EXHIBIT 2

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF NORTH CAROLINA
Southern Division

Civ. No. 7:08-CV-57-H

DEVON TYLER MCCARTNEY, a minor child, by his mother Penny McCartney, ERIC CROMARTIE, a minor child, by his mother Selena McMillan, and KATIE TIPTON, a minor child, by her father Greg Tipton, individually and on behalf of all others similarly situated, Plaintiffs, v. DEMPSEY BENTON, Secretary, North Carolina Department of Health and Human Services, in his official capacity, Defendant.	**AFFIDAVIT OF TARA LARSON**

I, Tara Larson, having been duly sworn, depose and state that:

1. I am a citizen and resident of Beaufort County, North Carolina. However, I live in Wake County due to my employment. I have personal knowledge of the matters stated herein.

2. I am the Chief Clinical Operating Officer for the North Carolina Division of Medical Assistance ("DMA"). I have held this position since May 1, 2008. Prior to that position, I was Acting Deputy Director of Clinical Policies and Programs for DMA since October, 2007. Prior to that position, I was Assistant Director of Clinical Policy and Programs for DMA since January, 2006.

3. As part of my duties, I am responsible for supervising DMA clinical staff and vendors, including ValueOptions, the behavioral health utilization review contractor for DMA. As Acting Deputy Director of Clinical Policies and Programs and Assistant Director of Clinical Policy, I was responsible for publication and implementation of all Medicaid clinical coverage policies, including the policies for Community Support – Adults, Community Support – Children, and the Community Alternatives Program.

4. Community Support Services ("CSS"), which are psychoeducational and supportive in nature, are intended to meet the mental health and/ or substance abuse needs of adults, children and adolescents who have significant functional impairments that seriously interfere with or impede their roles or functioning in family, school, or community. CSS is a type of enhanced mental health and/or substance abuse service. The definition for this service is found in DMA Clinical Coverage Policy No. 8A, Attachment A hereto, promulgated pursuant to the requirements set forth in N.C.G.S. §108A-54.2. Pursuant to these policy definitions, a Medicaid provider of mental health services must obtain prior authorization to provide CSS to recipients. The authorization period for CSS is a maximum of ninety (90) days.

5. A Medicaid recipient is eligible for CSS when: (A) a significant impairment is documented in at least two of the life domains related to the recipient's diagnosis that impedes the use of the skills necessary for independent functioning in the community; and (B) there is an Axis I or II MH/SA diagnosis as defined by the DSM-IV-TR or its successors, other than a sole diagnosis of Developmental Disability; and (C) for recipients with a substance abuse diagnosis, American Society for Addiction Medicine (ASAM) criteria are met; and (D) the recipient is experiencing difficulties in at least two of six criteria set forth in the service definition, as evidenced by documentation of symptoms; and (E) there is no evidence to support that alternative interventions would be equally or more effective based on generally accepted North Carolina community practice standards (e.g., American Society for Addiction Medicine, American Psychiatric Association) as available.

6. In order to facilitate a request for the initial authorization for CSS, a signed Person Centered Plan and the required authorization request form must be submitted to the Medicaid-approved vendor, which at all times relevant to this litigation has been ValueOptions, Inc. Relevant diagnostic information must be obtained to complete the Person Centered Plan. Services are based upon a finding of medical necessity, must be directly related to the recipient's diagnostic and clinical needs, and are expected to achieve the specific rehabilitative goals specified in the individual's Person Centered Plan. Medical necessity is determined by generally accepted North Carolina community practice standards as verified by independent Medicaid consultants.

7. If continued CSS are needed at the end of the initial authorization period, the Person Centered Plan and a new request for authorization reflecting the appropriate level of care and service must be submitted to the Medicaid-approved vendor for Medicaid services, or to the Local Management Entity for State-funded services. This should occur prior to the expiration of the initial authorization. There is no right to continued services at the expiration of the initial authorization. Services are authorized for discrete ninety (90) day periods based on current medical necessity criteria.

8. North Carolina Medicaid authorizes payment for services at the existing level of care pending the outcome of a timely filed appeal, either at the informal (DHHS Hearing Office) or formal (Office of Administrative Hearings) level, pursuant to 10A

NCAC 22H .0104. Whenever a service is authorized for a discrete time period, such as the ninety (90) day CSS authorization period or the one-year CAP authorization period, there is no "existing level of care" that must be continued. However, DMA has engaged in a voluntary practice of authorizing services at the previous authorization period's level of care pending the outcome of a timely filed appeal.

9. In the course of my regular employment and as part of my regular duties, I caused a search to be made of the paid claims and authorization of services history for Plaintiff Devon Tyler McCartney for the period January 2008 through May 2008. Plaintiff McCartney was approved to receive 120 units of CSS for April 2, 2008 through May 17, 2008. A unit equals fifteen minutes. The paid claims history for CSS billed by Plaintiff McCartney's CSS provider, Primary Health Choice, shows that neither Primary Health Choice, nor any other CSS provider, has billed Medicaid for CSS services for the approved prior authorization period of April 2, 2008 through May 17, 2008.

10. Since March 6, 2008, ValueOptions has not received any further requests for CSS from Plaintiff McCartney's case manager or any other provider on behalf of Plaintiff McCartney. He is not currently authorized to receive CSS because no request for CSS has been submitted to ValueOptions. Further, according to the Department's records, no appeal has been filed, either at the Department's Hearing Office or at the Office of Administrative Hearings, by Plaintiff McCartney or his parent, legal guardian or representative concerning the prior authorization for CSS through May 17, 2008.

11. In the course of my regular employment and as part of my regular duties, I caused a search to be made of the paid claims and authorization of services history for Plaintiff Eric Cromartie for the period March 2008 through May 2008. Plaintiff Cromartie has been approved to receive 1,092 units of CSS for the period March 19, 2008 through June 17, 2008, and was approved to receive 1,092 units of CSS for the period June 18, 2008 through September 15, 2008. The paid claims history for CSS billed by Cromartie's CSS provider, Direct Care Behavioral Services, shows that Direct Care has billed NC Medicaid for services rendered in March, April and May 2008. This authorization will be renewed periodically until there is a resolution of the appeal. Plaintiff Cromartie is continuing to receive the CSS services he requested pending the outcome of his appeal filed at the Office of Administrative Hearings.

12. In the course of my regular employment and as part of my regular duties, I caused a search to be made of the paid claims and authorization of services history for Plaintiff Katie Tipton for the period May 2008 through the present. Plaintiff Tipton is a Community Alternatives Program ("CAP") waiver recipient subject to a Continued Need Review ("CNR") every year, at which time her needs are evaluated and her requested services for the year are approved or denied. According to DMA's records, Katie Tipton's case manager submitted a request on March 8, 2008 seeking prior approval for the year beginning April 1, 2008 for the same level of care as the previous year. This included Home and Community Supports ("HCS"), Enhanced Respite ("ER") and Enhanced Personal Care Services ("PCS"). ValueOptions denied this request for prior approval on May 6, 2008. On the same date, Plaintiff Tipton was authorized to continue

to receive medical services at the same level she received for the year ending March 31, 2008 pending the outcome of her appeal filed at the Department's Hearing Office. This authorization was renewed on July 1, 2008 and will be renewed monthly until there is a resolution of the appeal.

13. The paid claims history for services billed by Plaintiff Tipton's provider, Team Daniel, shows that for the month of May 2008, Team Daniel billed Medicaid six hours per day for Home and Community Support Services, Code H2015; two to six hours per day of Enhanced Personal Care Services, Code T1019; and two to ten hours per day periodically for Enhanced Respite Services, Code T1005. Plaintiff Tipton is continuing to receive the services she requested pending the outcome of her informal appeal.

14. In the course of my regular employment and as part of my regular duties, I caused a search to be made of the Department's Hearing Office records for requests for reconsideration review filed by Plaintiff Katie Tipton concerning the ValueOptions May 6, 2008 denial. Attachment B is documentation from the Hearing Office showing that a request for reconsideration was timely filed by Greg Tipton on May 12, 2008. A hearing will be scheduled in due course and Plaintiff Tipton will continue to receive the services she requested pending the outcome of that appeal.

15. The Secretary of the Department of Health and Human Services does not make the final agency decision in contested cases filed at the Office of Administrative Hearings concerning actions taken by DMA. That duty has been delegated by the Secretary to the Director of the Division of Medical Assistance. Decisions made by the Department's Hearing Office automatically become final agency decisions if they are not appealed to the Office of Administrative Hearings within sixty (60) days of the date of the decision.

16. I am custodian of the above-named documents and certify that they are true and accurate copies of the documents in my possession.

I certify that I have read the foregoing Affidavit, and that the same is true to the best of my knowledge.

This the 1st day of July, 2008.

Tara Larson

STATE OF NORTH CAROLINA
COUNTY OF WAKE
Sworn to and subscribed before me this the 1st day of July, 2008.

Sandra Reaves
Notary Public

My Commission Expires: 11-16-09

Division of Medical Assistance
Enhanced Mental Health and Substance Abuse Services

Clinical Coverage Policy No.: 8A
Original Effective Date: July 1, 1989
Revised Date: February 1, 2008
Effective March 1, 2008

Table of Contents

Community Support – Children/Adolescents (MH/SA)
Medicaid Billable Service

Service Definition and Required Components

Community Support services are services and supports necessary to assist youth 3 through 17 years of age (20 years old or younger for children enrolled in Medicaid) and their caregivers in the youth's mental health and/or substance abuse rehabilitative and recovery goals. This medically necessary service directly addresses the recipient's diagnostic and clinical needs, which are evidenced by the presence of a diagnosable mental, behavioral, and/or emotional disturbance (as defined by the DSM-IV-TR and its successors), with symptoms and effects documented in the Person Centered Plan. [See **Section 2.2., EPSDT Special Provision,** in this policy (Clinical Coverage Policy 8A, *Enhanced Mental Health and Substance Abuse Services*).]

Community Support services, which are psychoeducational and supportive in nature, are intended to meet the mental health and/or substance abuse needs of children and adolescents who have significant functional impairment that seriously interferes with or impedes their roles or functioning in family, school, or community. The service is designed to

- increase skills to address the complex mental health and/or substance abuse needs of children and adolescents who have significant functional deficits in order to promote symptom reduction and improve age-appropriate functioning in their daily environments, and
- assist the child/youth and family in gaining access to and coordinating necessary services to promote clinical stability and support the emotional and functional growth and development of the child.

The rehabilitative service activities of Community Support consist of a variety of interventions that must directly relate to the recipient's diagnostic and clinical needs as reflected in a comprehensive clinical assessment and outlined in the Person Centered Plan. These shall include the following, as clinically indicated:

- One-on-one interventions with the recipient, unless a group intervention is deemed more efficacious, to develop interpersonal and community relational skills, including adaptation to home, school, work, and other natural environments
- Therapeutic mentoring that directly increases the acquisition of skills needed to accomplish the goals of the Person Centered Plan
- Symptom monitoring
- Self-management of symptoms
- Medication monitoring, with documented communication to prescribing physician(s)
- Direct preventive and therapeutic interventions that will assist with skill building
- Assistance with skill enhancement or acquisition
- Relapse prevention and disease management strategies
- Psychoeducation and training of family, unpaid caregivers, and others who have a legitimate role in addressing the needs identified in the Person Centered Plan
- Support for ongoing treatment and encouraging the achievement of functional gains
- Case management for the effective coordination of clinical services, natural and community supports for the child/youth and his or her family

The service includes providing "first responder" crisis response on a 24/7/365 basis to recipients experiencing a crisis.

In partnership with the family and/or the legally responsible person, the Qualified Professional is responsible for convening the Child and Family Team. The Child and Family Team is the vehicle for the Person Centered Planning process. The Qualified Professional consults with identified medical and non-medical providers, and engages community and natural supports and includes their input in the Person Centered Planning process. The Qualified Professional is responsible for monitoring and documenting the status of the recipient's progress and the effectiveness of the strategies and interventions with the Child and Family Team as outlined in the Person Centered Plan.

The Community Support Qualified Professional provides and oversees case management to arrange, link, monitor, and/or integrate multiple services. Case management includes assessment and reassessment of the recipient's need for services. The Community Support Qualified Professional provides coordination of movement across levels of care, both by interacting directly with the person and his or her family and by coordinating discharge planning and community re-entry following hospitalization, residential services, and other levels of care.

Community Support staff also inform the recipient about benefits, community resources, and services; assist the recipient in accessing benefits and services; arrange for the recipient to receive benefits and services; and monitor the provision of services. The provider organization assumes the roles of advocate, broker, coordinator, and monitor of the service delivery system on behalf of the recipient.

For Medicaid-funded services, a personally signed service order for Community Support services must be completed by a physician, licensed psychologist, physician's assistant, or nurse practitioner according to his or her scope of practice, along with other documentation requirements outlined in this policy. The service order must be based on an individualized assessment of the recipient's needs. For State-funded services, it is recommended that a service order be completed within the first visit.

Provider Requirements

Community Support services must be delivered by practitioners who are employed by mental health or substance abuse provider organizations that

- meet the provider qualification policies, procedures, and standards established by the Division of Medical Assistance (DMA);
- meet the provider qualification policies, procedures, and standards established by the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (MH/DD/SAS); and
- fulfill the requirements of 10A NCAC 27G.

These policies and procedures set forth the administrative, financial, clinical, quality improvement, and information services infrastructure necessary to provide services. Provider organizations must demonstrate that they meet these standards by being endorsed by the Local Management Entity (LME). Additionally, within three years of enrollment as a provider, the organization must have achieved national accreditation with at least one of the designated accrediting agencies. The organization must be established as a legally constituted entity capable of meeting all of the requirements of the Provider Endorsement, Medicaid Enrollment Agreement, Medicaid Bulletins, and service implementation standards. This includes national accreditation within the prescribed timeframe.

The Community Support provider organization is identified in each Person Centered Plan. For Medicaid services, the organization is responsible for obtaining authorization from the Medicaid-approved vendor for medically necessary services identified in the Person Centered Plan. For State-funded services, the organization is responsible for obtaining authorization from the Local Management Entity for the

medically necessary services identified by the Person Centered Plan. The Community Support provider organization must comply with all applicable federal, state, and DHHS requirements. This includes, but is not limited to, DHHS Statutes, Rule, Policy, Implementation Updates, Medicaid Bulletins, and other published instruction.

Staffing Requirements

Persons who meet the requirements specified (10A NCAC 27G.0104) for Qualified Professional (QP), Associate Professional (AP), and Paraprofessional status, and who have the knowledge, skills, and abilities required by the population and age to be served, may deliver Community Support. Qualified Professionals shall develop and coordinate the Person Centered Plan. Associate Professionals and Paraprofessionals will deliver Community Support services to directly address the recipient's diagnostic and clinical needs under the direction of the Qualified Professional.

All Associate Professionals and Paraprofessionals providing Community Support must be supervised by a Qualified Professional. Supervision must be provided according to supervision requirements specified in 10A NCAC 27G.0204 and according to licensure or certification requirements of the appropriate discipline.

A Certified Clinical Supervisor (CCS) or Licensed Clinical Addiction Specialist (LCAS) may also deliver and supervise Community Support as a Qualified Professional.

The following chart sets forth the activities that may be performed by a Qualified Professional, Certified Clinical Supervisor, Licensed Clinical Addiction Specialist, Associate Professional, or Paraprofessional. These activities reflect the appropriate scope of practice for these individuals.

Community Support	
Qualified Professional **Certified Clinical Supervisor** **Licensed Clinical Addiction Specialist**	**Associate Professional** **Paraprofessional (under the supervision of the Qualified Professional)**

• Coordination and oversight of initial and ongoing assessment activities
• Ensuring linkage to the most clinically appropriate and effective services
• Convening the Child and Family Team, including the recipient, family, and people identified as important in the recipient's life, for Person Centered Planning
• Initial development and ongoing revision of Person Centered Plan
• Monitoring the implementation of the Person Centered Plan, including involvement of other medical and non-medical providers, the recipient and family, and natural and community supports
• Supportive counseling to address the diagnostic and clinical needs of the recipient
• Case management functions to arrange, link, monitor, and/or integrate multiple services and referrals
• Coordination with the recipient's medical home (e.g., primary care physician)
• Monitoring of activities provided by Associate and Paraprofessional staff providing Community Support
• Provision of all activities, functions, and interventions of the Community Support service definition
	• Assistance with therapeutic interventions to rehabilitate
	  ○ Functional skills
	  ○ Daily and community living skills
	  ○ Adaptation, socialization, relational, and coping skills
	  ○ Self-management of symptoms
	  ○ Behavior and anger management skills
	• Therapeutic mentoring that directly increases the acquisition of skills needed to accomplish the goals of the Person Centered Plan
	• Psychoeducation and training of family, unpaid caregivers, and others who have a legitimate role in addressing the needs identified in the Person Centered Plan
	• Direct preventive and therapeutic interventions that will assist with skill building
	• Relapse prevention and disease management strategies
	• Ongoing symptom monitoring and management
	• Ongoing medication monitoring with report to medical providers
	• Service coordination activities within the established Person Centered Plan
	• Input into the Person Centered Plan modifications

All staff must complete a minimum of 20 hours of training specific to the required rehabilitative service activities and all other components of the Community Support service definition, including crisis response, within the first 90 days of employment.

Family members or legally responsible persons of the recipient may not provide these services for reimbursement.

Service Type/Setting
Community Support is a direct and indirect periodic service in which the Community Support staff member provides direct intervention and also arranges, coordinates, and monitors services on behalf of the recipient. Community Support services may be provided to an individual or a group of individuals.

Community Support providers must have the ability to deliver services in various environments, such as homes, schools, detention centers and jails (State funds only),* homeless shelters, street locations, and other community settings.

Community Support also includes telephone time with the individual recipient and collateral contact with persons who assist the recipient in meeting his or her rehabilitation goals. Community Support includes activities and meetings for the planning, development, and revision of the recipient's Person Centered Plan.

When children are inpatients in an Institution for Mental Diseases (IMD), the Qualified Professional may provide 8 units per month of the case management component of this service in order to facilitate transition to community services. This component may not be duplicative of hospital discharge planning.

***Note:** For all services, federal Medicaid regulations will deny Medicaid payment for services delivered to inmates of public correctional institutions (detention centers, youth correctional facilities, jails).

Program Requirements

Caseload size for a Community Support Qualified Professional may not exceed 1 Qualified Professional to 15 recipients. (Note: in computing caseload ratios, a recipient receiving fewer than 4 hours of service per week may be counted as half a recipient). Community Support services may be provided to groups of individuals, but groups may not exceed 8 individuals.

For each authorization period (90 days or less, depending on authorization), a minimum of 15% of the total billable community support services provided per recipient must be provided by the Qualified Professional. This is to ensure that medically appropriate clinical interventions are provided based on implementation/revision of the required Person Centered Plan. For each endorsed provider site, a minimum of 25% of the total aggregate billable Community Support services per month will be provided by all Qualified Professionals providing the service.

Program services are primarily delivered face-to-face with the recipient and in locations outside the agency's facility. The aggregate services that have been delivered by the endorsed provider site will be assessed and documented annually by each endorsed provider site using the following quality assurance benchmarks:

- all youth receiving Community Support must receive a minimum of two contacts per month, with one contact occurring face-to-face with the recipient;
- a minimum of 60% of Community Support services that are delivered must be performed face-to-face with recipients; and
- a minimum of 60% of staff time must be spent working outside of the agency's facility, with or on behalf of recipients.

Entrance Criteria

The recipient is eligible for this service when:

A. significant impairment is documented in at least two of the life domains related to the recipient's diagnosis that impedes the use of the skills necessary for independent functioning in the community. These life domains are as follows: emotional, social, safety, medical/health, educational/vocational, and legal.

AND

B. there is an Axis I or II MH/SA diagnosis (as defined by the DSM-IV-TR or its successors), other than a sole diagnosis of Developmental Disability

AND

C. for recipients with a substance abuse diagnosis, American Society for Addiction Medicine (ASAM) criteria are met

AND

D. the recipient is experiencing difficulties in at least **two** of the following areas as evidenced by documentation of symptoms:

1. is previously or imminently at risk for institutionalization, hospitalization, or placement outside the recipient's natural living environment
2. is receiving or needs crisis intervention services or Intensive In-Home services
3. has unmet identified needs related to MH/SA diagnosis as reported from multiple agencies, needs advocacy, and service coordination as defined by the Child and Family Team
4. is abused or neglected as substantiated by DSS, or is found in need of services by DSS, or meets dependency as defined by DSS criteria (GS 7B101)
5. exhibits intense verbal aggression, as well as limited physical aggression, to self or others, due to symptoms associated with diagnosis, which is sufficient to create functional problems in the home, community, school, job, etc.
6. is in active recovery from substance abuse or dependency and is in need of continuing relapse prevention support

AND

E. there is no evidence to support that alternative interventions would be equally or more effective based on generally accepted North Carolina community practice standards (e.g., Best Practice Guidelines per the American Academy of Child and Adolescent Psychiatry, American Psychiatric Association, American Society of Addiction Medicine).

Entrance Process

Medicaid covers up to 8 unmanaged Qualified Professional hours to collect information, convene the Child and Family Team in partnership with the family, and develop the required Person Centered Plan. These unmanaged visits are only for recipients new to the service system and not new to the provider. If the recipient has been receiving a Medicaid-funded MH/SA service previously, prior authorization is required from point of entry. For State-funded Community Support services, prior authorization by the Local Management Entity is required. When authorization is approved, the Qualified Professional will collect information, convene the Child and Family Team in partnership with the family, and develop the required Person Centered Plan.

Relevant diagnostic information must be obtained to complete the Person Centered Plan. This requirement may be fulfilled through the completion of any comprehensive clinical assessment service. If a substantially equivalent assessment is available that 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, state, and DHHS requirements, it may be utilized as a part of the current comprehensive clinical assessment.

For Medicaid, in order to facilitate a request for the initial authorization, the required Person Centered Plan with signatures and the required authorization request form must be submitted to the Medicaid-approved vendor.

For State-funded Community Support, in order to facilitate a request for the initial authorization, a required Person Centered Plan with signatures, the required authorization request form, and the Consumer Admission Form must be submitted to the Local Management Entity.

During the 8 unmanaged hours, or at any point while the child is receiving Community Support, the Qualified Professional shall link the recipient to an alternative service if an equally or more effective service is clinically indicated and functionally appropriate to the needs of the child. A full service note is required to document the activities that led to the referral.

Continued Stay Criteria

The desired outcome or level of functioning has not been restored, improved, or sustained over the time frame outlined in the recipient's Person Centered Plan; or the recipient continues to be at risk for relapse based on current clinical assessment, history, and the tenuous nature of the functional gains;
AND
One of the following applies:

A. Recipient has achieved current Person Centered Plan goals and additional goals are indicated as evidenced by documented symptoms.
B. Recipient 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 Person Centered Plan.
C. Recipient is making some progress, but the specific interventions in the Person Centered Plan need to be modified so that greater gains, which are consistent with the recipient's premorbid level of functioning, are possible or can be achieved.
D. Recipient fails to make progress and/or demonstrates regression in meeting goals through the strategies outlined in the Person Centered Plan. The recipient's diagnosis should be reassessed to identify any unrecognized co-occurring disorders, with treatment recommendations revised based on findings.

Discharge Criteria

Any one of the following applies:

A. Recipient's level of functioning has improved with respect to the goals outlined in the Person Centered Plan, inclusive of a transition plan to step down.
B. Recipient has achieved goals and is no longer in need of Community Support services.
C. Recipient is not making progress or is regressing and all reasonable clinical strategies and interventions have been exhausted, indicating a need for more intensive services.
D. Recipient or family/legally responsible guardian no longer wishes to receive Community Support services.
E. Recipient, based on presentation and failure to show improvement despite modifications in the Person Centered Plan, requires a more appropriate best practice treatment modality based on North Carolina community practice standards (e.g., the American Academy of Child and Adolescent Psychiatry and the American Psychiatric Association Practice Guidelines, American Society of Addiction Medicine).

Note: Any denial, reduction, suspension, or termination of service requires notification to the recipient and/or legal guardian about their appeal rights in accordance with the Department's recipient notices procedure.

Expected Clinical Outcomes
The expected clinical outcomes for this service are specific to recommendations resulting from clinical assessments and meeting the identified goals in the recipient's Person Centered Plan.

Expected clinical outcomes may include:
- Symptom reduction
- Maintain recovery
- Improve and sustain developmentally appropriate functioning in specified life domains
- Increase coping skills and social skills that mediate life stresses resulting from the recipient's diagnostic and clinical needs
- Minimize the negative effects of psychiatric symptoms and/or substance dependence that interfere with the recipient's daily living
- Uses natural and social supports
- Utilize functional skills to live independently
- Develop and utilize strategies and supportive interventions to maintain a stable living arrangement and avoid of out-of-home placement

Documentation Requirements
The minimum standard is a daily full service note written and signed by the person who provided the service that includes:
- Recipient's name
- Medicaid identification number
- Service provided (e.g., Community Support–Individual or Community Support–Group)
- Date of service
- Place of service
- Type of contact (face-to-face, phone call, collateral)
- Purpose of the contact
- Description of the provider's interventions
- Amount of time spent performing the interventions
- Description of the effectiveness of the interventions
- Signature and credentials of the staff member(s) providing the service (for paraprofessionals, position is required in lieu of credentials with staff signature)

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

Utilization Management
Services are based upon a finding of medical necessity, must be directly related to the recipient's diagnostic and clinical needs, and are expected to achieve the specific rehabilitative goals specified in the individual's Person Centered Plan. Medical necessity is determined by generally accepted North Carolina community practice standards as verified by independent Medicaid consultants, or the Local Management Entity for State-funded services.

If the needed medical information is not yet completed when the initial prior authorization request is submitted, the appointment date(s) and historical clinical information should be included. Interim prior authorizations with variable timelines for resubmission will occur to ensure the delivery of needed services.

Typically, the medically necessary service must be generally recognized as an accepted method of medical practice or treatment. Each case is reviewed individually to determine if the requested service meets the criteria outlined under EPSDT.

Medically necessary service is authorized in the most economic mode, as long as the treatment that is made available is similarly efficacious to services requested by the recipient's physician, therapist or other licensed practitioner.

For Medicaid, authorization by the Medicaid-approved vendor is required.

For State-funded Community Support services, authorization by the Local Management Entity is required prior to the first visit. The Medicaid-approved vendor or the Local Management Entity will evaluate the request to determine if medical necessity supports more or less intensive services.

Units are billed in 15-minute increments and must include the modifier to denote level of staff providing the service.

Medicaid covers up to 780 units for a 90-day period, based on the medical necessity documented in the required Person Centered Plan, the Medicaid vendor's authorization request form, and supporting documentation. Community Support services are not intended to remain at this level of intensity long term. If the initial benefit of 780 units is expended before the end of the 90-day period, a required Person Centered Plan and a new request for authorization must be submitted to the Medicaid-approved vendor to request additional units and/or equally or more effective clinically and developmentally appropriate alternative services.

For State-funded services, the Local Management Entity will determine the initial authorization period. A required Person Centered Plan, a request for authorization, and supporting documentation reflecting the appropriate level of care and service must be submitted to the Local Management Entity.

Additional units may be authorized on a time-limited basis to allow time for the Qualified Professional to coordinate for alternative services.

If continued Community Support services are needed at the end of the initial authorization period, the required Person Centered Plan and a new request for authorization reflecting the appropriate level of care and service must be submitted to the Medicaid-approved vendor for Medicaid services, or to the Local Management Entity for State-funded services. This should occur prior to the expiration of the initial authorization.

No additional Community Support services may be requested without a required Person Centered Plan with signatures and the Medicaid vendor's authorization form.

Service Exclusions/Limitations
An individual may receive Community Support services from only one Community Support provider organization at a time.

For the purposes of facilitating an admission to a service, making a transition to or from a service, ensuring that the service provider works directly with the Community Support Qualified Professional, and/or discharge planning, Community Support–Individual services may be billed for a maximum of 8 units per 30-day period for individuals who are authorized to receive one of the following services during the same authorization period:

- Child and adolescent day treatment
- Intensive in-home services*
- Multisystemic therapy*
- Partial hospitalization
- Substance abuse intensive outpatient treatment*
- Levels II through IV child residential treatment
- Substance abuse residential services
- PRTF
- Inpatient services

Note: For recipients under the age of 21, additional products, services, or procedures may be requested even if they do not appear in the N.C. State Plan or when coverage is limited to those over 21 years of age. Service limitations on scope, amount, or frequency described in the coverage policy may not apply if the product, service, or procedure is medically necessary.

***Provider of these services is responsible for the Person Centered Plan and all other clinical home responsibilities.**

ATTACHMENT B

May 6, 2008

Hearing Office
DHHS
2501 Mail Service Center
Raleigh, NC 27699-2501
FAX NUMBER: 919-715-6394

INFORMAL APPEAL REQUEST FORM

To ask for an **informal appeal**, please complete this form and send it by mail or fax to the address or fax number in the box above. Also, include a copy of the Notice of Change or Denial you want to appeal. Keep a copy of the notice and this completed form for your records. This **form must be received no later than 11 days from date of the attached notice.**

Katie A Tipton (MID # 946394236K)
400 Ciccone Dr
Hendersonvil, NC 28791

I would like to appeal the denial of Home and Community Supports, Enhanced Personal Care Services, and Enhanced Respite. Check which type of hearing you want.

☑ Telephone hearing with the DHHS Hearing Officer using the telephone number listed below.
☐ In-person hearing in Raleigh, North Carolina with the DHHS Hearing Officer.

Katie Tipton 5-12-08
Signature of Medicaid Recipient or Responsible Party Date

Gregory Tipton
Print Name That Appears on Line Above (Clearly)

Relationship to Recipient Father
Telephone Number (with area code): (828) 697-7647
Address (if different than above)