Vaya Partners

Outpatient Plus

H2021 U5

Service

Outpatient Plus (OPT Plus) is a combination of best-practice outpatient therapy services, monitoring, and support provided to individuals of any age with complex clinical needs that basic outpatient therapy cannot adequately address. OPT Plus is a treatment service focused on decreasing psychiatric and behavioral symptoms to reduce the need for higher levels of care and/or increase the likelihood of a successful transition to outpatient therapy from higher levels of care. The goal of OPT Plus is to improve the member's ability to navigate systems and improve functioning in familial, social, educational, and/or occupational life domains. OPT Plus services often involve the participation of family members, significant others, and/or legally responsible person(s) as applicable, unless contraindicated.

OPT Plus consists of evidence-based individual/family/group therapy using mental health and substance use disorder treatment interventions and activities that assist in the monitoring, support, and management of care, to include:

- Collaboration with Care Management on coordinating the delivery of services to reduce fragmentation of care and maximize mutually agreed-upon outcomes (includes case consultation, team meetings, and placement assistance);
- Support Care Management by facilitating access to/connecting the member to services and supports identified in the person-centered plan, including those that help the member as they transition to other levels of care;
- Assist the Care Manager by making referrals to other providers for needed services/supports, scheduling appointments with the member, and facilitating communication/collaboration among all service providers and the member;
- Helping the member establish and maintain a medical home with a primary care physician (PCP) (including assisting pregnant members in establishing obstetrician and prenatal care, as necessary);
- Monitoring and follow-up about activities and contacts necessary to ensure the person-centered plan is effectively implemented and adequately addresses the member's needs;
- Providing education and training related to skills development;
- Reinforcing and practicing skills and interventions that are introduced through therapy sessions; and
- Helping a member transition to and from a service (facilitating an admission to a service, discharge planning, or both).

Anticipated Outcomes

The anticipated outcomes of this service are to:

- Successfully transition a member to a lower level of care, such as basic outpatient therapy;
- Increase the member's use of available natural and social supports;
- Decrease behavioral interventions in the home, school, and community settings;
- Decrease frequency or intensity of crisis episodes in the home, school, and community settings;
- Increase engagement of the member and family in the treatment and recovery process;
- Reduce symptoms and improve functional skills and abilities in the home, school, and community settings; and
- Facilitate referral to appropriate evaluation (such as psychological, neurological, adaptive functioning) to be considered for discharge planning.

Service Frequency and Intensity

OPT Plus shall be delivered by a team of at least one licensed professional (LP) and one qualified professional (QP)/ certified peer support specialist (CPSS)/family partner (FP) with the appropriate clinical skills, knowledge, and abilities to address the mental health, substance use disorder, and/or co-occurring disorders of the member served.

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The LP is responsible for delivering individualized therapy to the member and family therapy (with or without the member present). At a minimum, the LP must provide one individual member or family therapy session per calendar week (Sunday to Saturday). This session must be face-to-face and a minimum of 30 minutes in length.

In addition to therapy, interventions to monitor, support, and manage care must be provided when deemed clinically appropriate. These service interventions can be provided by an LP, a QP, a CPSS, or an FP employed by the provider agency.

- At least 50% of the service interventions by the QP/CPSS/FP with the member in any given calendar month must be face-to-face, with a minimum of one face-to-face contact with the member per week.
- All service interventions with the member's family members, significant others, and/or guardian (if applicable) must be face-to-face or telephonic, must be directed exclusively toward the benefit of the member, and may occur with or without the member present.

A minimum of two hours and a maximum of six hours of combined interventions per week must be provided.

Concurrent Services

OPT Plus services may be provided and billed concurrently during the same or overlapping authorization periods with the following services:

- All detoxification services;
- Facility-based crisis programs;
- Specialized outpatient services (i.e., Trauma-Focused Cognitive Behavioral Therapy, Dialectical Behavioral Therapy group);
- Therapeutic Foster Care;
- Psychiatric inpatient services (excluding psychiatric residential treatment facility [PRTF] level of care).
- Psychological evaluation, neurological testing, adaptive functioning evaluation, or other recommended tests or evaluations.

For any concurrent service delivered during the same or overlapping authorization period as OPT Plus, the provider must obtain prior authorization from Vaya Partners to deliver OPT Plus. **This requirement is irrespective of any other service definition or requirement.**

Service Exclusions

A member may receive OPT Plus from only one provider agency during any active authorization period for this service. The following activities are not billable under this service:

- Transportation time (factored into the rate);
- Any habilitation activities;
- Any social or recreational activities (or the supervision thereof); or
- Clinical and administrative staff supervision, including team meetings (factored in the rate).

OPT Plus services cannot be provided during the same or overlapping authorization period or at the same time as the following services:

- Individual, group, and family therapy;
- Intensive In-home;
- Multisystemic Therapy;
- Day Treatment;
- Community Support Team;

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- High-Fidelity Wraparound;
- Substance Abuse Intensive Outpatient Program (SAIOP);
- Substance Abuse Comprehensive Outpatient Therapy (SACOT);
- Assertive Community Treatment (ACT);
- Child residential treatment services, Level III through Level IV;
- PRTF;
- Substance use residential services; or
- Nursing home services (for members residing in a nursing home facility longer than 30 days).

As this service includes a case management component, providers must clearly outline the member's care plan how they will collaborate with Tailored Care Management to ensure there is no duplication of services. The case management function of this service is to support treatment within the program to ensure progress and decrease the need for a higher level of care.

Provider Requirements

OPT Plus is a mental health and/or substance use disorder service and is delivered by behavioral health providers. The OPT Plus provider shall:

- Meet all qualifications for participation in NC Medicaid program, be credentialed by NC Medicaid, and be enrolled in NCTracks.
- Be enrolled as a network provider in Vaya Partners closed behavioral health provider network, in good standing, and contracted to deliver the service.
- Verify employee/independent contractor qualifications at the time the employee is hired/contracted.
- Provide verification of staff qualifications at least annually.
- Meet any and all provider qualifications, billing eligibility, compliance, claims-related, coordination of benefits, and other provider requirements for outpatient behavioral health services provided by direct-enrolled providers in the NC Medicaid Clinical Coverage Policy No. 8-C (CCP 8-C) in effect at the time-of-service delivery, unless otherwise covered by this service definition.

Staffing Requirements

OPT Plus shall be delivered by a team of at least one licensed professional (LP) and one qualified professional (QP); or associate professional (AP); or paraprofessional/certified peer support specialist (CPSS)/family partner (FP) with the appropriate clinical skills, knowledge, and abilities to address the mental health, substance use disorder, and/or co-occurring disorders of the member.

Licensed professional (LP) or an Associate Licensed Professional: An individual who (a) meets the qualifications set forth in CCP 8-C, Section 6.1, as amended from time to time, to bill basic outpatient services; (b) has the knowledge, skills, and abilities required by the population and age to be served; and (c) who has at least one year of experience with the population and ages to be served.

Qualified professional (QP); or Associate Professional (AP); or Paraprofessional: An individual who (a) who meets the requirements of a "qualified professional; or Associate Professional; or Paraprofessional" specified in 10A NCAC 27G .0104(19); (b) 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 members and their families; and (c) has at least one year of experience with the population and ages to be served.

Certified peer support specialist (CPSS): An individual who (a) has successfully completed the NC Certified Peer Support

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Specialist program; (b) is certified as a peer support specialist by the Division of MHDDSAS; (c) has the knowledge, skills, and abilities required by the population and ages 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 members and their families; and (d) who has at least one year of experience with the population and ages to be served.

Family partner (FP): An individual who (a) has successfully completed family partner trainings; (b) who has the knowledge, skills, and abilities required by the population and ages 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 members and their families; and (c) has at least one year of experience with the population and ages to be served.

Supervision of staff must be provided according to the supervision requirements specified in 10A NCAC 27G .0204. QPs/APs/Paraprofessionals/CPSSs/FPs must receive weekly supervision as outlined in an individualized supervision plan.

The LP will be responsible for all therapy provisions. The QP/APs/Paraprofessionals/CPSS/FP 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/APs/Paraprofessionals/CPSS/FP must coordinate all services under the direction of the treating clinician.

Member Eligibility Requirements

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

- Members must have NC Medicaid based on residency in a county located within Vaya Partners' region and be enrolled in Vaya Partners' Behavioral Health and I/DD Tailored Plan;
- Member has a mental health or substance use disorder diagnosis (as defined by the DSM-5, or any subsequent editions of this reference material); **AND**
- Members do not have service restrictions due to their NC Medicaid program eligibility category that would make them ineligible for this service.

Utilization Management

One unit equals one hour of treatment interventions.

Prior Approval Requirements:

1. The provider agency shall obtain prior approval from Vaya Partners before delivering OPT Plus to the member:
    a. An initial authorization period may not exceed a 180-day period. Concurrent requests for OPT Plus may not exceed a 90-day period. There is no maximum limit on the number of concurrent requests that may be approved for authorization if the service is medically necessary and meets continued stay criteria and other authorization requirements of this service definition.
    b. OPT Plus case monitoring, support, and management interventions are expected to taper in volume and frequency during the authorized benefit periods. It is expected the member will successfully step down to basic benefits with the existing treating clinician for continuity of care.
    c. Prior authorization by Vaya Partners is required on or before the first date of service for the authorization period requested.
2. The provider shall electronically submit the following to Vaya Partners' Utilization Management Team for prior approval:
    a. A fully completed service authorization request (SAR);
    b. A current comprehensive clinical assessment (CCA) demonstrates medical necessity for the service. 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 CCA;

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c. A valid and current person-centered plan or equivalent service plan must be included with initial authorization requests. A valid, current, and updated person-centered plan must be included with concurrent authorizations requests. Relevant diagnostic information shall be obtained and included in the person-centered plan/person-centered plan update;
d. A signed service order (on the person-centered plan) shall be completed by a physician, licensed psychologist, physician assistant, or nurse practitioner according to their 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 to bill Medicaid or the service. The service order shall be based on the member's CCA;
e. A LOCUS/CALOCUS (and ASAM for members with substance use disorders) must be submitted with the initial authorization request and updated at least annually thereafter for concurrent authorization requests. The need for more intensive attention, structure, and contact must indicate a Level III (High-Intensity Community-Based Services) score. Members with substance use disorders must meet ASAM Level 2.1 or higher; and
f. Any other records that support the request.

This service shall be covered when the service is medically necessary and:
The procedure, product, or service is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not more than the member's needs;
a. The procedure, product, or service can be safely furnished, and not equally effective and more conservative or less costly treatment is available statewide;
b. The procedure, product, or service is furnished in a manner not primarily intended for the convenience of the member, the member's caretaker, or the provider; and
c. The member meets the entrance criteria or continued stay criteria, as applicable, set forth below.

Entrance Criteria
- Based on the current CCA, this service is clinically indicated; **AND**
- Outpatient treatment services were attempted within one year of the requested initial authorization start date for the service but were found to be inappropriate, not effective, or required additional support to be effective as documented in the member's medical record; **AND**
- The member requires coordination among two or more agencies, including medical or behavioral health providers; *AND*
- Member meets **two or more** of the following:
  - Current or history of erratic behaviors or non-engagement in treatment based on barriers identified in the service plan.
  - In need of graduated step-down services from a higher level of care to outpatient therapy.
  - In a residential setting and needs coordination to transition to an alternate level of care where the transition is expected to occur in a timeframe of six months or less.
  - At risk of a higher level of care, it is determined that this service will reduce that risk.
  - Symptoms and behaviors are unmanageable at home, school, or other community setting due to the deterioration of the member's mental health or substance use disorder condition, requiring intensive, coordinated clinical interventions with a greater level of required collateral contact and involvement.
  - Unable to manage their 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

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EPSDT SPECIAL PROVISION

Exception to Policy Limitations for a Medicaid Member 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 member 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 member'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 member's right to a free choice of providers.

EPSDT does not require the state Medicaid agency to provide any service, product, or procedure:

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

EPSDT and Prior Approval Requirements:

If the service, product, or procedure requires prior approval, the fact that the member is under 21 years of age does NOT eliminate the requirement for prior approval.

Important additional information about EPSDT and prior approval is found in the NC Tracks Provider Claims and Billing Assistance Guide and on NC DHHS: Early Periodic Screening, Diagnostic and Treatment Medicaid Services for Children.

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 member's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of an additional health problem.

Documentation Requirements

OPT Plus services shall be properly and contemporaneously documented in accordance with this section and the Division of MHDDSAS Records Management and Documentation Manual 45-2 (RMDM) prior to seeking reimbursement from Vaya Partners. A daily full-service note or grid that meets the criteria specified in the RMDM is required.

Regardless of the service type, significant events in the member's life that require additional activities or interventions shall be documented over and above the minimum frequency requirements.

Providers shall make all documentation supporting claims for service reimbursed by Vaya Partners available to Vaya Partners and to any state and/or federal regulatory authority, upon request.

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Claims-Related Information

Providers shall comply with the NCTracks Provider Claims and Billing Assistance Guide, applicable Medicaid bulletins issued by the NC Division of Health Benefits (DHB), applicable NC Medicaid Clinical Coverage Policies, this service definition, Vaya Partners fee schedule and other requirements, and any other relevant documents for specific coverage and reimbursement for Medicaid.

1. **Claim Type:** Professional (CMS-1500/837P transaction) billed through Vaya Partners.
2. **International Classification of Diseases, Tenth Revisions, Clinical Modification (ICD-10-CM) and Procedural Coding System (PCS):**
    a. Provider(s) shall report the ICD-10-CM and Procedural Coding to the highest level of specificity that supports medical necessity. Provider(s) shall use the current ICD-10 edition and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for code description.
    b. A diagnosis of mental health or substance use disorder must be present to bill for this service (see 42 CFR § 435.110).
3. **Codes and Modifiers:** Provider(s) shall report the most specific billing code that accurately and completely describes the procedure, product, or service provided. Provider(s) shall use the Current Procedural Terminology (CPT), Health Care Procedure Coding System (HCPCS), and UB-04 Data Specifications Manual (for a complete listing of valid revenue codes) and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for the code description. If no such specific CPT or HCPCS code exists, then the provider(s) shall report the procedure, product, or service using the appropriate unlisted procedure or service code.
4. **Billing Units:** Providers bill this service on a unit basis. 1 unit = 1 hour of service.
5. **Place of Service:** Member's home/community/school.
6. **Prior Authorization:** Provider must have a prior authorization for the delivery of services to the member approved by Vaya Partners prior to submission of claims for payment to Vaya Partners.
7. **NCTracks Enrollment:** Providers must be enrolled in NCTracks and ensure valid NPIs, taxonomies, sites, ZIP code (+4), and all other provider demographic information provided to Vaya Partners matches the information in NCTracks in order to bill Vaya Partners and be reimbursed for this service.
8. **Coordination of Benefits:** Providers must file with primary payor(s) prior to submission of claims for payment to Vaya Partners, if applicable.
9. **Reimbursement**: Vaya Partners reimburses providers for clean claims for services rendered in accordance with this service definition.

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