

Enrollment

* For further questions about enrollment, contact CSC toll free at 1-866-844-1113 or DMA Provider Services at 919-855-4050

1. I am an individual practice but did not enroll as a group – getting paid via NC Medicaid almost 10 years. Do I now have to enroll as a group?

If you have previously been enrolled in Medicaid as an individual practice, you do not have to obtain a group number. If you are newly enrolling you must obtain both an individual and a group number, whether you are enrolling as a solo practice or as a group practice. See the Provider Qualifications and Requirements Checklist on the NC Tracks website <http://www.nctracks.nc.gov> to determine who can enroll in Medicaid and what the qualifications and requirements are for enrollment. Or contact CSC toll free at 1-866-844-1113.
2. Why can't certified nurse practitioners bill for Med Management? Medicaid said they can't be linked to our Medicaid provider number.

DMA enrolls NP's as type 085Nurse Practitioner/ specialty 061CRNA or NP. Nurse Practitioners can be linked to Nurse Practitioner groups and Physician Group practices.
3. I started working at a CABHA agency. I applied to be a Medicaid provider a few weeks before that. I still have not received a Medicaid number. Will I be able to go back and bill for services I have provided so far?

Without being enrolled as a Medicaid provider, there is not a way to obtain authorizations or bill for services. **At their own risk**, providers can begin providing medically necessary services once they have submitted their Medicaid enrollment application, but have not yet received their Medicaid number. On their enrollment application they need to list a date for enrollment to begin, otherwise CSC will choose the date the application was received. Once they receive their MPN, they can submit requests for authorization to the UR vendor for dates with a start date for the authorization that must not be before the effective date of the enrollment number. That request should also contain the enrollment letter with enrollment date from CSC. They do run the risk that the UR vendor may not approve the services as medically necessary. Once they receive the authorization (but not before) they will be able to bill for the service.
4. For individual practitioners who have an individual number and need a group number, do we apply to NC TRACKS or to the LME?

Presently for most areas of the state you would enroll with NC Medicaid -- to enroll as a group Medicaid provider visit <http://www.nctracks.nc.gov> and select the link Provider Enrollment. Once your area is gone under the 1915 b/c waivers, you would enroll with the LME/MCO. See <http://www.ncdhhs.gov/dma/lme/MHWaiver.htm> for more information.
5. Does a physician, when billing 'incident to' have to be linked with the outpatient group number or do you have to create a physician group?

To determine provider type visit <http://www.nctracks.nc.gov>. Select the Provider Enrollment link and select the download Provider enrollment application link and see Determine Provider

Type. Or contact CSC toll free at 1-866-844-1113. Physicians can be linked to a multi-specialty group practice and can be linked to a specialty-specific group practice.

6. How do we protect our Medicaid/NPI #s from further use after terminating the relationship with an agency? This is a problem for licensed clinicians who are unaware if this information is being used after they leave an agency.

To report a change visit <http://www.nctracks.nc.gov>. Select Provider Services and select Report a Change. Or contact CSC toll free at 1-866-844-1113. If an agency continues to use a licensed clinicians Medicaid or NPI #s, that is considered fraud and should be reported to DMA Program Integrity.

7. Group # -- does this mean the NPI or is it another number?

The organization/group number would be the Medicaid Provider Number (MPN) associated with the NPI.

8. How long does it take to get a Medicaid ID number after your enrollment package is officially complete?

From the NC Tracks website [at http://www.nctracks.nc.gov](http://www.nctracks.nc.gov): NC DHHS recognizes the need to promote access to care by enrolling all providers in a timely manner and is committed to ensuring the provision of quality care for our citizens. The enrollment process includes credentialing, endorsement, and licensure verification. The CSC EVC Center completes this verification to ensure that all providers meet the professional requirements and are in good standing. Once participation as a DHHS provider has been approved, providers are notified by mail and may begin submitting claims to NC DHHS for services rendered. The CSC EVC Center cannot provide special consideration for processing of enrollment applications due to provider error, incomplete information, or due to a delay in obtaining credentialing, endorsement or licensure information from another agency. Applicants must meet all program requirements and qualifications for which they are seeking enrollment before they can be enrolled as DHHS providers. Specific qualifications for each provider type are listed in the Provider Qualifications and Requirements Checklist.

9. Can a provisionally licensed professional direct enroll with Medicaid and receive a Medicaid number?

No, not at this time.

10. We are a group practice and only have a select few Medicaid providers. Do we have to have a group number as well as the individual's having their own Medicaid number?

Yes, group practices must have a group/organization number and the individuals within that group must have their own individual Medicaid numbers as well. To determine provider type visit <http://www.nctracks.nc.gov>. Select the Provider Enrollment link and select the download Provider enrollment application link and see Determine Provider Type. Also see the [Provider Qualifications and Requirements Checklist](#) on the NC Tracks to determine who can enroll in Medicaid and what the qualifications and requirements are for enrollment. See the Basic Medicaid Billing Guide for more information on group provider enrollment packets.

11. Should I enroll as a group under my name or under my agency name?
To determine provider type visit <http://www.nctracks.nc.gov>. Select the Provider Enrollment link and select the download Provider enrollment application link and see Determine Provider Type. A Group is an organization is an entity, facility, or institution that may be an affiliation of individual providers.
12. Is there a “normal” limit of the # of individuals to be in a group?
An organization (group) must have one or more individual providers affiliated.

Authorization

*For further questions about authorization, contact the appropriate UR vendor:

ValueOptions – 1-888-510-1150

The Durham Center – 877-839-0301

Eastpointe – 800-513-4002, option 2

13. How long does it take for authorization to download from ValueOptions to Medicaid to avoid denials?
The authorization should be available as soon as the determination is made. Turn around time is five days for a behavioral health service, 10 days for a CAP service, and 15 days for an EPSDT request.
14. Why can't authorizations be switched easily (and without cost) to another clinician within the same group?
This is an administrative service and therefore cost associated with this function results in a fee.
15. Retro request requires Medicaid Eligibility letter from client – many times this is not possible – can we submit DMA Eligibility page with an auth request?
Yes, if it is clear what period is covered retroactively.
16. Online auth submitted by Q?
Submissions require a valid provider number. Unless licensed, QPs cannot direct-enroll with Medicaid and thus will not have a valid number.
17. How are retro auths to be submitted? Authorization letters stating retro required?
Clients do not return with letters. Instructions are available on the UR vendor websites;
18. What is the best way for CSACs to request additional auths through VO and Provider Connect?
Question unclear; the process would be the same for all Licensed Independent Practitioners.
19. I was told by VO staff that the LME MPN would auto-populate into the ORF2 based upon consumer county of eligibility. Is this not true?

Providers must type the LME MPN into the Attending Provider Number field of the ORF2 if billing through the LME. The Attending Provider Number field does not pre-populate. As a reminder, only provisionally licensed professionals can bill through the LME with a referral from the LME.

20. Can auths be denied due to an illegible signature by a physician if his name, etc. is printed on the top of the page? Please explain.

A valid signature is required.

21. If a client has Medicaid secondary to Medicare do they still require prior authorization for visits beyond the unmanaged visits?

No.

22. Who can access auth letters online?

The provider connect account holder associated with the request.

23. What forms must be submitted for outpatient MH auths?

An ORF and a valid (signed) service order.

24. When PA is on file for SAIOP but for another provider and then comes to us, are all unmanaged visits still gone for us?

Unmanaged visits referenced in the 8C policy and in this Q&A document only apply to outpatient services, not to the enhanced services such as SAIOP.

25. When did an ORF2 become required to be submitted with Psych Testing request?

This has been required for several years.

26. On 10/13/2011, I received an email from ValueOptions regarding Federal MH Parity that went into effect 1/1/2011. It indicates the "pass through" model is replaced by an "outlier model". What exactly does this mean? It sounds like it eliminates the current authorization process, but that does not appear to be the case based on today's training.

The email referenced was sent to providers enrolled in ValueOptions' commercial network serving recipients under other contracts. The information does not pertain to providers serving North Carolina Medicaid recipients. If you provide services to the ValueOptions Commercial membership, information regarding Mental Health Parity is found at:

http://www.valueoptions.com/providers/Files/pdfs/Mental_Health_Parity_FAQ.pdf

27. Does 90801 require prior authorization (i.e. new consumer to agency who has used up unmanaged units elsewhere, but we don't know this or have all information yet to get authorization to cover this date? All CPT codes in DMA Clinical Coverage Policy 8C count towards the unmanaged visit limit. So, yes 90810 may require PA if the unmanaged visit limit has been reached. It would be advisable to seek PA if you are uncertain about unmanaged units left.

28. If you have a contract with the LME, can you use their LME number for the authorization number or use the PCP? You should use the number of the referrer—the LME or the PCP. The number indicates that the child has been referred for services.
29. Do unmanaged visits start over in January each year?
Yes, these are based on calendar year.
30. If the CCA (90801 & 96116) are required to establish care and get information needed to request authorization, is prior approval still required for these 2 codes?
If unmanaged visits have been exhausted, PA is required.
31. How does the provisionally licensed clinician enter authorization requests into Provider Connect without their own number to enter into Provider Connect?
Direction to providers on how to submit such requests is included in the ProviderConnect User Guide and ProviderConnect FAQs both of which are available on the ValueOptions website: http://www.valueoptions.com/providers/Network/North_Carolina_Medicaid.htm. The submitting provider types in the Attending Provider Name and Attending Provider Number (LME MPN or MD MPN in case of provisionals) these fields are not pre-populated. ValueOptions issues the authorization to the Attending MPN listed. Outpatient authorizations are made to the MPN(s) listed in the Attending Medicaid Provider # field. The LME MPN or the direct-enrolled physician's MPN should be listed in these situations. The MPN included on the submission will be replaced by ValueOptions with the MPN(s) listed in the Attending Medicaid Provider # field at the time of review.
32. Please explain in detail how to transition authorizations for H-codes to CPT codes when provisionally licensed therapists start billing "incident to"?
If a provisionally licensed therapist has been billing H codes through the LME but is going to begin billing 'incident to' the physician instead, the provider should submit a new authorization request asking for the relevant CPT code(s) and include the MD's MPN as the attending provider number. Assuming it meets medical necessity, authorization would be entered to the MD's MPN.
33. When completing the ORF, how many codes can you request? Many are different time increments (90812, 90810, 90814) and it is hard to anticipate which one you will need for any given session. Also, I want to request family w/child and family w/out child as needed. You should request what is clinically indicated, and request additional units as needed.
34. If you can list 3 attending providers on the ORF, why can't 1 be listed for testing? Ex. Multi-disciplinary Autism Assessments – One Psychologist does Vineland and another provides other developmental testing.
The genesis of allowing multiple MPNs on outpatient requests was to allow for "reserve therapists when clinically appropriate." The oft used scenario to illustrate this situation is group therapy in which there are co-therapists and possibly another designated back-up therapist. It allows for flexibility in case of absence for an on-going service which is typically authorized for many months. Psych testing, however, is a onetime discrete service. The

example provided indicates different providers with different roles with regard to testing, a situation which does not lend itself to the "reserve therapist" theory. Each provider should submit their own complete psych testing request online which identifies the specific tests he/she will administer and the time required for each.

35. If you have been approved for services but feel the date used for the start date is inaccurate and the vendor does not agree that date should be changed, is there a grievance or appeal process?

The start date of authorizations is determined by the date of submission and current NC Due Process guidelines. See the DMA Due Process guidelines for more details:

<http://ncdhhs.gov/dma/bulletin/DueProcessSpecialBulletin5311.pdf>

36. If a prior approval is already in place for services to another agency, can a different agency get concurrent authorization?

No, this would be a new auth according to DMA Due Process guidelines (see above).

37. What if we forget to attach something to the ORF2? If we resubmit an attachment after, will it come back as duplicate?

If you submit a second time, it will come back as a duplicate.

38. Do medication management visits get taken from auths for clinicians? Do you have to get prior authorization for a 90862 med check?

No, these are not included in the managed visits and you do not have to get prior authorization. Only physicians, PAs, and Nurse Practitioners can bill that code.

39. Do authorizations apply to individual providers? Or do they also get shared?

The authorizations apply to the attending provider noted on the ORF 2.

40. How do you submit a service order electronically?

Upload to the respective UR vendors Provider Connect.

Billing

*For further questions about billing, contact HP Enterprise Services at 1-800-688-6696

41. We see patients for testing and bill a 90801 for the hour prior to the testing for the initial assessment. Are we allowed to see them on the same day for 96101?

No. This is considered duplicative billing per the National Correction Coding Initiative (NCCI). As a result of NCCI, Assessment Codes (ex. 90801, 90802, H0001, & H0031) CANNOT be billed by the same attending provider on the same date of service as individual, group, and family therapy codes (ex. 90804 – 90808, 90847, 90849, & H0004) or other assessment or psychological or developmental testing codes (ex. 96101 & 96111). Please refer to the April 2011 Medicaid bulletin.

42. All EPSDT claims must be submitted paper claims to DMA directly? We currently have to bill Community Support Claims (H0036HA) to DMA after receiving denials from the regular claim submissions. This takes 1-2 months before claims are processed.

Yes—they do. EPSDT services are current non-covered codes. Providers do not bill DMA—they submit RAs and denied claims in order for DMA to initiate payment for non-covered services. This is the same procedure for all non-covered services at DMA. For any claim denials, please contact Medicaid Provider Services at 1-800-688-6696, Option 3.

43. How can you tell if a client is NCHC or Medicaid when they come in?

Effective 10/1/2011, all NC Health Choice recipients were issued a new ID card. If the recipient is a NC Health Choice recipient, the respective ID card will reflect the NC Health Choice logo in the upper right hand corner of the card. If Medicaid, the card will reflect Medicaid in the upper right hand corner of the ID card. Providers may also verify eligibility by utilizing one of the verification methods outlined in presentation or Appendix F of the Basic Medicaid/Health Choice Billing Guide.

44. Why are we getting denials for MDs for incorrect referring providers?

A referral is required for recipients under age 21. This referring provider number could either be a group or individual provider number. Provider should utilize the NPI associated with the MPN indicated. Providers may utilize the Community Care of North Carolina/Carolina Access (CCNC/CA) Primary Care Provider (PCP), Local Management Entity (LME), or a Medicaid Enrolled Psychiatrist. This number will also be indicated on the recipient's ID card, however, we encourage providers to verify the recipient's eligibility as the ID card is not always current and subject to change at any time. Providers may utilize one of the verification methods indicated in the presentation or Appendix F of the Basic Medicaid/NC Health Choice Billing Guide. Services provided by a physician do not require a referral.

45. What services count towards unmanaged visits?

All of the outpatient behavioral health services listed in DMA Clinical Coverage Policy 8C count towards unmanaged visits with the exception of medication management (90862 or other E/M codes).

46. Can a provider bill med management and outpatient therapy for the same client on the same date of service when the OPT therapist is provisional and billing 'incident to' a physician and the physician is the one providing med management?

As a result of NCCI, if a physician were to provide Med Management (90862) and a provisionally licensed professional billing "incident to" were to provide another outpatient service on the same date of service, the second code would deny as it would look like that same attending provider had provided the service. In this one situation, NCCI modifier 59 may be appended to CPT Codes 90801, 90802, 90846, 99408, or 99409 which will allow the system to pay both claims. The SC modifier should also be appended to indicate billing "incident to".

CPT Codes 90804, 90806, 90847, and 90853 CANNOT be overridden by appending NCCI modifiers. These codes can continue to be billed "incident to" but will need to be provided on

a separate DOS. Alternatively, if individual therapy (90804 & 90806) and Med Management are provided on the same DOS, one code (90805 or 90807) may be billed to indicate that both individual therapy and Med Management were provided. The SC modifier should also be appended to indicate billing "incident to".

Providers may look up any code pairs on the CMS website prior to rendering or billing the service to ensure whether or not those codes can be billed on the same DOS. Also refer to April 2011 Medicaid bulletin regarding NCCI and Behavioral Health services.

47. How do you submit an 837 void transaction?

Contact Medicaid ECS at 1-800-688-6696, Option 1.

48. Can Provisionally Licensed staff bill HP Medicaid by putting the LME's provider number as the attending number?

When billing through the LME, the LME's NPI number will be placed at the Billing and the Attending will be the Attending Provider for which the prior approval obtained (which may be the LME's number). If provisional is billing 'incident to' (not through the LME), the Group number will be placed at the Billing and the Attending will be the MD for which the prior approval was obtained for which the provisional is billing "incident to".

49. Is there any database (online or telephone) to use to determine the number of visits used (in system at that time) per patient (to help determine if auth is needed before the first visit or on the 3rd visit, etc.)?

There is no system check to keep track of unmanaged visits used, this is the responsibility of the provider. When in doubt, get Prior Approval.

50. How would the billing of LME by PLCSW look?

You will need to contact your LME. In general, the LME would be the billing provider and the Attending provider will be the attending for which the prior authorization was obtained (which may be the LME's number).

51. Can the Medicaid billing form online be streamlined?

At this time there are no expectations of streamlining or updating the NCECSWebtool. For any questions related to the NCECSWebtool, contact Medicaid ECS at 1-800-688-6696, Option 1 or Medicaid Provider Services at 1-800-688-6696, Option 3.

52. If we bill Medicare and they deny it and they send it on to Medicaid, can we bill the patient for the remaining copay?

Services covered by both Medicare and Medicaid are not subject to a Medicaid copayment. However, if Medicare denies the service and the provider submits the claim to Medicaid, the recipient may be responsible for the appropriate Medicaid copayment. This information can be found in the Basic Medicaid Billing Guide Section 9.

53. When billing provisional licensed providers, should we bill through Medicaid with modifiers or through the LME using H-codes?

Either. Both scenarios are essentially being billed or paid by Medicaid. Utilize the appropriate CPT code for the service rendered. The SC modifier must be appended to all CPT codes used to bill for the services of the provisionally licensed professional 'incident to' a physician. CPT codes include: 90801, 90802, 90804, 90806, 90846, 90847, 90853, 99408, and 99409. Please refer to the March 2009 Medicaid Bulletin for guidelines on billing "incident to". Provisionally Licensed Professionals billing through the LME has been extended through June 30, 2012. When billing through the LME, provider should utilize "H Codes" which include H0001, H0004, H0005, and H0031. Refer to November 2011 Medicaid Bulletin for limits on H codes for provisional's.

54. When will the self audit tools be available? Does it have to get denied before I can put the 59 modifier on the claim for "incident to"?

No. The provider may look up any code pair prior to rendering/billing those services. Providers will need to follow the steps outlined in presentation in order to verify if an NCCI associated modifier may be appended to a CPT code in order to bypass an NCCI edit. If the code pair you are billing is listed with a modifier indicator of "1", provider may append an NCCI associated modifier prior to billing or after claim has been denied.

55. What is the best way to verify county of eligibility prior to seeing the patient?

Providers may utilize any of the eligibility verification methods outlined in presentation or in Appendix F of the Basic Medicaid/NC Health Choice Billing Guide.

56. If a patient travels 2 hours to have psych testing done and does 4-6 hours of testing in one day, how do we bill for that?

There is a maximum of five units (hours) that can be billed for psychological testing on an individual date of service. Larger batteries such as neuropsychological testing may be performed, billing up to five hours a day on multiple dates of service. Therefore, the provider might bill five hours on one day and three hours on a separate date of service in order to complete a more comprehensive testing battery. If billed with more than five units (hours) on the same date of service for the same provider, the claim will deny.

57. Billing provisionally licensed through the LME – is this using Medicaid or State funds?

Although you are billing through the LME, the claim will be processed and paid under Medicaid utilizing Medicaid funds if the recipient is eligible for Medicaid. See the LME about billing for state funds.

58. We have a child we serve who has Blue Options as primary and Medicaid as secondary insurance. We have billed and been reimbursed by Blue Options then billed Medicaid and have not received reimbursement yet. What are we doing wrong in our billing Medicaid?

Medicaid is the payor of last resort. Providers should bill all commercial/private insurance and Medicare prior to billing Medicaid. For questions related to denied claims, please contact Medicaid Provider Services at 1-800-688-6696, Option 3.

59. When provisional's bill 'incident to' LME with LME's MID# and NPI#, does the provisional group # go anywhere on the billing?

The provisional will not have a group number as they are not direct enrolled.

60. Provisional's billing 'incident to' the physician, is the SC modifier required when Medicare is primary?

Medicare does not recognize provisionally licensed providers as Medicare providers. Providers should follow all Medicare rules for dual eligible service provision and billing. .

61. Is the SC modifier also required when provisional's bill through the LME?

No.

62. Can a 90806 SC and a 90862 be billed on the same date of service?

No. This is considered duplicative billing. CPT codes 90804, 90806, 90847, and 90853 can continue to be billed "incident to" but will need to be provided on a separate DOS. Alternatively, if individual therapy (90804 & 90806) and Med Management (90862) are provided on the same DOS, one code (90805 or 90807) may be billed to indicate that both individual therapy and Med Management were provided. The SC modifier should also be appended to indicate billing "incident to".

63. Carolina Access: Can we still use CA override forms if the PCP refuses to give authorization and we get an LME authorization number?

Carolina Access overrides will not be granted for Mental Health services. Providers should obtain a referral for recipients under age 21 from the Community Care of North Carolina/Carolina Access (CCNC/CA) Primary Care Provider (PCP), Local Management Entity (LME) or a Medicaid Enrolled Psychiatrist. If referral is received from the LME, the LME NPI number may be utilized as the referral number on the claim in block 17b of the CMS-1500 claim form.

64. 3 hours/units of 96101 (psych testing) = 1 unit of initial preauthorized units. Is that correct?

This seems to contradict past policy?

There is a maximum of five units (hours) that can be billed for psychological testing on an individual date of service. Larger batteries such as neuropsychological testing may be performed billing up to five hours a day on multiple dates of service. Therefore, the person might bill five hours on one day and three hours on a separate date of service in order to complete a more comprehensive testing battery.

Managed Care

*For further questions about LME/MCOs, contact DMA Behavioral Health Policy at 919-855-4290 and visit the DMA website: <http://www.ncdhhs.gov/dma/lme/MHwaiver.htm>

65. I am an LPC and enrolled with WHL and Medicaid. Why do I never receive referrals from WHL and or I am not on a list of providers?

You need to contact Western Highlands Network (WHN) directly. WHN does not begin Medicaid managed care operations until January 1, 2012, which may be why you have not received any referrals yet.

66. Since NC is going to use the LOCUS/CALOCUS instead of GAF scores – will DMA modify forms or does GAF have to be used?
Current utilization review (UR) forms will not be modified as they will be used in the parts of the state not included under managed care (1915 b waiver). The LME-MCOs will be utilizing the TAR, which will have the LOCUS/CALOCUS included. Specific training will be offered to providers by each LME-MCO.
67. If you are credentialed with one LME does it transfer to a neighboring LME?
No, each LME-MCO will need to credential and enroll all of their providers.
68. Don't you need a Medicaid number from DMA to enroll with your MCO?
No, there will be a provider number assigned specific to the LME-MCO.
69. Does 8C policy apply when I am under MCO?
Yes. All state plan services will apply.
70. Will Program Integrity or PCG still be monitoring/reviewing us when we come under the MCO? Or will only the MCO do the reviews/audits?
The LME-MCO will do reviews and audits, but will be submitting appropriate reports including fraud and abuse to DMA Program Integrity for further review and follow up.
71. Will referral number still be needed once we are under an MCO?
All 8C requirements will still apply as written in the service definition. The LME-MCOs will be doing prior authorization and approval of medically necessary services.
72. Is the enrollment application the same or different for CSC and the Waiver?
The enrollment application is standardized across LME-MCOs. It will be separate from the application to be a fee for service provider (CSC enrollment).
73. What is DMHDDSAS' role in a 1915 b/c environment?
The LME-MCOs will still have LME functions such as monitoring state funded services. DMHDDSAS will monitor those activities.
74. How will LME/MCOs know when a provider has been suspended in order to stop billing and payment of pass-through billing?
The LME-MCO will also be managing the provider network and thus would be responsible for the suspension. The LME-MCO will do all of the enrollment and monitoring of their own provider network. They would actually be the entity suspending the provider. All LME-MCOs and DMA will share information on suspended providers.
75. Can LMEs enroll/credential public agencies (such as DSS) as behavioral health providers under the waiver system?
The LME-MCOs can enroll and credential all agencies that are currently licensed and enrolled to provide behavioral health services that are covered under the waiver capitation.

76. When the MCOs take over in 2013, does that mean independent practitioners will no longer use the ECS system, but the MCOs will do all of the billing?
Yes, all billing will be submitted directly to the LME-MCO.
77. Will individual practitioners be “grandfathered in” with the switch to MCO or will they be let go after a 1 year contract? How will we qualify for contract renewal?
All practitioners in good standing will be offered a contract when the LME begins initial enrollment. Contract renewal will be dependent both on ongoing provider performance and network needs.
78. Will each MCO develop their own billing program or will we continue with the same billing program?
Each LME-MCO will be able to accept electronic claim submission from providers. Each LME is required to have a specific billing mechanism for Medicaid claims—it may be different from historic billing for state-funded services.
79. Once the Medicaid waiver takes place, will Dr. referrals/psychiatrist referrals be able to make these directly to a private provider or have to go through the LME?
Providers can always refer to one another. The LME will prior authorization services, regardless of referral. The LME will only pay for services that meet medical necessity guidelines.
80. What will happen with provisionally licensed billing once LMEs become MCOs under the 1915 b/c waiver?
81. How does an independent provider coordinate care for a client and make the LME/MCO aware?
Prior authorization, concurrent requests, and claims submissions will all be done through the LME-MCO, and thus care managers (at the LME) will be available to monitor client progress.
82. How to know my potential/future MCO?
This is available on the DMA website at <http://www.ncdhhs.gov/dma/lme/MHWaiver.htm>
83. When change over to the MCO and get re-credentialed will there be new re-credentialing fees?
Not at this time.
84. Will FQHC behavioral health providers (LCSWs) need to enroll as Medicaid providers under the LME/MCO? Or, are we carved out from this process and we continue direct billing to the State? If FQHCs are exempt, do we use VO for auths?
Currently FQHCs are exempt from inclusion under the managed care waiver. As a reminder, behavioral health providers working within an FQHC must bill the T code with HI modifier through the FQHC.

85. What provision is made for therapists that have clients with Medicaid, originating in different catchment areas in order to avoid multiple credentialing necessary with each MCO?

Each LME-MCO is at risk for their network and will need to credential and enroll all of their providers. The enrollment form will be standardized.

86. For NCHC for prior authorization, will those go through the local MCO like Medicaid or through VO?

Health Choice will continue to be authorized through VO through 2013.

87. If I work for a CABHA and also offer outpatient therapy, will I need a contract with the MCO when our LME merger goes through? Or, since I will be billing through the CABHA, will I NOT need an individual contract?

You will not require an individual contract if you ONLY bill through the CABHA. If you offer outpatient therapy independently in addition to your CABHA services, you will need to seek a Licensed Independent Practitioner contract.

88. If a patient is enrolled in a MCO county and goes to a provider who is outside the area (not enrolled in the MCO), can the patient be seen and what is the process? Also will it be obvious in eligibility screen if a client is in a MCO area?

Out of network provisions are available for recipients, but every effort will be made to provide recipients with suitable treatment within the network. Efforts are currently underway to make the recipient's county of eligibility listed in all methods for checking Medicaid eligibility. At this time, the Web Portal states county of eligibility. Please review Medicaid bulletins for further information. Contact the LME matching the recipient's county of eligibility for additional information on obtaining authorizations, billing, and enrolling as an out-of-network provider.

Program Integrity (Patrick)

*For further questions about Program Integrity, contact DMA Program Integrity at 919-647-8000.

89. How does Program Integrity interface with LMEs?

The Department of Health and Human Services has a contract with the LMEs and in the contract it outlines responsibilities for each entity to include the LME as an agent for the Division of Medical Assistance. DHHS will delegate program integrity and monitoring activities to the LME. See

<http://www.ncdhhs.gov/mhddsas/statspublications/Contracts/DHHS-LMESFY11Contract.pdf>

90. What happens for record loss (i.e. fire)?

All providers are responsible for records of Medicaid recipients in its care. Should a fire occur the provider should notify the proper authorities and have supporting documentation from the local fire department regarding the nature of the fire, type, and level of destruction. This supporting documentation may not excuse the provider from liability, however it does

provide support that a fire occurred and what was destroyed. The provider should also report the incident via the DMHDDSAS Incident Reporting System and to DMA Program Integrity.

91. After an investigation has occurred, how long after it is conducted for a provider to receive results?

When an investigation has been conducted by DMA Program Integrity, the expected timeframe to notify the provider regarding the results is approximately 120 days. Should potential fraud or significant abuse be discovered during the investigation, the provider may warrant further investigation by the Medicaid Fraud Investigation Unit or a local law enforcement agency.

92. Who do you request information from to find out details of a DMA investigation when it has been conducted by DMA Program Integrity?

All DMA Investigations are confidential per 10 A NCAC 22F until investigations are closed. After an investigation is closed, individuals may submit a written Freedom of Information Act request to obtain detailed information about an investigation. DMA Program Integrity is moving toward electronic notification and plans to have a website for providers, consumers, agencies, advocates, and concerned individuals to access whenever providers have received a remedial measure such as prepayment review or adverse actions, i.e. recoupment, suspension of payment, suspension of provider number, probation, or termination.

93. What is the deadline for documentation to be included in files after services are rendered in order for reimbursement to be paid?

72 hours.

94. Is the OIG Exclusion List available to providers to review? Where can you find it?

Yes. Providers can find the OIG Exclusion list at: <http://exclusions.oig.hhs.gov/>

95. How do you check potential employees' "good standing" with insurance?

Providers may have to check with the local professional boards to find out if the employees are in "good standing". Should the Provider agency wants to know if the Professional employee is in "good standing" with DMA, the provider would need send a notice to Manager, DMA Provider Enrollment Services, 2501 Mail Service Center, Raleigh, NC 27699-2501

96. Can the LME be notified if a provider is on pre-payment review? (provider in their catchment area/endorsed by them)

Yes. When a provider is placed on prepayment review a copy of the provider's notice will be sent to the LME.

97. Since using a provider's number is so serious, why can I Google my name and see my NPI number pop up in numerous places?

A Medicaid Provider Number is different than a NPI number. The NPI number is a national number that does not fall under HIPAA or Confidentiality Laws. DMA has no authority over the regulation of NPIs. These numbers are issued by the Centers for Medicare and Medicaid Services (CMS)

98. Isn't it a conflict of interest to have an agency to facilitate an audit and allowing that agency to receive a percentage of out of compliance claims?

There is no conflict of interest. No local governmental agency or State agency that facilitates an audit receives a percentage for out-of-compliance claims found. DMA Program Integrity has vendors that facilitate audits and receive a percentage of the overpayment recovered from out-of-compliance claims after hearings have been exhausted and funds are collected by the DHHS Controller's Office.

99. To assist in Fraud detection, wouldn't it be more beneficial to send paid claims to the individual/family so they can review the paid claims and then report any fraudulent claim to Program Integrity?

You are correct. It is beneficial to send paid claims to legally responsible individuals or recipients to review dates of service of paid claims. This type of support is always appreciated by our investigators when such method or technique is used, however these individuals have the right not to participate in the investigative process.

100. What sorts of indicators typically trigger an audit?

A list of examples that may trigger an audit includes but not limited to; when provider's billing practices are outside the norm, paid significant amount of dollars in a short time span, paid significant amount of dollars for small number of recipients, billing for more than 12 hours in a day, billing for more than 24 hours in a day, all recipients have same exact diagnoses, providing services to recipients greater than 50 miles, complaints related to billing for services not rendered, or significant number of quality of care concerns.

101. How much time elapses between notification of an audit and review of a clinician's records?

When an investigation/audit has been conducted by DMA Program Integrity or vendor, the expected timeframe to notify the provider regarding the results is approximately 120 days. Should potential fraud or significant abuse be discovered during the investigation, the provider may warrant further investigation by the Medicaid Fraud Investigation Unit or a local law enforcement agency which may extend the notification period to an unspecified timeframe.

102. What percentage of independent providers get audited?
As stated in previous 8C presentations, Outpatient Independent Mental Health / Substance Abuse providers have not been audited collectively. There have been several investigations conducted on Outpatient Independent Mental Health / Substance Abuse providers but all done on an individual basis due to complaint allegations or Data Analytics from our Fraud and Abuse Management (FAMS) and Detections Systems (FADS). Within the next few months, these providers will be audited based on reporting and data mining associated with FAMS and FADS.
103. What is a “canned note”?
“Canned” service notes are to be avoided. Examples of canned notes are notes that are cut and pasted from a personal computer or photocopied, with new dates and/or signatures attached, or notes that are copied verbatim, or almost verbatim by hand from previously-written notes. Each service note should have its own value as documentation of a separate and unique event and should reflect: the actual and relevant activities that occurred during the service event; important issues discussed; the interventions provided, the effectiveness of the interventions/individual’s response; and relevant observations and updates that occurred and were specific to the service delivery provided that day. “---DMHDDSAS Records Management and Documentation Manual, 4/1/09
104. What is a clean claim?
In our Prepayment Program, a clean claim is determined when a provider’s claim has met all the conditions (eligibility and documentation) to be paid via the fiscal intermediary.
105. Can provider agencies sue PCG?
Any provider has right to file legal action against DMA or a vendor should a valid issue or reason exists.
106. Per Patrick, “about 10% of providers are fraudulent and cause problems for the rest”. Why then don’t you come up with a way to find that 10% rather than driving up costs and beating up on the other 90%. Suggestion – send “auditors” to provider location and do high level reviews. If basics are in place for 6-8 events (note, PCP, service order), move on to another agency. Leave the good ones alone and you will find the bad ones quick. DMA has a way with addressing those providers that have complaints, erroneous billing practices, and significant quality of care issues. We are using our Fraud Abuse Management and Detection Systems to help us focus on those providers that bring the greatest risk to the Medicaid program.
107. How would I find out if an agency or individual is using my provider number?
Contact Program Integrity at (919) 647-8000

108. Is it true that your auditing vendors get paid bonuses for finding violations (e.g. mistakes in documentation, missing initials, etc.)

No. Vendors are paid based on contractual payment agreement only. No bonuses are ever given to our postpayment vendors for the work they conduct for DMA Program Integrity.

109. Under Program Integrity part – statement under “Trends in Behavioral Health – Improper changes in dates on documentation.” What is an improper change?

An example of an improper change is someone used white-out to cover up a date, name, etc or copying a signed signature from a previous document and taping it into a current document to pass-off as approved document with necessary signatures.

110. Are notices of audits sent by certified mail?

Providers are notified via telephone and DMHDDSAS Program Accountability website regarding Joint Medicaid audits conducted by DMA and DMHDDSAS. All other Audits or investigations may be announced or unannounced in accordance with NC GS. 108C-11. Internal policy in Program Integrity requires a notice of investigation or audit to be sent to the provider via certified mail when a Desk Review is conducted.

111. Where will we find the self-audit packet online?

The Self Audit Packet is located at

<http://www.ncdhhs.gov/dma/program%20integrity/SelfAuditPackagePISA0001.pdf>

112. Is PCG required to payback anything when they are erroneous in their findings? Appeal process is excessively expensive.

PCG is paid according to the contractual agreement. If the Error Rate for reviewing a provider's claim is greater than 5%, PCG will incur a deduction from its future payments.

113. You stated that we will hear from Public Consulting Group to look at post payment claims. Have you given us notice that all providers will get a review (onsite or otherwise) as a quality check or only if there is a concern based on complaints or billing practices?

Providers will hear from DMA Program Integrity or its vendors based on complaints and billing practices triggered via FAMS or FADS.

General policy (referrals, 'incident to', documentation, H codes, etc.)

*For further questions about Clinical Policy, contact DMA Behavioral Health Policy at 919-855-4290.

114. Is EMDR considered evidence based intervention for PTSD? Where can you get an updated list of Evidence-based practices?

Yes, EMDR is on the Substance Abuse Mental Health Services Administration (SAMHSA) National Registry of Evidence-based Programs and Practices (NREPP). More evidence-based programs may be found at <http://www.nrepp.samhsa.gov/>

115. Can I get reimbursed for services provided by non-licensed providers (ex. Pre-doctoral interns or psycho metricians)?

No. At this time, direct-enrolled licensed providers may provide and bill for services. Only professionals who are provisionally licensed through their licensing board may bill 'incident to' a physician or through the LME. Non-licensed professionals who meet the qualifications delineated in the Enhanced Behavioral Health Services in policy 8A may provide enhanced Medicaid services (listed in DMA Clinical Coverage Policy 8A) within the scope of their practice, but may not provide outpatient services as delineated in policy 8C.

116. How should outpatient therapist deal with a self referral or word of mouth referral that is not through an LME, Dr., or psychiatrist?

If the consumer is 21 years or older, then no referral is necessary to provide or bill for services. If the consumer is under 21 years old, then the therapist will need to contact the individual's CCNC/CA primary care provider, the LME, or a Medicaid-enrolled psychiatrist to obtain a referral for services. As best practice, coordinating with the primary care provider and the LME is strongly encouraged, regardless of the age of the consumer.

117. Is there a specific form used? What kind of follow through and collaboration is expected of the PCP or Dr.?

At this time there is not currently a specific form to use when communicating with the primary care provider. The MH/DD/SA Integrated Care Toolkit, published in the August 2011 Medicaid Bulletin, <http://www.ncdhhs.gov/dma/bulletin/0811bulletin.html#car>, provides information on expectations of the primary care provider.

118. LPCs are licensed by NC counseling board to do testing/evaluations. Why is Medicaid only paying for psychologists to perform evaluations for clients (we are required to do assessments of which testing is often necessary)?

Thank you for your question and we are researching this issue. At present, Licensed Professional Counselors are limited to those CPT codes listed in the LPC section of the 8C policy.

119. For NCCI – we have to see clients for more than 1 hour. When they come 1-2 hours away. We see the client (under 21) for an individual 90806 or 90808 and then with the parent 90847. Why is that not allowed?

This is considered duplicative billing under the National Correct Coding Initiative. A 90847 (family therapy) encompasses both individual and family treatment. It may be in the best interest of the client to assist them in finding a therapist closer to their home; the LME can assist with referrals.

120. Does the Division recognize the disconnect between what providers are expected to do and the insufficient reimbursement rates for outpatient services? How long can we be expected to provide A+ services at D- rates?

DMA appreciates that work of our OTPT therapists. We are actively working with our new LME vendors (LME-MCOs) to develop better reimbursement rates for those outpatient therapists/practices that produce positive outcomes with Medicaid recipients.

121. If a recipient is receiving both outpatient therapy and medication management from the same agency, but only the outpatient therapist is completing the treatment plan, should we include a medication management goal on the plan?

Yes.

122. Can I bill "incident to" for fully licensed clinicians who are still waiting on their Medicaid number and who are providing psychological assessment services? In other words, if I am licensed and still waiting on my provider number, can I get pre-certification for psychological testing using a physician's provider number? Is it ok for a fully licensed therapist (LCSW) without a Medicaid provider number to bill under another fully licensed (LCSW) with a Medicaid provider number when they work for the same agency?

'Incident to' is not allowed for fully licensed professionals. Billing under anyone else's Medicaid number (except in the instance of billing 'incident to' the physician) is never allowable. Without being enrolled as a Medicaid provider, there is not a way to obtain authorizations or bill for services. **At their own risk**, providers can begin providing medically necessary services once they have submitted their Medicaid enrollment application, but have not yet received their Medicaid number. On their enrollment application they need to list a date for enrollment to begin, otherwise CSC will choose the date the application was received. Once they receive their MPN, they can submit requests for authorization to the UR vendor for dates with a start date for the authorization that must not be before the effective date of the enrollment number. That request should also contain the enrollment letter with enrollment date from CSC. They do run the risk that the UR vendor may not approve the services as medically necessary. Once they receive the authorization (but not before) they will be able to bill for the service.

123. For clients who have a chronic mental health diagnosis (ex. Bipolar or OCD) will they be able to keep on-going supportive therapy (in order to alleviate/prevent decompensation)? In order to continue in a service, clients must meet medical necessity for that service per CMS guidelines. Therapists should request additional sessions via the standard prior approval process (ORF2).

124. How to prove evidence based therapy and improved outcomes?

You would have documentation as to your training in various evidenced based practices. Your documentation (progress notes, treatment plan) would indicate how you implemented the evidenced based practices you have chosen. Improved outcomes would be documented by service record indicating that the person is making progress. You could also utilize rating scales to document progress.

125. 90846 allowed for each family member on same date? (i.e. each child has open chart)

Family therapy treats the entire family unit, not just one child at a time. A 90846 is "family therapy without patient." Therefore, presuming each child has the same parent/guardian, then only one 90846 should be provided to that one parent/guardian regardless of the number of children with open cases. A 90846 should never be used to treat the mental health needs of a parent/guardian who does not have insurance coverage. A 90846 is for the

benefit of the identified client. In addition, family therapy with the client present (90847), should only be billed once for the identified family member per date of service.

126. Who pulls from unmanaged limits – psych, therapist?

All of the outpatient codes listed in clinical coverage policy 8C count towards the outpatient unmanaged visits regardless of provider, except for 90862 or other E/M codes.

127. We thought that H-codes were to be used for CBT – Solution – Future oriented therapy and CPT codes 90806, etc. were to be used for psychoanalytical therapy which is mostly set in the past? Please explain how this is related to best practice!

Per the CPT manual, CPT codes should be used for both “past” and “future” oriented therapy.

128. LCAS that are direct enrolled through Medicaid – can they provide and bill outpatient therapy if the client does not have a SA diagnosis?

The LCAS's scope of practice includes SA and co-occurring treatment but not MH only.

129. Can an agency (CABHA) who provides primarily child services, do adult assessments if staff has experience with that population?

Yes – if it is within the scope of the staff's practice and experience.

130. Clarify first responder – “does not mean you shall always have a phone or answer the call” (right away, 15 minutes, 24 hours). Expected time frame to call client back?

If your agency is a CABHA, see IU #86 for expectations related to first responder responsibilities. If not, Clinical Policy 8C requires that outpatient services providers should follow Section 7.5 in Clinical Coverage Policy 8C. The timeframe is not in policy and this is an agency policy decision. The intent is that a clinician should be able to respond immediately in a crisis.

131. If a client is needing a specialty treatment and I'm the only provider in the area, can I then see the Medicare/Medicaid client? I'm an LCAS.

Medicare does not enroll the LCAS and if a person has both Medicare and Medicaid, the provider treating them must be enrolled with both insurance carriers.

132. Are there any changes in billing codes for CSACs?

The CSAC may not directly enroll with Medicaid and thus may not provide outpatient treatment reimbursed by Medicaid.

133. If I see a consumer and parent while a sibling is in track practice and then see the other sibling with the parent after practice, can I not bill family therapy for those two family therapy sessions? Each sibling has separate issues or may have some common issues with the parent or within the home?

In most cases, the family should be treated as a unit. Documentation must clearly reflect the clinical rationale for providing two family therapy sessions. See item #125 for additional information.

134. 96101 is on the MD service array but training stated PhDs and LPAs were the only ones to perform these. Understand clinically that is best but can MD provide and bill for psych testing?

Physicians may provide this service but they should have had training and experience in the administration and interpretation of the psychological tests being utilized.

135. Is documentation needed in chart re: referral from PCP, LME, or psychiatrist other than their NPI number?

Documentation should reflect when the referral was made, who was spoken to, reason for referral, etc.

136. H-codes – is there a replacement code for these services for billing?

For each H-code that is being eliminated, there is a comparable CPT code.

137. How does the billing restriction apply to substance abuse programs where the provider can be certified (CSAC) or provisionally licensed (LCAS-P) when billing Medicaid?

For outpatient services covered under Medicaid Clinical Policy 8C, the CSAC may not directly enroll or provide this service. The LCAS-P can only bill under “Incident to” or through the LME using H codes.

138. When patients have regular Medicaid than are switched to family planning or pregnancy Medicaid, it will no longer cover a psychiatrist. Claims are denied. How does the mental health provider get paid?

Although family planning Medicaid is very limited in what it covers, pregnancy Medicaid does cover outpatient behavioral health services, including services by a psychiatrist.

139. Do people in nursing facilities and adult care homes need a Carolina Access #?

There is a statewide effort going on now to enroll all eligible Medicaid recipients (including those in nursing facilities and adult care homes with a CCNC/CA primary care provider. The need for the Carolina Access number on the claim only applies to individuals under 21.

140. When doing parent consults, must the child be present?

No, but this is a clinical decision based on medical necessity.

141. Rumor has it that Targeted Case Management is going away. Without a substitute service, OPT therapists will need to do many of these functions without the opportunity for reimbursement. Are there plans to address this? How do you bill for coordination of care?

Coordination of care activities are not separately billable services but are a usual, customary part of providing holistic mental health treatment. Targeted Case Management is going away under the 1915 b managed care waiver. TCM will be replaced by care coordination performed by the LME-MCO.

142. How do you request auth before doing assessment and getting a diagnosis code? How do you submit an accurate prior authorization if you've never seen the client and they've used their unmanaged visits?

At the time of the request, you should provide the information available in order to request authorization for the assessment. Once the assessment is complete, that information may be used to request further outpatient services if appropriate.

143. Is the referring PCP NPI# on the claim adequate "evidence" for the PCP referred services (for child outpatient treatment)?

There should also be some documentation of the actual referral from the PCP in the service record.

144. Is the PCP referral # the same as the NPI?

Yes.

145. Service Access – each client has their own crisis plan with actions for them to take – can this substitute as 24 hour access?

No, the 24 hour access requires the capacity for the clinician to respond directly to the recipient in a crisis situation.

146. Can outpatient individual plans be written in the progress notes?

Yes. There is no prescribed format for individual plans. If written in the progress note, it needs to include the elements noted in the policy and needs to be easily recognizable to an auditor.

147. How often must service plans be reviewed? What is the rule for reviewing goals as to the time frame or how often they must be reviewed?

The treatment plan should be reviewed and updated on an ongoing basis.

148. Do you anticipate that provisionals billing through the LME will be again extended beyond 6/30/12?

The Department is actively working on identifying alternatives billing methods for provisionals providing outpatient services in the Medicaid system. The goal would be to enroll as OTPT clinicians providing outpatient therapy.

149. Can providers bill for telephone calls if therapy is taking place? Under what conditions?

At this time, CMS only recognizes outpatient therapy when it takes place face to face, or through the use of telemedicine with the approved technology per Clinical Policy 1H.

150. Can you sign notes with a rubber stamp and date?

No. The signature must be handwritten or must conform to the electronic signature guidelines as published in the September 2011 Medicaid Bulletin --

<http://www.ncdhhs.gov/dma/bulletin/0911bulletin.html#gui>. The credentials and date may be rubber stamped.

151. How do you get permission to bill with the LME # for provisionals?
Each LME that allows provisionals to bill through their number has a different process. You will need to contact the LME for your area.
152. Besides provisionally licensed staff supervision by the boards, are there other standards for documentation (i.e. does someone need to sign off) if billing H-codes through the LME?
This is up to each LME.
153. Do individual outpatient notes have to list the goal on the actual note? Obviously the intervention and effectiveness will be on the note but is it really necessary for clinicians to write out the goal?
Referencing the goal(s) is adequate. You do not have to restate the goal(s).
154. As a licensed Psychologist (doctorate level), may I provide the written service order required annually for my own clients? How about for other providers in my group (e.g. an LPC)?
Yes. See DMA Clinical Coverage Policy 8C.
155. Do Evaluation and Management codes count in the unmanaged units?
No, the E&M codes billed by physicians do not count toward the unmanaged limit for behavioral health but there are limits on E&M codes and they count towards the annual visit limit for adults. If using E/M codes, it is critical to coordinate with the recipient's PCP as they are the gatekeeper for the E/M codes to ensue that the individual does not run out of medical visits prior to the end of the year.
156. If a person with 16 unmanaged visits is served by an agency that decides to request authorization in January...What happens to the unmanaged visits that another agency might use?
Once authorization is on file for outpatient services, all unmanaged visits go away, and prior authorization must be obtained from that point forward.
157. Why is there not a method for obtaining unmanaged visit information?
Our current system does not allow us to accurately count the unmanaged visits. There are many reasons for this. Some providers may hold on to their billing and once they submit claims for earlier dates of service, it may impact what appeared to be unmanaged visits. Once PA has been sought, the unmanaged visits go away which could also not be reflected in the system. When in doubt, providers are encouraged to get PA.
158. Regarding services being "rehabilitative", what about Art Therapy or Music Therapy as part of a comprehensive therapy plan?
If the clinician is licensed as one of the practitioners listed in Policy 8C and directly enrolled with Medicaid, they could utilize Art Therapy or Music Therapy as a treatment modality as medically necessary. There are not specific CPT codes to bill for these therapies.

159. If a patient is under 21 (between 16-21) living independently, not married, and pregnant, do they fall under the requirement mandating physician oversight or involvement?

Yes, because they are under 21, they would still fall into that category.

160. When you refer to "H" codes, is this the same as "H & B" codes?

"H" codes refers to HCPCs codes. We are not familiar with "H&B" codes.

161. Under what circumstances would Medicaid reimburse for a Psycho-educational evaluation (i.e. cognitive & achievement testing)?

Cognitive testing may be medically necessary in assessing a person's behavioral health needs (e.g., testing for individuals with IDD) but achievement testing is covered by the school system and thus is not covered by Medicaid.

162. Why were PhD level psychologists not considered eligible to be billed "incident to"? This is offensive but also undermines training of future psychologists in working with Medicaid populations.

"Incident to" is both a billing practice and a method to ensure that physicians oversee any care billed under their number. It does not take the place of licensing requirements for supervision and oversight of clinical care. NC DMA follows 'incident to' rules set by the Centers for Medicare and Medicaid (CMS). Psychologists can continue to supervise and mentor future psychologists. Medicaid does not allow any billing for students or interns. At the point that a professional obtains their LPA license, they are able to directly enroll and bill Medicaid with their own number. "Incident to" billing is not needed.

163. How do you bill for scoring if you can't bill when you did not see the client (on testing)?

The psychologist may only bill for psychological testing on a date the recipient was actually seen. The scoring, interpretation, and write up of the testing done on the date of service that the recipient was seen, may be completed on a different date. Medicaid billing is always tied to the date that the recipient was actually seen and not a date the scoring or write up was completed.

164. "Incident to" – return to the office (MD) in what time period?

The policy states: "Be readily available to the provisionally licensed professional at all times. "This means readily available by phone and able to return to the office if the patient's condition requires it." The exact time frame is the clinical judgment of the physician.

165. After January 1, can provisionally licensed people bill H-codes "Incident to" MD? Or just the LME?

After January 1, provisionals can either bill 'incident to' the physician using CPT codes, or through the LME (if the LME allows it) using H codes. Provisionals were never able to bill H codes 'incident to' an MD.

166. Can licensed providers provide 5 units of H-codes if medically necessary?

On and after January 1, 2012, fully licensed providers may not bill using H codes. They must use the comparable CPT code.

167. Should the service order include the service to be provided (e.g. should 90806, 90847, etc. be mentioned in service order)?

Yes, the service order should include the service(s) to be provided, but does not need to indicate level of CPT code specificity. It is enough that the service order indicate the need for individual, group, and/or family therapy.

168. For provisionally licensed billing "incident to" a physician, is the reimbursement rate the same as the physician rate?

Yes. The 'incident to' rate is the physician rate. This is due to the added physician supervision.

169. How does DMA address or their plans in the future regarding: 1) co-payments owed to providers 2) high no-show rate, no-show fee for Medicaid and Health Choice recipients?

This is the responsibility of the clinician to address these issues but please note that Medicaid recipients may not be charged "no show" fees.

170. Can LCPA provisionally licensed providers that work with private practices use LME billing codes?

Yes. Provisionally licensed providers (including LPCAs) can bill through the LME (if the LME allows it) using H codes.

171. If two providers work in a group why can't one do parent training while the other works with the child? Parents are too busy to come on separate days. Working with parents is evidence based practice. Medicaid does not pay for 'parent training.' Medicaid requires that licensed clinicians perform services as described by the CPT manual. .

172. Who is Carolina Access and how do clinicians know which ones are/are not?

Community Care of North Carolina (CCNC) and Carolina Access (CA). See the DMA website <http://www.ncdhhs.gov/dma/ca/ccncproviderinfo.htm> or the CCNC website <http://www.communitycarenc.org/> for more information. The Medicaid card indicates if the recipient has their care managed by Carolina Access or CCNC.

173. For Psych Testing – If you do testing on Monday, are you supposed to score, interpret, and write report the same day? If you can't bill for it when you don't see the client?

The psychologist may only bill for psychological testing on a date the recipient was actually seen. The scoring, interpretation, and write up of the testing done on the date of service that the recipient was seen, may be completed on a different date. Medicaid billing is always tied to the date that the recipient was actually seen and not a date the scoring or write up was completed.

174. Can a service order be written before the unmanaged sessions?

Yes, a service order can be written at any time prior to the ending of the unmanaged sessions. It must be in place at the time that prior authorization is requested.

175. Can a doctorate level school psychologist without a Medicaid ID sign service orders?
Licensed by DPH.
No. They must be direct-enrolled with Medicaid in order to sign service orders for Medicaid services.
176. Is it possible for a nurse practitioner to sign the service order for PSR services?
Yes, a physician, PA, Licensed Psychologist, and a Nurse Practitioner may sign the service order for PSR.
177. Why do H-codes pay more per hour than a CPT code? (e.g. H-code =4units @ \$80.84 and CPT code 90806 = \$59.24). So unlicensed folks make more money than licensed folks?
The 90806 is 45-50 minutes and three units (45 minutes) of H0004 is reimbursed at \$60.63. Historically, H code reimbursement rates were developed for provisionally licensed professionals and included funding for supervision. .
178. 90847 is just a phone call, will it continue to be paid?
90847 is family therapy with patient and this is not just a phone call. This requires face to face therapy with the recipient and family. You should contact Medicaid about performing a self audit if any services have been billed inappropriately.
179. 24 hour coverage – My county has a 24 hour crisis line which screens for necessity of ER versus just talk down from crisis. Is this sufficient to meet the 24 hour coverage requirement?
I am an independent solo private practice and this is difficult to meet otherwise.
No. Each enrolled provider must have a means of providing 24 hour emergency coverage.
180. Does each Medicaid recipient have to have an Individualized Plan? Is an intake note sufficient? Is this kept in the chart? Do we give a copy to the recipient?
Yes, every Medicaid recipient receiving outpatient services must have an individualized plan. There is not set format for the plan so an intake note may be sufficient as long as it includes the required elements as laid out in the policy. Yes, the plan should be kept in the chart.
Yes, it is good practice to give a copy to the recipient.
181. Are service orders required once per year?
Yes.
182. Are Health and Behavior codes 96150-96154 billable to Medicaid and do they or will they fall under the 8C billing guidelines?
Codes 96150 and 96151 are billable to Medicaid when billed through the physician – they are meant for use in integrated care practices. They do not fall under the 8C billing guidelines at this time.
183. If the UR vendor approves a certain number of units for psych testing and it's in excess of 5 units, does the 5 unit/day limit still apply?
There is a maximum of 5 unit/day limit.

184. How are providers expected to gain authorization from PCP and do ORF before seeing the client when it is medically necessary but we are at the mercy of awaiting doctor order form?
The provider should coordinate with the primary care physician at the time they plan assessment for the recipient. The ORF is a simple form, that does not take much time to complete. A person centered plan (PCP) is not required for OTPT treatment. Please see Clinical Coverage Policy 8C for service plan requirements.

185. How to continue to billing for outpatient services after becoming fully licensed while waiting for Medicaid billing number (during credentialing process) – was billing 'incident to' physician while provisionally licensed.

While waiting for the Medicaid number, the provider who recently became fully licensed can provide medically necessary services to recipients 'at their own risk' and seek retro authorization after becoming enrolled with Medicaid. At the time of the retro authorization request, the provider needs to also submit their Medicaid enrollment letter from CSC.

186. Can you bill 'incident to' a psychiatrist who has an MD?

Yes, a psychiatrist is an MD.

187. Is it appropriate for an LCAS to be doing IDD assessments?

The scope of practice for an LCAS is substance abuse and co-occurring.

188. In regards to 'incident to' billing, a physician assistant (PA) is being supervised by a psychiatrist/physician providing supervision at our agency. Can the physician assistant provide face-to-face with the recipient on or before the recipient's first visit with the provisional licensed therapist?

The physician who is allowing 'incident to' billing to his/her number must be the one who meets with the recipient face to face prior to 'incident to' billing beginning.

189. We have an LCAS who is also an LPCA. He has experience working with children and is under specific supervision for that population. Can we bill under his LCAS or should it be billed 'incident to' our physician?

There is not enough information to address the question e.g. what service.

190. Regarding progress notes: can individual progress towards a goal(s) be a check box, for example: same, improvement, deteriorating, other?

This would not be adequate to meet the requirement for a full service note, but could be used in addition to a narrative note.

191. Does the diagnosis code need to be on the progress note?

No, the diagnosis code does not need to be on the service note.

192. When is the PCP/person-centered plan due in order to bill it?

The PCP is not billed and a PCP is not required for outpatient services. A service/treatment/individualized plan must be in place on or before the first day of service.

193. Which comes first, the referral or the CCA?
A referral should come prior to service delivery, then a CCA, then the beginning of treatment. Before claims are submitted for under 21, the referral must be in place.
194. What are some examples of entities that outpatient providers can contract with to provide crisis services?
A licensed clinician.
195. Where can I locate surveys, measurement tools, to assess my client's progress?
Most evidence based practices tend to have a pre and post test scale. When goals are measurable it is always possible to measure progress benchmarked against the desired outcome of the goal.
196. Working in a CABHA and having children move along the continuum of care, can I bill for consultation and meetings with coworkers who are providing enhanced services? Example – meeting with Targeted Case Managers, meeting with IH or DT staff to discuss clients either to provide historical information or coordinate transition of services and care?
No. See Section 7.2.2.
197. Does DMA understand the consequences of the elimination of H Codes for licensed clinicians? Specifically: the most severely disordered clients on SSI, who have Medicare and Medicaid, will be severely underserved, and hospitalizations will go up dramatically! LPAs, LPCs, LMFTs, will NOT be able to use H-codes and serve these clients to assist in diversion. Ph.D. psychologists and LCSW's are in short supply. This may lower outpatient costs but hospitalization costs will go up.
When an individual has insurance such as Medicare, Medicaid is always the payer of last resort, meaning that Medicare must be billed first. As Medicare does not accept H codes and only recognizes certain clinicians (LCSWs and licensed psychologists) as providers eligible to bill for outpatient behavioral health services, the attending provider treating dually enrolled (Medicare/Medicaid) recipients, must be credentialed and enrolled with both Medicare and Medicaid. To circumvent filing the claim with Medicare, by billing H codes, would not be appropriate and could be considered fraud. The requirement to bill Medicare first and the requirement to meet Medicare qualifications in order to serve dual eligible's are not new requirements.
198. Does the physician have to be considered as a supervisor by the provisional therapist's licensing board?
No. The supervision by the physician is separate and apart from the supervision required by the licensing board.

199. Why hasn't the exempt diagnosis list been updated to reflect DSM-IV-TR diagnoses? Many of the individual diagnoses are no longer valid for enhanced benefit services! OTPT services are not enhanced benefit services. The exempt diagnosis list is based on ICD-9.
200. Define "attending" within the CABHA, (i.e. is a CABHA 1 attending or is each enrolled provider within the CABHA considered an attending)?
For outpatient services, the "attending" is the individual who rendered the service. Each enrolled provider within the CABHA would be the "attending".
201. With electronic MR, how do we document "written consent" in the individualized treatment plan?
See electronic signature guidelines that were published in the September 2011 Medicaid Bulletin. More information on electronic signatures will be forthcoming from the Department.
202. Can a client receive individual outpatient therapy and medication management on the same day from a therapist and a psychiatrist in the same CABHA? (different attending number, same group number?) Same question for CST, IIH, etc. Two different services may be rendered in the same day from two different attending providers. NCCI does not impact the enhanced services.

Comprehensive Clinical Assessments

203. What is the difference between a CCA and a DA? Different codes?
Please see Clinical Coverage Policy 8C for CCA requirements and Clinical Coverage Policy 8A for the requirements of a DA.
204. We have to complete a CCA prior to service delivery however since 90801 is counted towards unmanaged visits we are getting denials!
It is recommended that you submit a prior authorization request to the UR vendor before delivering the service.
205. How many units are allowed for 90801? Per year?
Beginning January 1, 2012, the 90801 is included in both the unmanaged and managed visit count. Providers must seek prior approval for any 90801 after unmanaged visits have been exhausted. When an individual experiences a significant life event, a change in functioning, or changes providers, it may be clinically appropriate and medically necessary to do a new assessment or to add on to an existing one.
206. For Psych Testing, if 3 hours are used for testing for one date of service, does that mean that you have used 3 unmanaged visits? Do the visits deduct per hour or date of service?
The unmanaged visits are reduced per service code not by hour or date of service.
207. Can 96116/96118 for Neuro-Psych be billed with a medical diagnosis?
Yes.

208. Our agencies practice is to have CCAs completed by an intake clinician, then the case is assigned to a different therapist who completes the service plan at the next appointment. If the client does not return after the CCA, no service plan is completed. Is this acceptable practice?

Yes. However, recommendations for additional assessments, services, support, or treatment based on the results of the comprehensive clinical assessment is required.

209. A good CCA (90801) often takes longer than an hour (sometimes up to 3 hours). Is there any way to collect for that?

The 90801 is an event billing code and no additional codes may be billed.

210. How can we be compensated for write up time for assessments? As far as I know you can only bill 90801 for 90 minutes and then I may spend 2-3 hours of write up time and sometimes you may see the client for 2 ½ hours for the assessment.

The 90801 is an event billing code and no additional codes may be billed. The write up time is not billable event.

211. Scoring, interpretation, and report writing for psychological testing always takes longer than the amount of time allotted by ValueOptions. Is there any way to collect for the extra time?

There is a maximum of 5 unit/day limit. If you feel the authorization is not adequate to cover the service, you should provide justification to the UR vendor to address the issue.

212. What code is used for CCAs? 90801 or H0031?

90801 and 90802 are the current CCA codes for fully licensed professionals.

213. If you are serving a client that brings with them a current CCA from another agency – can that CCA be updated by the “new” agency? If yes, is that billable? What are the requirements when updating a CCA? Are there any required elements?

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 utilized as a part of the current comprehensive clinical assessment. Relevant diagnostic information shall be obtained and be included in the treatment/service plan. The elements are found in Clinical Coverage Policy 8C Section 5.5.

214. What's the structure that must be followed to revise a CCA?

A CCA is a part of the service record once completed and is not revised. A CCA may be updated per Clinical Coverage Policy 8C Section 5.5.

215. H0031/90801 (mental health assessment) – is this service count toward psych. Behavioral therapy visits? Is prior approval needed for 90801 also?

Yes. At present, assessment codes count towards the unmanaged visits. Prior approval is needed after the unmanaged visits but is recommended that you obtain prior approval before providing services.

216. Service plans are to be developed prior to the service (individual, family, group, etc.).
Service plans can't be developed prior to a CCA. Correct?
You are correct – the CCA should help shape the service plan.
217. Who can update another clinician's CCA? Do they have to match or can the new provider make it? Should this be in an addendum? Would all of the elements have to be reassessed? What should this document look like?
A licensed professional should not add an addendum to anyone else's CCA. The CCA is a part of the medical record and should not be altered or appended. This question might be referring to a policy that allows one clinician to reference a previous CCA as a part of their performing their own CCA. For example, if a previous CCA was recently completed and had a very good social history section, the fact section could be referenced in the current CCA. However, the current CCA has to offer an updated and current evaluation.
218. Is it required to write a service note for and in addition to completing a Comprehensive Clinical Assessment?
No.
219. If you are seeing a person in an integrated practice (e.g. primary care office), do you have to start treatment with a complete clinical assessment? How does this fit with the integrated practice brief treatment models, such as the SBIRT model?
Yes. A CCA is required to begin outpatient treatment. SBIRT codes allow for screening and brief interventions and referral is required for more intensive evaluation and treatment.
220. Like with psychological testing, can we bill (for date person seen) for the face-to-face CCA and the interpretation/write up?
No. The CPT codes used for psychological testing have the interpretation/write-up built into them per the CPT manual. A general assessment 90801 does not have this built in.
221. Is it realistic to expect fully licensed therapists working for CABHAs to complete CCAs quickly? The CPT rate is very low and equates to maybe 1.5 hours of time, but the CCA components are so expensive that it usually takes therapists at least 3 + hours start to finish on the document. The licensed professional should complete the CCA in the time necessary to address the required elements in order to identify the services needed by the consumer.
222. Is there a standardized 90801 document/sample that you can send to providers?
There is no standardized format for the CCA at this time.
223. Can we have our provisionally licensed staff conduct CCAs (great training/development tool) and just NOT bill for that service if we do not meet all "incident to" standards (our LME will NOT allow us to bill provisional staff services through the LME)?
Yes, you can provide services and not bill for them. If billing Medicaid, you must meet the requirements as laid out in policy.

224. If a consumer is getting Intensive In-Home services and they get stepped down to Outpatient Therapy, does the clinician have to do another CCA? Or do they just do an addendum or since the CCA has Intensive In-Home listed on it does that cover the step down since therapy is a part of that service?

An addendum would be sufficient, indicating the change in level of care/treatment needs.

225. If you are just doing a CCA, do you need a plan? Does the plan need to be signed and reviewed every 3 months?

If you are just doing a CCA, then a plan is not needed. If a plan is developed, it should be based on the CCA.

226. Do I need initial goals and timeframes of the CCA on the CCA?

Goals and time frames may be a part of the recommendation portion of the CCA but formal goals and time frames that would be on a treatment plan are not required to be on the CCA.

227. Is the CCA the same as a 90801? Is DMA adding elements (it seems it is) beyond the CPT code book? Or, is this an enhanced service DA?

A CCA is required prior to providing services and serves as the basis for the treatment plan (or PCP for enhanced services). The 90801 CPT code may be utilized to bill for the CCA. The elements of the CCA outlined in this policy but are specific to DMA policy 8C requirements and reflect elements traditionally found in any quality biopsychosocial assessment. 90801 is a means of billing the CCA.

228. CCA – I understand that this means a CCA according to IU 36 and not an addendum to someone else's CCA. Speak to addendums – is there any authority for them?

A licensed professional should not add an addendum to anyone else's CCA. The CCA is a part of the medical record and should not be altered or appended. This question might be referring to a policy that allows one clinician to reference a previous CCA as a part of their performing their own CCA. For example, if a previous CCA was recently completed and had a very good social history section, the fact section could be referenced in the current CCA. However, the current CCA has to offer an updated and current evaluation.

229. How do you bill, or do you bill, for unlicensed technicians performing specific neuropsychological tests?

Medicaid does not reimburse for unlicensed technicians to perform psychological testing. Policy 8C states that billing only licensed psychologists and psychological associates may provide psychological testing. As the services are billed to Medicaid, the attending provider must be the licensed psychologist or psychological associate who provided the service.

230. What is the billing code for report preparation?

There is not a specific billing code for report preparation. The CPT manual specifies that the psychological testing codes include: "face-to-face time with the patient and the time spent interpreting and preparing the report." Therefore, the appropriate psychological testing code should be billed with the number of units to include face-to-face time with the

recipient as well as the time necessary to interpret and prepare the report. Medicaid does not reimburse for any other type of report preparation beyond psychological testing codes as per CPT guidance.

231. When providing CST and client comes up for review, needs an independent assessment – how is this provider paid?

They should be able to bill for the CCA and get paid accordingly. Depending if there are any unmanaged visits remaining, they may need to obtain PA.

Health Choice

*For further questions about Health Choice and Behavioral Health Policies, contact DMA Behavioral Health Policy at 919-855-4290.

232. Do you need a full PCP for NC Health Choice recipient?

The requirements are the same as for Medicaid. Outpatient services do not require a Person-Centered Plan.

233. Does NCHC bill under the CABHA #?

Yes. Outpatient services provided within a CABHA for Health Choice recipients should be billed the same as for Medicaid recipients.

234. Can provisionally licensed therapists now bill NCHC?

Yes. They would follow the same guidelines for provisionally licensed therapists billing Medicaid.

235. Will NCHC now cover 90849 (multifamily group)?

Yes.

236. With NCHC can we now bill 'incident to'?

Yes. See question #267 above.

237. Will NCHC policy be updated to use H codes?

Yes. Provisionally licensed professionals billing through the LME will be able to use H codes. See question #267 above.

238. Will VO continue to do all Health Choice reviews until the MCOs take over?

Yes. VO will continue to do Health Choice reviews until managed care is implemented statewide in 2013.

239. I have my license and have applied to NC Medicaid to be a provider. Do I need to apply with NC Health Choice?

No, if you are Medicaid-enrolled provider, you may provide services to Health Choice recipients.

240. Will MCOs eventually take over Health Choice auths, claims payment, etc.?
Yes. MCOs will eventually take over Health Choice auths and claims payment once managed care is implemented statewide in 2013.
241. Re: Health Choice – does it still run 7/1-6/30? If so, I do not understand about unmanaged visits beginning again October 1?
In line with Medicaid, the count for unmanaged visits will run on a calendar year, beginning January 1. The unmanaged visits began on October 1, on a one-time-basis only, when administration of Health Choice was transferred from BCBS to Medicaid.
242. For NCHC, can we get a referral number from the LME if the client does not have a PCP?
Yes. The referral number may come from the CCNC/CA PCP, the LME, or a Medicaid-enrolled psychiatrist.
243. I heard that NC Health Choice can be billed H codes for licensed clinicians. That is, licensed clinicians can bill H codes for NC Health Choice services. Is this true?
In line with Medicaid, fully licensed clinicians could bill H codes through December 31, 2011. As of January 1, 2012, fully licensed clinicians must bill the appropriate CPT code.

Other

244. Is DSS considered a CCNC/CA?
No. A Community Care of North Carolina/Carolina Access (CCNC/CA) is a primary care provider that is enrolled in the CCNC/CA network.
245. How do you know who your LME is?
You can check on the DMHDDSAS website:
<http://www.ncdhhs.gov/mhddsas/lmeonblue.htm>
246. What is the web address for the presentation?
<http://www.ncdhhs.gov/dma/semreg/OutpatientBehavioralHealthSeminarPresentation.pdf>
247. When does the 2.67% rate reduction begin? If it was 10/1/11 why is it not coming out already?
The rate reductions were effective 11/1/11.
248. Where is the new fee schedule posted after the cuts?
The revised fee schedules are posted on the website at
<http://www.ncdhhs.gov/dma/fee/index.htm>
249. The link given for the policy takes you to the DHHS provider home page. Where are the policies located?
<http://www.ncdhhs.gov/dma/mp/index.htm>

250. Is Medicaid going to pay more if Medicare is primary? Difference in Medicare payment and contracted rate?

Medicare/Medicaid crossover percentages may be found at
<http://www.ncdhhs.gov/dma/fee/index.htm>

251. If patient has Medicare and Medicaid, how (or can we) bill Medicaid if the provider opted out of Medicare?

In order to work with dually eligible Medicare/Medicaid recipients, the attending provider must be direct-enrolled with both Medicare and Medicaid. Medicare must be billed first as Medicaid is always the payor of last resort.

252. Do we need consent from the client before calling the CA-PCP for a referral (prior to the first visit)?

No.

253. If a Medicaid card is over a year old should we accept it?

The annual card is issued from the date it was either 1) first generated with the “mass” issuance in September when we changed to annual cards; 2) the date Medicaid was approved for that individual (and the card is first issued); 3) if there was a change in PCP, that results in a new “annual” issuance date; 4) If the card is lost and a new card is issued, that results in a new “annual” issuance date. The next card is issued 12 months from the issued date on the card with the PCP change. If it has been more than 12 months since the individual was eligible for Medicaid, they will receive a new card. If it has been less than 12 months, they will not receive a new card unless they ask the county DSS to request one. Providers are strongly encouraged to utilize any of the eligibility verification methods outlined in presentation or in Appendix F of the Basic Medicaid/NC Health Choice Billing Guide.