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MEMORANDUM

TO: Joint Legislative Oversight Committee Members on HHS Commission for MH/DD/SAS
Local CFAC Chairs State CFAC
NC Council of Community Programs NC Assoc. of County Commissioners
County Managers County Board Chairs
State Facility Directors LME Directors
LME Board Chairs DHHS Division Directors
Advocacy Organizations Provider Organizations
MH/DD/SAS Stakeholder Organizations NC Assoc. of County DSS Directors

FROM: Dr. Craigan L. Gray
Steven Jordan *SS*

SUBJECT: Implementation Update #97
PRTF Inventory Processing of TFC Claims for NCHC /EPSDT
Outpatient BH Provider Audit/Investigation NCHC Claims for SAIOP
Innovations 1915c Waiver Amendment Co-Pay Issues for NCHC Claims
Extension of Current CAP-MR/DD Waiver Office Relocations for PI/Finance/Hearings
Referral forms for Primary Care/Beh.Health

Psychiatric Residential Treatment Facility Inventory

In 2011 the Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS) conducted an information inventory of all then active Psychiatric Residential Treatment Facilities (PRTF) in state and within 40 miles of the North Carolina border. The purpose was to gather basic information such as access, capacity, and clinical specializations of the PRTFs for placement and service assessment. The results of those inventories can be found on the DMH/DD/SAS Child and Family Mental Health Services webpage at: <http://test.dhhs.state.nc.us/mhddsas/providers/childandfamilymhs/prtf/index.htm>.

Upcoming Provider Audit and Investigation Initiative, February 28, 2012 - June 30, 2012 for Outpatient Direct Enrolled Behavioral Health Providers

On February 28, 2012, the Program Integrity Unit, Behavioral Health Review Section and its partners began conducting unannounced and announced provider audits and investigations for several Outpatient Behavioral Health providers identified through IBM Fraud and Abuse Management System and complaints or referrals. The audits and investigations span all geographical regions of the state and will involve independent providers

and group practices to include Critical Access Behavioral Health Agencies – outpatient group and independent practices. According to Session Law 2011.399 or North Carolina General Statutes 108C, these Behavioral Health Providers are designated as “high categorical risk.”

There are four phases during this audit and investigation initiative. Phase I includes attending providers with high dollar claims and the associated group practices, top 50 attending providers with the high dollar claims for a period of 3/1/2009 to 12/31/2011 and providers with complaint/referral allegations. Phase II includes attending providers with paid claims amount greater than or equal to \$300,000 by individual calendar years and their associated billing providers. Phase III includes attending providers with paid claims greater than or equal to \$200,000 to \$299,999 by individual calendar years and their associated billing providers. Phase IV includes attending providers with paid claims greater than or equal to \$100,000 up to \$199,999 and their associated billing providers.

This initiative is the first of its kind for Outpatient Behavioral Health providers. The first announcement of this initiative was conveyed by Program Integrity during the November 2011, 8C Training conducted in Asheville, Charlotte, Raleigh, and Wilmington. Providers should review the Program Integrity webpage at <http://www.ncdhhs.gov/dma/pi.htm>, and Special Medicaid Bulletin, <http://www.ncdhhs.gov/dma/program%20integrity/Special%20Bulletin102011.pdf>. There are several partners assigned to this initiative to include the Division of Medical Assistance (DMA) Program Integrity, Behavioral Health Review Section, Public Consulting Group (PCG): Advanced Med (Medi-Medi Contractor for the State of North Carolina); Carolina Centers for Medical Excellence (CCME); IBM Technical and Business Support Team; DMA Clinical Policy-Behavioral Health Section, Information Technology Unit, and Provider Services Unit; Computer Science Corporation-Enrollment, Verification and Credentialing Unit, and Hewlett-Packard.

Advance Med will focus on Medicare claims associated with each provider’s billing and payments received. PCG is an extension of Program Integrity and will continue to conduct onsite audits and investigations.

Program Integrity identifies provider claims for review and assigns cases to an investigator, analyst, or PCG. The full scale of operations includes but not limited to the following:

- Receive Fraud and Abuse Management and Detection Systems leads, complaints, and/or referrals.
- Determine a time period to review claims and pull a population of claims.
- Establish a statistically valid claim review sample from the population of claims.
- Conduct an administrative and/or clinical audit or investigation.
- Use the RAT-STATS Software 2007 Version 2.0 (Windows-based software approved by the U.S. Office of the Inspector General) to determine the sample size and extrapolated overpayment amount.

Program Integrity’s and PCG’s responsibilities include:

- Initiating contact with the provider, announced or unannounced.
- Informing the provider of the post payment audit or investigation process requirements to include entrance and exit conference.
- Working closely with the provider to complete the audit/investigation in a timely manner with the least disruption to the provider agency.
- Advising the provider who to submit documentation to and establishing points of contact during the onsite.
- Addressing provider questions regarding the post payment audit or investigation process.
- Comply with hours of operation, unless owner or management are willing to extend the hours during this time.

Provider’s responsibilities:

- According to Session Law 2011.399 or N.C.G.S. 108 C-11, providers shall cooperate with all announced and unannounced site visits, audits, investigations, post-payment reviews, or other program integrity activities conducted by the Department of Health and Human Services (DHHS). Providers who fail to grant prompt and reasonable access or who fail to timely provide specifically designated documentation to the DHHS may be terminated from the North Carolina Medicaid or North Carolina Health Choice Program.
- Establish a convenient workspace for the Program Integrity’s or PCG’s staff, preferably an office or conference room.

- Access to managerial, financial, administrative, and clinical staff, if necessary.
- Refrain from adjusting claims with Hewlett-Packard for the designated period in question.
- Participate in entrance and exit conference.

If the provider's claims are determined to be out of compliance, a Tentative Notice of Overpayment letter will be sent to the provider in the amount of the overpayment. In accordance with [10A NCAC 22F.0402](#), reconsideration and appeal rights will be offered to the provider if the provider does not agree with the findings of the review. Instructions for the reconsideration review and appeal rights are included with the Tentative Notice of Overpayment letter.

If the preliminary investigation supports the conclusion of possible fraud, as defined in [NCGS 108A-63](#), the case shall be referred to the appropriate law enforcement agency for a full investigation, in accordance with [10A NCAC 22F.0203](#). As a reminder, the False Claims Act (State FCA) legislation was enacted by the N.C. General Assembly on January 1, 2010, in [Session Law 2009-554](#) to deter persons from knowingly causing or assisting in causing the State to pay claims that are false or fraudulent. This legislation applies to any service that is reimbursed with State funds, not just claims for Medicaid services. The legislation stipulates that any person who presents or causes to be presented a false or fraudulent claim is liable for three times the amount of damages sustained by the State; the cost of the civil action brought by the State; and penalties of between \$5,500 and \$11,000.

The review tool and guidelines will be posted on the DMA Program Integrity webpage for provider's convenience and to help providers conduct their own internal quality assurance reviews.

Approval of Innovations 1915 (c) Waiver Amendment

The Centers for Medicare and Medicaid (CMS) has approved the amendment to the Innovations waiver with an effective date of October 1, 2011. This approval authorizes the state to expand the service area from the previously approved five counties to 65 counties, add waiver capacity, update service definitions, and to update provider qualifications and performance measures. This approval allows for the implementation of Innovations for the following local management entities-managed care organizations (LME-MCOs):

- Western Highlands Network LME/MCO effective January 3, 2012
- East Carolina Behavioral Health (ECBH) LME/MCO effective April 1, 2012
- Smoky Mountain LME-MCO and Sandhills LME/MCOs effective July 1, 2012

Extension of Current CAP-MR/DD Waiver and Process for Submitting Authorization Requests

CMS has granted an extension until June 29, 2012 for the current 2008 Community Alternatives Program for Persons with Mental Retardation/Developmental Disabilities (CAP MR/DD) waiver. The extension was granted to allow time for DMA and DMH/DD/SAS to continue to work with CMS on a transition plan for individuals who are living in facilities that do not meet the CMS-approved "home and community characteristics." DMA will submit an additional request to CMS to extend the waiver to 6/30/2012 to allow for ease of transition. When the waiver is approved by CMS, DMA will publish the final service definitions, along with the effective start date of the waiver.

DMA and DMH/DD/SAS appreciate the amount of time that recipients, families, case managers, and providers have spent working on developing transition plans. To that end, we have drafted the following guidelines in an attempt to minimize further disruption for recipients and their families to determine if the case manager and recipient/family need to submit an updated revision (authorization request), including the Person Centered Plan (PCP) revision form with appropriate signatures, CAP Targeted Case Management (CTCM form), and updated cost summary.

- If services were authorized to fit the new waiver requirements and the recipient/legally responsible person accepted the plan/services, then a revision (authorization request) does not need to be submitted. Specifically, if a request to change Home Supports services to Home and Community Supports and Personal Care has been approved, those services can be provided.

- If services currently authorized under the 2008 CAP MR/DD waiver are not in compliance with the newly proposed waiver requirements, then a revision (authorization request) does not need to be submitted at this time. A revision for authorization of new services must be submitted by July 1, 2012 to have services meet the requirements under the new waiver.
- If an authorization request was approved to change services to meet the new waiver requirements, and the recipient/legally responsible person would rather continue with their current services under the 2008 CAP waiver, then the case manager needs to document this information into a case management note and update the PCP and cost summary for the recipient record. This updated PCP will serve as the authorization in the interim until July 1, 2012. The case manager does not submit this information to the utilization review (UR) vendor. The plan that was to go into effect previously will now go into effect on July 1, 2012. If an authorization is requested at this time, a revision must be submitted to the UR vendor.
- If a Continued Needs Review (CNR) with an effective date of April 1, 2012 has been approved or is currently being reviewed by a UR vendor, and the recipient/legally responsible person would rather continue with his or her current services, then the case manager needs to update the PCP and cost summary to show three months of services under the current waiver and nine months of services in compliance with the requirements of the new waiver. This updated CNR must be submitted to the UR vendor by July 1, 2012.
- The plan that has been updated by the case manager serves as the authorization of services. A case manager can send an updated CNR and CTCM form to the appropriate UR vendor at any time and ask for an updated authorization letter.

Recommended Referral Forms for Use between Primary Care and Behavioral Health Providers

Community Care of North Carolina (CCNC), in partnership with local LME-MCOs, primary care physicians (PHP), and Critical Access Behavioral Health Agencies (CABHAs), has developed a set of three referral forms (see attachments) for use between primary care and behavioral health providers to facilitate easier consultation and communication.

Form #1 – **Behavioral Health Request for Information** – This form is for behavioral health providers who begin working with a new consumer or have identified a potential medical need and wish to make contact with the PCP.

Form #2 – **Referral to Behavioral Health Services Section I** – This form is for PCPs to make a direct referral to a behavioral health provider for an assessment and/or services.

Form #3 – **Behavioral Health Feedback to Primary Care Section II** – This form is to be used in conjunction with Form #2 (above). It is for behavioral health providers to complete and send back to the PCP after receiving a referral.

Providers are encouraged to obtain consent for release of information, as is necessary in the sharing of substance abuse information.

Processing of Therapeutic Foster Care Claims for N.C. Health Choice and Early Periodic Screening, Diagnosis, and Treatment Recipients

LMEs and LME-MCOs must continue to process Therapeutic Foster Care (TFC) claims for N.C. Health Choice (NCHC) recipients and for Medicaid recipients who receive (enhanced) TFC under Early Periodic Screening, Diagnosis and Treatment through the fee-for-service system, even after Waiver implementation has occurred in your area.

This process requires that LMEs maintain their current LME Medicaid number. LMEs will need to continue processes for reimbursing the TFC provider. In situations in which LMEs merge, the LME must designate one LME fee-for-service Medicaid number to serve this purpose. This arrangement will need to continue until NCHC and EPSDT TFC services are included in the capitated contract with DMA.

N.C. Health Choice Claims for Substance Abuse Intensive Outpatient Program

Substance Abuse Intensive Outpatient Program (SAIOP), HCPC code H0015, was inadvertently omitted from the benefit plan for NCHC. This procedure code has now been added to the HP claims system and providers may bill. Claims for this service will now process correctly.

Co-Pay Issues for N.C. Health Choice Claims

DMA has identified problems resulting from the transition of claims processing from Blue Cross Blue Shield to HP Enterprise Services for NCHC recipients. The issues below are generating denied claims and are being addressed through data system changes. These issues are:

The application of inappropriate co-pays for specific NCHC services. The claims for services which have had a co-pay deducted in error will need to be voided and then resent when the system has been corrected to bypass the co-pay requirement. Please do not resend these claims until you have been notified that the system changes are complete. The affected services are:

H2012 HA	Day Treatment—Child and Adolescent
T1023	Diagnostic/ Assessment
H2022	Intensive In-home Services
H2011	Mobile Crisis Management
H2033	Multisystemic Therapy
H0035	Partial Hospitalization
H0015	Substance Abuse Intensive Outpatient Service
H0014	Ambulatory Detoxification
H0020	Outpatient Opioid Treatment
H0032	Targeted Case Management - MH/SA
T1017 HE	Targeted Case Management - IDD
RC 911	PRTF
RE100	Inpatient Hospitalization
H0046	Level I Family Type
S5145	Level II Family Type - Therapeutic Family
H2020	Level II Group Home
H0019	Level III & IV Group Homes

Office Relocation: Program Integrity, Finance Management, Hearings

The Program Integrity Unit, Finance Management Unit and Hearings Unit of the N.C. Division of Medical Assistance have moved to a new office location effective May 21, 2012. These three units have relocated to 333 East Six Forks Road, Raleigh, North Carolina 27609. The mailing address and new contact information is listed below:

DMA Program Integrity

New Central Phone Number (919) 814-0000
New Fax Number (919) 814-0035

Mailing Addresses – Remains the Same

Division of Medical Assistance – Program Integrity
2501 Mail Service Center
Raleigh, NC 27699-2501

Division of Medical Assistance – Program Integrity
Third Party Recovery Section
2508 Mail Service Center

Raleigh, NC 27699-2508

Overnight Delivery Address

Division of Medical Assistance – Program Integrity
333 East Six Forks Road, 3rd Floor
Raleigh, NC 27609

DMA Finance Management

New Central Phone Number (919) 814-0000
New Fax Number (919) 814-0031

Mailing Address – Remains the Same

Division of Medical Assistance – (Rate Setting or Audit)
2501 Mail Service Center
Raleigh, NC 27699-2501

Overnight Delivery Address

Division of Medical Assistance – (Rate Setting or Audit)
333 East Six Forks Road, 2nd Floor
Raleigh, NC 27609

DMA Hearings

New Central Phone Number (919) 814-0000 / (919) 814-0090
New Fax Number (919) 814-0032

Mailing Address – Remains the Same

Division of Medical Assistance – Hearings
2501 Mail Service Center
Raleigh, NC 27699-2501

Overnight Delivery Address

Division of Medical Assistance – Hearings
333 East Six Forks Road, 2nd Floor
Raleigh, NC 27609

As a reminder, all Medicaid-enrolled providers billing for services are expected to adhere to all Medicaid and Health Choice policies and guidelines and are expected to stay informed about any changes. Medicaid Bulletins are published monthly and may include articles not found in the Implementation Updates. Medicaid Bulletins can be found at: <http://www.ncdhhs.gov/dma/bulletin/index.htm>.

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

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