

Alternative or “in Lieu of” Service Description
Template

1. Service Name and Description: Case Support- Special Situations

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Procedure Code: T1016-CR Medicaid

License: N/A

Description: The service includes activities with and/or on behalf of a member of with Mental Health (MH), Intellectual/ Development disabilities (IDD) and Substance Use Disorder (SUD) diagnosis.

Case Support interventions will include but are not limited to:

Case support activities are performed by an individual employed by a provider agency for members that do not have other services in place that can provide this type of clinical support or have had services temporarily suspended due to extenuating circumstance such as a pandemic. The service is designed to meet some of the broad healthcare, educational, vocational, residential, financial, social and other non-treatment needs of the member. The service includes the arrangement, linkage or integration of multiple service and providers involved in the member’s care. This includes making referrals to enhanced service providers and following up to ensure services are initiated. This can also include provision of supportive contacts, skill reinforcement, skill development through telephonic or other technology means. These services may be needed when individuals are not able to attend to receive their typical site-based services, or face-to-face services when these services are not able to be provided due to the pandemic. They are performed by an individuals employed by a provider agencies for members that do not have other services in place that can provide this type of support or have had services temporarily suspended due to extenuating services. The service is designed to meet some of the broad healthcare needs, educational, vocational, residential, financial, social and other non-treatment needs of the member and prevent decompensation or a need for higher levels of care.

Interventions include strategies and actions for the purposes of coordinating treatment and assisting the member in connection to community supports. These are typically associated with members receiving services through the walk-in clinic or advanced access provider. They may also be provided as a follow up after acute crisis episode when enhanced services are not clinically indicated but some time limited periodic support is needed to ensure successful

stabilization after these treatment episodes. These also may be needed when individuals are not able to attend their typical site-based services, or when other enhanced services are not able to be provided due to extenuating circumstances

The following strategies and actions may occur in addition to the above treatment intervention. Note that this is not an all-inclusive list, but includes some typical activities.

1. Activate referrals and connections to other providers
2. Initiate bed finding/placement activities
3. Assist in connection to housing resources
4. Monitor member's safety, medical and psychiatric status (beyond time spent in the clinical activities billed separately)
5. Provide food, hydration, and comfort items for those members where this is needed to stabilize or where assistance may be needed to access these needed elements
6. Peer Support Specialist services to educate on WRAP plans, Advanced Directives, etc. (time limited while at the clinic, may also link member to Peer Support Services for ongoing support)
7. Provide community resource information
8. Assist in benefit coordination, inclusive of assisting member to complete paperwork to apply for needed benefits
9. Assist in applying for patient assistance programs for medication or
10. Assist in coordination with physical health providers including linkage and referral to these providers
11. Identify natural supports and creative ways to maintain support system during special circumstances, which result in isolation
12. Monitor as needed based on first evaluations where transfer to more intensive services is needed and is being coordinated
13. Provide additional coaching and support to family members that are caring for the member to assist them in being able to manage their needs

2. Information About Population to be Served:

Population	Age Ranges	Projected Numbers	Characteristics
Children and adolescents, and Adults with MH, SUD, and IDD or any combination of the above	3+	Unable to give a valid estimate due to the uncertainties of the pandemic	<p>The member is eligible for this service when:</p> <p>A. There is a DSM-5 (or subsequent editions) diagnosis present, or the person has a condition that may be defined as a developmental disability as defined in GS 122C-3 (12a).</p>

			<p>AND</p> <p>B. Level of Care Criteria, LOCUS/CALOCUS, ASAM, or SNAP/SIS deemed eligible for services based on a documented developmental delay or disability.</p> <p>AND</p> <p>C. The member is experiencing difficulties in at least one of the following areas:</p> <ol style="list-style-type: none">1. Has financial concerns, but is unsure what resources may be available.2. Has unmet, identified, needs from multiple agencies.3. Needs advocacy and service coordination to direct service provisions from multiple agencies.
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3. Treatment Program Philosophy, Goals and Objectives:

The program is expected to help maintain members in the community and reduce the need for crisis intervention or higher level care. The service is expected to be delivered in a flexible manner to meet the identified needs of the members. Objectives for each member will be individualized but may include maintenance activities when they are not able to participate in their typical facility-based programs, linkage to appropriate services, providing supports to maintain in the community and prevent avoidable crisis events. While the objective is to connect the member to treatment services where this is necessary, in circumstances where those treatment services are not available due to the pandemic the goal is to provide individualized supports to the member to ensure behavioral stability and assess any social determinant of health needs and link members to supports that can help address these such as food, medication, technology for communication.

Recipients must have Medicaid and be unable to participate in their standard program/facility due to the pandemic. Once the state of emergency is rescinded, this definition is not used.

Expected Outcomes:

- a. Decrease in the frequency/ need for crisis intervention (use of ED, Mobile Crisis, and Facility Based Crisis)
- b. Connection to supports that are able to assist in meeting the identified needs which may be beyond the MH/IDD/SUD treatment system such as food, shelter, supplies
- c. Maintenance of skills that have been developed through more intensive treatment programs.
- d. Connection to unemployment, or other necessary resources

4. Staffing Qualifications, Credentialing Process, and Levels of Supervision Administrative and Clinical) Required:

Training:

Staff will have the same training as the service this is being utilized in lieu of, allowing for any flexibility that is given for training modifications through Federal or State guidance resulting from the pandemic

Supervision:

Supervision should be provided at the intensity required based on the level of staff providing the treatment and intervention, following the providers established policies for supervision of staff, and staff written supervision plans where these are required.

5. Unit of Service: 1 unit = 15 minutes

6. **Anticipated Units of Service per Person:** 36 to 240 units per person. This is a broad estimate as it is currently unknown as to the length of time members will not have access to the typical service array due to the pandemic
7. **Targeted Length of Service:** 2 to 3 months- this is an estimate based on current available information, but may require to be extended longer based on the pandemic and length of time before programs can resume normal service operations.
9. **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.**

Alliance Health's members are in need services that can replace those facility based or face to face services that are unable to be delivered due to special circumstances such as a pandemic. This service was developed to be extremely flexible so that individualized support can be provided to members through a variety of methods, to best support them. This is not designed to replace clinical services that can continue to be provided via alternative means such as tele-health, but to provide an additional layer of support to members receiving those services, particularly when it may be difficult for members to be able to be active in the community and may need to be homebound do to the special circumstances being experienced.

Service Exclusions

This service may not be provided to members linked with enhanced services when these services are actively being provided. The maximum per day is 20 units (5 hours). There is no specific weekly maximum, but the records must clearly support the frequency of service that was provided inclusive of the clinical rationale.

Description of Process for Reporting Encounter Data (include record type, codes to be used, etc.):

Providers will submit 1 unit per 15-minute unit, under the code of T1016-CR. Post-services reviews will be connected as necessary, and frequency of utilization monitoring to identify any patterns of over utilization.
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Providers will maintain a minimum standard of a service note/service grid for IDD for each contact, service event, or intervention.

Description of Monitoring Activities :

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

The LME/MCO will monitor service utilization through prior authorizations, utilization management, and utilization reviews.

Documentation Requirements

A full service note/service grid for IDD providers, for each contact or intervention (such as individual session, case management, crisis response) for each date of service, written and signed by the person(s) who provided the service will contain the following information: recipients name, service record number, Medicaid identification number if applicable, service provided, date of service, place of service, type of contact (face to face, telephone call, collateral), purpose of contact, providers interventions, time spent providing interventions, description of effectiveness of intervention, and signature and credentials of the staff member(s) providing the service.

Beginning at the time of admission, all interventions/activities regarding discharge planning and transition with member, family/caregiver, and team will be documented.

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

Records should support the intensity of contacts needed, and the appropriateness of treatment delivery method. Ex. If all contact is done via phone, are there limitations to tele-health service provision, etc.