CPT codes based on their licensure and/or certification.</p>
17	<p><b>Entrance Criteria</b></p> <ul style="list-style-type: none"> <li>• <b>Individual consumer recipient eligibility for service admission</b></li> <li>• <b>Anticipated average level of severity of illness, or average intensity of support needs, of consumer to enter this service</b></li> </ul> <p>The recipient is eligible for this service when:</p> <p>A. An Axis I or II diagnosis is present or the person has a condition that may be defined as a developmental disability as defined in GS 122C-3 (12a)</p> <p><b>AND</b></p> <p>B. LOCUS/CALOCUS Level 1, ASAM Level I (American Society for Addiction Medicine)</p> <p><b>AND</b></p> <p>C. The recipient is experiencing difficulties in at least one of the following areas:</p> <ol style="list-style-type: none"> <li>1. functional impairment,</li> <li>2. crisis intervention/diversion/aftercare needs, and</li> <li>3. at risk for placement outside of the natural home setting:</li> </ol> <p><b>AND</b></p> <p>D. The recipient's level of functioning has not been restored or improved and may indicate a need for clinical interventions in a natural setting if any one of the following apply:</p> <ol style="list-style-type: none"> <li>1. Unable to remain in the family or community setting due to symptoms associated with diagnosis, therefore being at risk for out of home placement, hospitalization, and/or</li> </ol>

	<p>institutionalization.</p> <ol style="list-style-type: none"> <li>2. Intensive, verbal and limited physical aggression due to symptoms associated with diagnosis, which are sufficient to create functional problems in a community setting.</li> <li>3. At risk of exclusion from services, placement or significant community support systems as a result of functional behavioral problems associated with diagnosis.</li> <li>4. 4. Functional problems which may result in the recipient's inability to access clinic based services in a timely or helpful manner.</li> <li>5. Persistent or recurring behaviors or symptoms that result in the need for crisis services contacts, diversion from out of home placement related to MH/DD/SAS diagnosis, or voluntary commitment within the relevant past.</li> <li>6. Service is a part of an aftercare planning process (time limited step down or transitioning) and is required to avoid returning to a higher, more restrictive level of service.</li> <li>7. Medication administration and monitoring has alleviated limited symptoms, but other treatment interventions are needed.</li> </ol>
18	<p><b>Entrance Process</b></p> <ul style="list-style-type: none"> <li>• <b>Integration with team planning process</b></li> <li>• <b>Integration with Person Centered Plan and clinical assessment</b></li> </ul> <p>PBH requires that a written person-centered plan be developed by the Person Centered Planning team prior to service implementation for the delivery of medically necessary services. PBH expects that consumers play an active role in directing the type, frequency and intensity of services to ensure that the service meets the needs, abilities, preferences and expectations of the consumer and their goals for recovery. It is also PBH's expectation that the PCP is informed by strong clinical data that supports medical necessity of a given service. Together these processes ensure that services are appropriate for meeting the consumer's needs but are supported by clinical evidence to ensure medical necessity.</p>
19	<p><b>Continued Stay Criteria</b></p> <ul style="list-style-type: none"> <li>• <b>Continued individual consumer recipient eligibility for service</b></li> </ul> <p>The desired outcome or level of functioning has not been restored, improved, or sustained over the time frame outlined in the recipient's service plan, or the recipient continues to be at risk for relapse based on history or the tenuous nature of the functional gains or any one of the following apply:</p> <ol style="list-style-type: none"> <li>A. Recipient has achieved initial service plan goals and additional goals are indicated.</li> <li>B. Recipient is making satisfactory progress toward meeting goals.</li> <li>C. Recipient is making some progress, but the service plan (specific interventions) needs to be modified so that greater gains, which are consistent with the recipient's pre-morbid level of functioning, are possible or can be achieved.</li> <li>D. Recipient is not making progress; the service plan must be modified to identify more effective interventions.</li> <li>E. Recipient is regressing; the service plan must be modified to identify more effective interventions.</li> </ol>
20	<p><b>Discharge Criteria</b></p> <ul style="list-style-type: none"> <li>• <b>Recipient eligibility characteristics for service discharge</b></li> <li>• <b>Anticipated length of stay in service (provide range in days and average in days)</b></li> <li>• <b>Anticipated average number of service units to be received from entrance to discharge</b></li> <li>• <b>Anticipated average cost per consumer for this service</b></li> </ul> <p>Recipient's level of functioning has improved with respect to the goals outlined in the service plan, inclusive of</p>

	<p>a transition plan to step down; or no longer benefits; or has the ability to function at this level of care and any of the following apply:</p> <ul style="list-style-type: none"> <li>A. Recipient has achieved goals, discharge to a lower level of care is indicated.</li> <li>B. Recipient is not making progress, or is regressing and all realistic treatment options have been exhausted.</li> </ul>
21	<p><b>Evaluation of Consumer Outcomes and Perception of Care</b></p> <ul style="list-style-type: none"> <li>• <b>Describe how outcomes for this service will be evaluated and reported including planned utilization of and findings from NC-TOPPS, the MH/SA Consumer (Satisfaction) Surveys, the National Core Indicators Surveys, and/or other LME outcomes and perception of care tools for evaluation of the Alternative Service</b></li> <li>• <b>Relate emphasis on functional outcomes in the recipient’s Person Centered Plan</b></li> </ul> <p>For services that require completion of NC TOPPS, MH/SA Consumer Surveys, and/or National Core indicators, PBH will monitor to ensure that evaluation tools are completed within mandated time frames and reported to the required reporting bodies. PBH will also use the data obtained from these measures to track trends that effect service satisfaction, accessibility and utilization. This data then can be used to leverage changes in the PBH provider network related to quality and availability of services.</p> <p>The expected outcome of this service is consumers are appropriately connected to community services and activities. Continued utilization of this service will be determined by medical necessity reviewed annually or more often as needed. PBH has established a systematic method of reviewing the quality, appropriateness, and comprehensiveness of the person-centered plan. Each goal on the person-centered plan is reviewed separately, based on the target date associated with each goal to ensure that services are individualized to meet the strength, needs, abilities and preferences of the consumer.</p>
22	<p><b>Service Documentation Requirements</b></p> <ul style="list-style-type: none"> <li>• <b>Is this a service that can be tracked on the basis of the individual consumer’s receipt of services that are documented in an individual consumer record?</b></li> </ul> <p><input checked="" type="checkbox"/> Yes    <input type="checkbox"/> No        <i>If “No”, please explain.</i></p> <ul style="list-style-type: none"> <li>• <b>Minimum standard for frequency of note, i.e. per event, daily, weekly, monthly, etc.</b></li> </ul> <p>Minimum standard is a full service note per intervention that includes the purpose of contact, describes the provider’s intervention(s), and the effectiveness of the intervention.</p>
23	<p><b>Service Exclusions</b></p> <ul style="list-style-type: none"> <li>• <b>Identify other service(s) that are limited or cannot be provided on the same day or during the same authorization period as proposed Alternative Service</b></li> </ul> <p><b>None Noted</b></p>
24	<p><b>Service Limitations</b></p> <ul style="list-style-type: none"> <li>• <b>Specify maximum number of service units that may be reimbursed within an established timeframe (day, week, month, quarter, year)</b></li> </ul>

	Adults = 8 without prior authorization <b>Children = 12 without prior authorization</b>
25	<b>Evidence-Based Support and Cost Efficiency of Proposed Alternative Service</b>  <ul style="list-style-type: none"> <li>• <i>Provide other organizational examples or literature citations for support of evidence base for effectiveness of the proposed Alternative Service</i></li> </ul>
26	<b>LME Fidelity Monitoring and Quality Management Protocols for Review of Efficacy and Cost-Effectiveness of Alternative Service</b> PBH QM Department will monitor this service for quality and fidelity to the definition through billing audit reviews.
27	<b>LME Additional Explanatory Detail (as needed)</b>