



North Carolina Department of Health and Human Services
Division of Mental Health, Developmental Disabilities and Substance Abuse Services
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Beverly Eaves Perdue, Governor
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Steven Jordan, Director

July 13, 2011

MEMORANDUM

TO: All Interested Parties
FROM: Steven Jordan *SS*
SUBJECT: **REVISED** Summary Version of Implementation Update #87

Please send any input or suggestions for the Summary version to us at ContactDMH@dhhs.nc.gov. Readers who want to view the Implementation Updates and other summaries may find them on our website at <http://www.ncdhhs.gov/mhddsas/servicedefinitions/servdefupdates/index.htm>; refer to the detailed version as the authority.

Clarification of Unmanaged Outpatient Behavioral Health Visits

- As clarified in the March 2011 Medicaid Bulletin and Implementation Update #86, beginning January 1, 2011, children under the age of 21 have 16 unmanaged outpatient visits before prior authorization is required.
- Adults (21 years and older) have 8 unmanaged outpatient visits before prior authorization is required. This visit count begins each calendar year and runs from January-December.
- For recipients reaching their 21st birthday in a calendar year: these recipients still count as 'children' for unmanaged visit counts until the end of that calendar year; therefore the 16 unmanaged visit limit applies to that calendar year.
- Beginning January 1 of the next calendar year, the 8 adult unmanaged visit limit will apply.
- Providers are responsible for recognizing when prior approval is required.

Extension of Coverage for Provisionally Licensed Providers Billing Outpatient Behavioral Health Services through the Local Management Entity and National Correct Coding Initiative Update

- The coverage of provisionally licensed providers delivering outpatient behavioral health services as a reimbursable service under Medicaid funds and billed through the Local Management Entity (LME) has been extended to June 30, 2012.
- Providers are strongly encouraged to review the Division of Medical Assistance National Correct Coding Initiative (NCCI) webpage at <http://www.ncdhhs.gov/dma/provider/ncci.htm> and the Centers for Medicare and Medicaid Services (CMS) National Correct Coding Initiative webpage at <http://www.cms.gov/MedicaidNCCICoding/> for further information and to confirm which procedure code pair combinations are allowable.

Requests for Non-Covered Services: Alcohol and Drug Abuse Treatment Centers



Location: 325 N. Salisbury Street • Albemarle Building • Raleigh, N.C. 27603
An Equal Opportunity / Affirmative Action Employer

- As of May 1, 2011, all requests for Alcohol and Drug Abuse Treatment Centers (ADATC) for consumers ages 18-21 will be reviewed as “non covered services requests” by Eastpointe LME, a Medicaid utilization review (UR) vendor.
- All new requests should follow guidelines for requesting approval found at: <http://www.ncdhhs.gov/dma/epsdt/>.
- Providers should fill out the form on the website: <http://www.ncdhhs.gov/dma/Forms/NonCoveredServicesRequest.pdf>.
- Providers should not submit in-patient treatment reports (ITRs) or person centered plans (PCPs).

All requests should be sent to:

Eastpointe LME
Eastpointe
ATTN: Anna North
PO Box 369
Beulaville, NC 28518
Fax: 910-298-7189

Note: A recipient under the age of 21 may receive a medically necessary service not included in the North Carolina Medicaid State Plan **only** when the service may be covered under federal Medicaid law and when it will “correct or ameliorate” a diagnosed condition in accordance with Federal Medicaid law at 42 U.S.C.§ 1396d(a) and (r) of the Social Security Act.

Frequently Asked Critical Access Behavioral Health Agency Billing Questions

- See the full version of Implementation Update #87 for more detailed answers at <http://www.ncdhhs.gov/mhddsas/servicedefinitions/servdefupdates/index.htm>

Q1: How do providers bill for Dates of Service prior to becoming a Critical Access Behavioral Health Agency?

A1: The effective date of the Critical Access Behavioral Health Agency is extremely important. If billing for Dates of Service prior to the effective date of the Critical Access Behavioral Health Agency, claims should be billed with the Enhanced Mental Health Services National Provider Identifier. In other words, they should be billed as they were billed prior to becoming a Critical Access Behavioral Health Agency.

Q2: How do providers bill for Mental Health/Substance Abuse Targeted Case Management (MH/SA TCM) under the Critical Access Behavioral Health Agency?

A2: This can differ based on how the provider chose to link these services at enrollment. See the full version of this document at <http://www.ncdhhs.gov/mhddsas/servicedefinitions/servdefupdates/index.htm>

Q3: Where should providers list their Critical Access Behavioral Health Agency National Provider Identifier on the claim, at the Billing level or the Attending level?

A3: The Critical Access Behavioral Health Agency National Provider Identifier will ALWAYS be at the Billing level. If the Critical Access Behavioral Health Agency National Provider Identifier is placed at the Attending Level, the claim will deny.

Q4: What claim form should providers use to bill for their Critical Access Behavioral Health Agency? What should they put on the claim?

A4: Claims for all core and enhanced mental health Critical Access Behavioral Health Agency services will be billed using the professional claim (CMS-1500/837P) format.



Q5: If a provider has multiple locations, how can they easily distinguish which location performed the service when all claims and reimbursement are returned on the Remittance and Status Report (RA) under the Critical Access Behavioral Health Agency NPI?

A5: To determine the site where the service was performed, providers can include site identifying information within the Patient Account Number submitted on the claim.

New Critical Access Behavioral Health Agency Provider Affiliation Denial Code

- Division of Medical Assistance (DMA) in collaboration with the Computer Sciences Corporation (CSC) Enrollment Verification Credentialing (EVC) Call Center conducted provider outreach to all Critical Access Behavioral Health Agency providers to verify that the provider enrollment information on file with N.C. Medicaid is accurately linked to your Critical Access Behavioral Health Agency billing provider number.

Changes in Medicaid Prior Approval and Recipient Due Process (Appeal Rights) Policies and Procedures

- The Division of Medical Assistance adopted new prior approval and recipient due process (appeal) policies and procedures effective May 27, 2011; the specific details are noted in the May 2011 Special Bulletin located at: <http://ncdhhs.gov/dma/bulletin/DueProcessSpecialBulletin5311.pdf>.
- For additional information on upcoming training and locations refer to Implementation Update #87 <http://www.ncdhhs.gov/mhddsas/servicedefinitions/servdefupdates/index.htm>
- Training slides may be found on the Division of Medical Assistance website at <http://www.ncdhhs.gov/dma/provider/epsdthealthcheck.htm>.

Peer Support Service Update

- Peer Support is a very effective support service for individuals with mental health and substance abuse challenges. It is a highly valued service by consumers and families and they have been actively engaged in promoting this as a Medicaid reimbursed service.
- A service definition was developed, to be provided only by Critical Access Behavioral Health Agencies and approved by Centers for Medicare and Medicaid Services.
 - Implementation was scheduled for July 1, 2011.
 - Since the approval of the definition there have been numerous concerns raised, especially that the definition itself does not reflect true peer support and is too embedded in the medical model.
 - Rate setting resulted in a rate that providers have indicated will result in substantial losses and they do not intend to offer the service.
 - This feedback comes from providers who are fully supportive of peer support, train peer support specialists, and currently hire peer support specialists to work on team services such as Assertive Community Treatment Team (ACTT).
 - This has led to the general sentiment in the provider and advocate community that this service will not be successful when implemented.
- Peer support can be offered as a (b)(3) service within the 1915 (b)(c) waiver.
 - PBH has offered a very successful peer support program that is generally perceived as being more “true” to peer support than the definition approved by Centers for Medicaid and Medicare Services.
 - The Department is committed to supporting peer support and to ensure its success and viability.
 - To achieve this goal and in response to the concerns raised by stakeholders, the peer support service definition previously approved by Centers for Medicare and Medicaid Services will not be implemented July 1, 2011 as planned.
 - Peer support will be offered through the 1915 (b)(c) waiver sites.
- In the interim, Local Management Entities are strongly encouraged to utilize the already approved alternative service definition for peer support utilizing state funds (YA 308 Peer Support Individual, YA 309 Peer Support Group, YA343 Peer Support Hospital Discharge and Diversion).
 - Each of these three alternative service definitions have been opened to allow all Local Management Entities to bill these services.



- Peer Support Specialists may continue to provide services as team members under Community Support Team and Assertive Community Treatment Team.

We are grateful for the input from advocates, consumers, and providers and believe this response will meet the concerns about the definition and provide the necessary support to offer the service successfully.

Compliance Verification Protocol for Out-of-State Placement/Enrollment of Residential Services

- Recent events have brought into question the lack of awareness of the out of state placement utilization review process.
 - It is important that if adequate services cannot be accessed within the state, that the systems involved work in strong partnership to ensure appropriate placement and on-going monitoring.
 - Local Management Entities are critical to this process as they have access to paid claims and authorization data for the purpose of tracking the services consumers within their catchment area are receiving.
 - In addition, two Implementation Updates (42 and 43) reference Local Management Entity contact persons with Utilization Review agencies (ValueOptions, Durham or Eastpointe) and the need for the Local Management Entity Director and Community Collaborative involvement in all out of state placements.

Implementation Update #43

- It is the intent of the service system to develop and provide medically necessary services and supports for children and youth with serious behavioral health needs and their families in their home community.
 - However, in a few instances, this may not be possible.
 - In these cases, a compliance verification protocol must be completed for a specific child or youth with serious behavioral health treatment needs that meet medical necessity and for whom all clinically appropriate services and in-state resources have been explored and tried without improved outcomes as outlined in the person centered plan.
- For additional information and compliance verification protocol refer to Implementation Update #87 <http://www.ncdhhs.gov/mhddsas/servicedefinitions/servdefupdates/index.htm>

North Carolina-Treatment Outcomes and Program Performance System Enhancements:

- Effective July 2011, providers who submit consumer outcomes information to North Carolina – Treatment Outcomes and Program Performance System will notice a more user-friendly and streamlined design.
 - Please be watching for more information to come later this month on a user test site which will give providers an opportunity to familiarize themselves with the new design.
 - The overall goal of the redesigned system was to make it more functional and efficient for users.
- In addition, we are pleased to announce new enhancements to the “Outcomes at a Glance 2.0” online dashboard, including more user choices for time period selection and improvements to methodology, which increases data available for provider agencies.
- You can access the dashboard by going to the North Carolina –Treatment Outcomes and Program Performance System homepage at: <http://www.ncdhhs.gov/mhddsas/nc-topps/> and clicking on the icon “NC-TOPPS Outcomes at a Glance 2.0.”
- Input and feedback from stakeholders has been very helpful in the continual improvements to North Carolina –Treatment Outcomes and Program Performance System.
 - We appreciate this collaborative effort and continue to seek your suggestions for improving our consumer outcomes system.
 - If you have questions regarding North Carolina –Treatment Outcomes and Program Performance System or the dashboard, please send them via electronic mail to: ContactDMHQuality@dhhs.nc.gov.

Mental Health/Substance Abuse and Intellectual/Developmental Disabilities Targeted Case Management Audits: Positive Trends and Area of Concern

- The Division of Medical Assistance and the Division of Mental Health, Developmental Disabilities and Substance Abuse Services recently completed an audit of Targeted Case Management (TCM) services.



- These audits were conducted from March 1, 2011 through March 31, 2011 for services delivered between the dates of November 1, 2010 and January 31, 2011.
- Results of these audits indicate positive improvements in the delivery of services but also point out continuing areas of concern. Following are a summary of these findings:

Mental Health and Substance Abuse Targeted Case Management

Positive Trends and Findings

- Service authorizations from the Medicaid vendors are in place for Mental Health and Substance Abuse Targeted Case Management
- Service plans are in place and valid, meaning they have the appropriate signatures, are reviewed as required and have the appropriate services indicated.
- Eligibility criteria for Mental Health and Substance Abuse Targeted Case Management were met for people receiving the service.
- Providers requiring disclosure of criminal convictions by prospective employees prior to hire were in place.
- Health Care Personnel Registry checks prior to hire were in place.
- The majority of case managers met the education and experience requirements to provide the service.

Areas of Concern

Service Plan Signatures

- There continue to be issues with Person Centered Plans being signed prior to the plan date and signatures not being dated by the signatory.
 - Signatures must be on or after the plan date and a signature is validated only after the signatory enters the date of the signature.

Service Documentation

- Review of the documentation of the delivery of services resulted in several areas of concern:
 - The absence of a monthly face to face meeting with the person receiving services was the most prevalent issue.
 - Content of service documentation that did not meet the requirements of the service definition. Some examples of this are:
 - Documentation indicating checking Medicaid eligibility status as the only intervention for the week of service.
 - Researching resources for potential future needs.
 - Calling to inform individuals of the Case Managers' schedule or other issues not related to the individual.
 - Calling weekly to check on the individual's status with no evidence of on-going issues or noted needs. This type of intervention appeared to be more for the purpose of the agency billing the service versus the need for the service by the individual.
 - Documentation of individual counseling.
 - Excessive reviewing of the Person Centered Plans and other documentation without a clear need being evident.

Qualifications/Training

- The main area of concern was the lack of training specifically required by the new service definition.

Intellectual/Developmental Disabilities (I/DD) Targeted Case Management (TCM)

Positive Trends and Findings

- Service authorizations are in place for Intellectual/Developmental Disabilities Targeted Case Management.
- Service plans are in place and valid, meaning they have the appropriate signatures, are reviewed as required and have the appropriate services indicated.



- Eligibility criteria for Intellectual/Developmental Disabilities Targeted Case Management was met for people receiving the service.
- Providers requiring disclosure of criminal convictions by prospective employees prior to hire were in place.
- Health Care Personnel Registry checks prior to hire were in place.
- The majority of case managers met the education and experience requirements to provide the service.

Areas of Concern

Service Plans

- There continues to be issues with non Community Alternatives Program-Mental Retardation/Developmental Disabilities Person Centered Plans being signed prior to the plan date and signatures not being dated by the signatory.

Service Documentation

- There was some concern of excessive monitoring and reviewing of the Person Centered Plans and other documentation without a clear need being evident.
- Some provider's "electronic signatures" failed to meet the requirements as noted in the Records Management and Documentation Manual (APSM-42), specifically that the system did not prevent the entry from being deleted or altered.

Qualifications/Training

- Lack of training as required by the State Plan Amendment and service definition was the major area of concern.

Unless noted otherwise, please email any questions related to this Implementation Update Summary to ContactDMH@dhhs.nc.gov.

