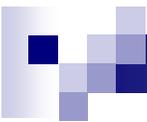




# LME/UM PROJECT

LME Director's Meeting  
September 24, 2008

Presented by  
Tara Larson and Leza Wainwright



# OVERVIEW OF PRESENTATION

- Legislative mandate
- LME agency requirements for participation
- Required Utilization Management/ Review activities
  - Services
  - Timeliness standards
  - Appeals
  - Other required review activities
- Information systems and reporting capabilities
- Staffing requirements
- Timeframes for implementation
- Questions and answers



## LEGISLATION

- The North Carolina General Assembly House Bill 2436 Section 10.15 (x) requires the Department of Health and Human Services to return service authorizations, utilization reviews, and utilization management functions to the Local Management Entities (LMEs) for all clients. By 7/1/09 UM for 30% of the population served must be returned to the LMEs.



## LEGISLATION

- LMEs must demonstrate readiness to meet all requirements of existing vendor to be approved to provide UM services
- DHHS shall not contract with an outside vendor for these services, effective September 2009.



## DEPARTMENT'S APPROACH

- DMA and DMH have identified a team of staff who are preparing for this transition.
- A package is being created to send to all LMEs.
- Included in the package will be detailed policy and technical requirements and response guidelines.
- Selected LMEs must respond to DMA indicating their business and technical plan for meeting all requirements.



## DEPARTMENT'S APPROACH

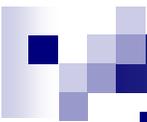
- DMA and DMH staff will review all LME/UM responses received.
- Site visits will be conducted.
- LMEs notified of their selection and will at that point be added, along with VO and EDS, to the work team.



# LME REQUIREMENTS FOR PARTICIPATION

(more to come)

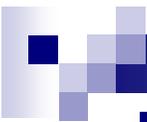
- Must be fully divested before performing Utilization Management and Utilization Review for Medicaid
  - LME cannot provide any Medicaid reimbursable services.
  - Must enter in contract with Medicaid



# LME REQUIREMENTS FOR PARTICIPATION

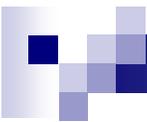
- Must be accredited

- By January 1, 2012, to be eligible to perform (or continue to perform) Medicaid UR, an LME will have to be accredited by NCQA or URAC. This requirement currently applies to all other DMA vendors.
- Be nationally accredited or able to demonstrate that you have submitted an accepted application to an accrediting body.
- DHHS will accept any of the four national accrediting bodies: NCQA, URAC, CARF, or COA
- Must have evidence of a formal relationship with an accrediting body by 12/31/08, with the goal of achieving national accreditation by 12/13/09.



# LME REQUIREMENTS FOR PARTICIPATION

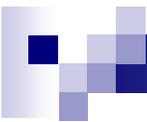
- Have financial resources to meet all requirements
  - No Medicaid start up funding available
  - Payment by transaction (authorized plus denied) via monthly invoice to DMA. Payment is received after invoice is reconciled and audited.
  - Unit price per review (see handouts for rates and volume by LME)
- Have Utilization Management Plan, structure and program, approved by DMA
- Use standardized forms and processes provided by DMA and established Medicaid Clinical Care Criteria for each service
- Conduct all activities and produce all scheduled and ad hoc reports required by DMA



## PROVIDER RELATIONS (more to come)

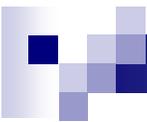
Including but not limited to:

- Provide sufficient staff to deal with provider questions, complaints, and problems during regular business hours
- Log all complaints into an automated call tracking system. Track date/time of contact, caller, provider, and issue resolution.
- Capture hold times, abandoned rates, etc.
- Provide sufficient lines and staff to ensure calls are answered within 5 rings and 95% of the time
- Return all calls within 2 business hrs of receipt
- Provide monthly DMA reports on call information/stats,
- Quarterly trend analysis of issues and proposed solutions.



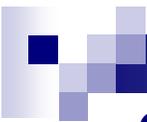
# STAFFING REQUIREMENTS

- One full time Medical Director holding an unencumbered NC Medical License and board certified in psychiatry
  - Position may not be divided among two or more individuals meeting these requirements
- A psychiatrist holding an unencumbered NC Medical License and board certified or eligible in child psychiatry to conduct reviews of children under age 21 and for all reviews requiring discussions between the contractor's psychiatrist and the attending physician.
- ASAM certified physician holding an unencumbered NC Medical License and board certified or eligible in ASAM to conduct reviews of people with SA and all reviews requiring discussions between the contractor's psychiatrist and the attending physician.
- Licensed psychologist is allowed to conduct reviews/hearings for people with DD who have no co-occurring disorders
- A contract manager (1FTE) with a clinical background



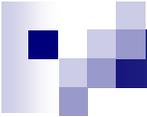
# STAFFING REQUIREMENTS

- A Director of Information Management Systems with a minimum 2 years experience in data management in a large health care contract covering, at a minimum, 100,000 lives
- A Special Review Team of one Ph.D. psychologist and a professional licensed or certified in the specialty relevant to the specific review
- Mental health and substance abuse licensed practitioners with training and expertise in the disability area they will review
  - With relevant education, certification and licensure are required as relevant to the specialty of each staff
  - in sufficient numbers to meet contractual timeframes for each type of review conducted and hearings
- Must be at least one licensed/certified staff for population group served by these Medicaid services such as expertise with children, the elderly, etc.



# STAFFING REQUIREMENTS

- Reviewers may include the following, as appropriate to the required area of expertise and review activities:
  - Licensed psychologists and associate psychologists
  - Licensed Professional Counselors,
  - Licensed Marriage and Family Therapists
  - Licensed clinical social workers
  - Nurse practitioners certified as Advanced Practice Nurse Practitioners
  - Clinical Nurse Specialists in Psychiatric mental health advance practice
  - Certified Clinical Supervisors
  - Certified Clinical Addictions Specialists



## STAFFING REQUIREMENTS

- Staff conducting reviews of service requests for persons with co-occurring disorders must have advanced degree in one area and two years experience in working with the co-occurring disorder
- Staff conducting CAP/DD Waiver services or other DD services reviews must be Qualified Developmental Disability Professionals with BA degrees in Human Services and a minimum of 2 years experience in mental retardation/developmental disabilities or an RN or BSN with two years experience in MR/DD services



## STAFFING FOR ADVERSE DECISIONS

- Adverse decisions are reduction, termination, or denial of a service request.
- Adverse decisions based on any reason other than administrative must be made by a physician or Ph.D. for DD only with no co-occurring disorders.



## REQUIRED UM/REVIEW ACTIVITIES

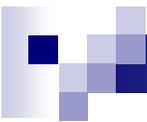
- Medicaid services to be authorized
- Notice timeframes
- Initial reviews
- Concurrent reviews
- Retrospective reviews
- EPSDT reviews
- Post payment reviews
- Special team reviews

Piedmont is not included



## *Medicaid Services to be Authorized*

- Outpatient Mental Health and Substance Abuse
  - Enhanced Behavioral Health Services: 36 services including: MST, IIH, Day Tx, PSR; ACTT; SA; Facility Based Crisis; Mobile Crisis; Detox
  - Independent Practitioners
- EPSDT for recipients under 21
- CAP/MR/DD Services and Plans of Care; TCM
- Inpatient Hospital Services, including review of CONs
- PRTF
- Criterion 5
- Residential Services I-IV
- Out of state services (DMA oversight required)
- Distribution of authorization data by LME (handout)



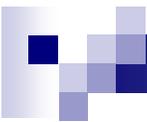
## *Initial Reviews*

- Perform reviews by onsite clinical staff licensed by the State of NC
- Require providers to submit a pre described package of forms provided by DMA to begin the auth process –must have web based online submission such as Provider Connect.
- Notify provider of approval by letter
  - May be posted electronically with written follow up by mail.
- Notify provider of adverse decisions by track able mail in accordance with policy.
- All decisions must be based on approved practices and use of DHHS established clinical triggers and protocols.



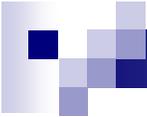
## *Concurrent Reviews*

- Ensure the service continues to be appropriate at current level and is the least restrictive most cost-effective option
- All decisions must be based on approved practices and use of DHHS established clinical triggers and protocols.



## *Retrospective Eligibility Reviews*

- Medical necessity reviews after the service is delivered will be based on the following criteria:
  - Perform if recipient did not have Medicaid at time the service was provided
  - Provider must submit all inpatient records to the LME within 30 days of discharge if the recipient applied for Medicaid during admission
  - Provider must submit all inpatient records to LME within 4 months after the Medicaid application date if recipient applied for Medicaid after discharge
  - All outpatient records must be received by LME within 90 days of the Medicaid application date
  - Notification of review results are same as for initial/concurrent reviews.



## *EPSDT Reviews*

- LME's must provide EPSDT review of all request for services beyond established limits or exclusions for recipients under 21 under EPSDT requirements (42 U.S.C. 1396d(r) {1905(r)} of the Social Security Act. EPSDT does not negate the need for Prior Authorization. Denials must be made by an MD, and defended if decision is appealed.
- Reviews must be completed within 15 days of receipt.
- EPSDT review of non covered mental health substance abuse services for recipients under 21 year of age must be reviewed and recommendations must be sent to DMA for final decision.
- Non covered MH/DD/SA or other Medicaid will be packaged and forwarded to DMA
  - Provider notified of DMA referral by letter.



## *Post Payment Reviews*

### *Inpatient*

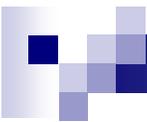
- The LME must perform post payment reviews on random sample of service as directed by DMA
- Purpose is to establish that services were:
  - Delivered in a manner consistent with purpose for which they were authorized
  - The least restrictive and most cost efficient service option which appropriately addressed the need as presented at authorization
  - Medically necessary
- Provide written review summaries and send via track able mail to DMA PI monthly using DMA issued format.
- Calculate any overpayment amount

*All other services (more to come)*



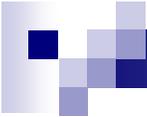
## *Special Team Reviews*

- Perform on site special team evaluations upon request by DMA
- Team includes a clinical psychologist and a second professional representing the disability being monitored. Additional professional team members may be needed to represent multiple needs of an individual
- Provide DMA written results within 10 working day of completion of review.



## NOTICE TIMEFRAMES

- Emergent requests for service authorization are responded to within 4 business hours (by fax or phone).
- Routine requests for service authorization are responded to within 5 business days.
- Service requests that are covered by EPSDT standards are responded to within 15 business days.
- Plan of care for CAP/MR/DD services are responded to within 10 business days.
- Continued need review for CAP/MR/DD services are responded to on annual date. 3-5 days
- Discrete CAP/MR/DD services are responded to as per change in plan of care. 3-5 days



# ADVERSE DECISIONS

- In all cases where authorization is denied, reduced or terminated, the LME must:
  - Notify the individual and his/her guardian by track able mail
  - Notify the provider by regular mail
  - Notify OAH by regular mail or electronically per policy (more to come)
- Use the DHHS approved adverse determination notices
- Provide an explanation of why service was denied with citation
- Provide explanation of appeal rights and a statement of manner the individual may appeal the adverse determination. (See further information on appeals slides.)
- Provide the recipient/guardian an appeal request form.
- For minors, notices need to be addressed to parent of or legal guardian



## *Adverse Decision Notice Timeframes*

- Notice of decision must be within one day of the decision.
- The date of the notice of adverse determination must be the date the notice is mailed.
- For initial requests for services, the effective date of action is the actual date the notice is to be mailed.
- For concurrent requests for services the effective date of action is 30 days from the date the notice is to be mailed.
- Capability must exist to pre-populate information on the standardized forms.



## APPEALS

- Recipients have the right to appeal any adverse decision that results in a decrease, change or termination of service
- FY07-08, Value Options has defended approximately 9,000 appeals of VO's decisions by recipients.
- Appeals data by LME



## *New Appeals Process*

- Effective October 1, 2008, if a recipient chooses to appeal an adverse determination, an appeal request must be submitted directly to the OAH and DHHS.
- Recipients will no longer have the choice of an informal (DHHS) for an adverse determination.
- Recipients will have access to a hearing process with the Office of Administrative Hearings.



## *New Appeals Process*

- OAH will first offer a recipient mediation at one of the state wide locations of the Mediation Network of North Carolina.
- If mediation is requested, must have a licensed professional for MH and SA or QDDP for DD.
- Other staff may have to be present at hearing upon request. For example, if the recipient has a psychiatrist present, the LME must have a psychiatrist present.
- If mediation is successful, the case is dismissed.
- If an offer of mediation is rejected or mediation is unsuccessful, the case will proceed to OAH and a formal hearing.



## *New Appeals Process*

- At OAH Hearings, LMEs must have a psychiatrist present.
- Once a formal hearing is completed, Medicaid is responsible for making a final agency decision.
- The recipient is allowed to petition to Superior Court when not in agreement with agency final decision.



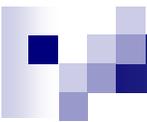
## *New Appeal Process*

- During the Appeals process, LME must authorize continued Maintenance of Service, if applicable, to recipient if the hearing is requested in specified timeframe.
- The LME must enter Maintenance of Service/Prior Authorization within 2 days of appeal filing.



## *New Appeals Process*

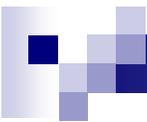
- Mailing & tracking of recipient notices, and electronic copies to OAH/DHHS.
- Entering and managing maintenance of service during appeal as applicable.
- Preparing defensible and specific, i.e., medical necessity determinations based on best practice.
- EPSDT reviews as may be required, i.e., when hard limits exceeded.
- Participation in mediation & OAH formal hearings.



# QUALITY ASSURANCE/POST PAYMENT

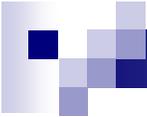
(more to come)

- Perform QA monitoring on all services not reviewed for post payment and on outpatient services billed with CPT, HCPCs, and CAP-MR/DD codes.
- DMA will select a sample of cases at random for review.
- This review process will:
  - Validate that information provided for authorization was documented
  - The service provided meets medical necessity criteria for appropriate level of care and quality of care
  - Criteria was applied in consistent manner.
- Forward relevant documentation to DMA concerning problems identified and results of review within 30 days of review.



## PERFORMANCE STANDARDS (more to come)

- On an predetermined basis, a random sample of cases will be selected by DMA from the LME's data base for review and be subject to reimbursement to DMA for errors in authorizations.
- The LME must be able to receive and process authorization requests via surface mail, telephone submissions, secure electronic submission including email, web-based and fax.
- Reviews must be completed within in 4 hours for hospital admissions, 5 business days for all outpatient services, 15 days for EPSDT
- Performance must be at 93% compliance or better utilizing DMA methodology for determining.



## PERFORMANCE STANDARDS

- Notification of decision must be made on same day it is made mailing confirmation in writing within one day (93% compliance required)
- Telephone Access: LME must ensure that there are sufficient telephone lines for all calls to be answered in 5 rings at least 95% of time
- Abandonment rate
- Provider representative: all calls between 8:00 am and 5:00 pm must be returned within 2 hours of receipt. (at least 95% compliance)
- Retrospective Reviews and Post Payment Reviews (more to come)



## TECHNICAL REQUIREMENTS (more to come)

- Compliance with NC Statewide Technical Architecture and HIPAA standards
- Security requirements
- Disaster recovery
- Hardware and software
- Utilization Review system
- Reporting and Data Analysis
- Interactive voice response technology
- Prior Approval data submission



## *North Carolina Statewide Architecture and HIPAA*

- Policies can be found at [www.its.state.nc.us/Information/Standards.asp](http://www.its.state.nc.us/Information/Standards.asp)
- See tab for Statewide Architecture
- HIPAA policies can be found at [www.ncdhhs.gov/dma/hipaa.htm](http://www.ncdhhs.gov/dma/hipaa.htm)



## Security

- Secure worksite – ID badges, restrictive entry, account for people coming and going after hours. Use of main door only. No use of back doors.
- Data at rest– if have server room must be locked with restrictive entry, locked workstations, if data is portable it must be encrypted or password protected (laptop, thumb drive, etc)
- Data in transit – web browsers with on line access must be data encrypted with SSL, FTP files must be by secure ftp, data mailed on CDs encrypted and labeled as confidential
- Passwords on all applications
- All workforce trained to know the rules for HIPAA and NC Identity Theft. Statements signed that they have received this training, understand it, and accept responsibility.
- Security plan



## *Disaster Recovery*

Disaster Recovery plan that is documented and tested at least annually to include but not exclusively the following items:

- Backup software at an off-site location
- Daily backups of files
- Off site location that has been tested to replicate the current working environment
- Disaster recovery plan and escalation process in the event of a disaster



## *Hardware and Software*

- Internet connectivity
- Local area network (LAN)
- Office automation software for word processing, electronic mail, spreadsheets, and database applications run under Windows on each workstation on the LAN
  - LAN capacity determined by number of personnel needed to support the anticipated client base
- Software to support the required report generation, data analysis, and extracts for submission to the state and fiscal agent.
- Imaging software with unique identifiers for case identification



## *Utilization Review System*

- DMA will issue minimum data fields
- Ability to:
  - electronically capture all required data to authorize or deny a Prior Approval request.
  - capture clinical data to track and report the effectiveness of services
  - Document and track all case activity and correspondence (written, oral, other) and provide this information upon request to DMA, DMH, or DOJ
- Ability for providers to submit authorization requests and check statuses via a secure website



## *Reporting and Data Analysis (more to come)*

- Ability to generate pre defined reports annually, quarterly, monthly, and daily (as appropriate).
- Ability to generate on demand (ad hoc) reports with same day notice
- Ability to create customized reports
- Some examples of required report information would be:
  - Individual demographics
  - Review outcomes by provider, region, and diagnosis
  - Frequency of specific diagnosis
  - Analysis and recommendations concerning availability of lack of availability of service resource
  - Provider outcome measures
  - Denials, authorizations, ratios
  - Appeals
  - CPT and HCPCs



## *Reporting Examples*

- Quarterly or as requested
  - Review authorization outcomes by provider; region; diagnosis; frequency of dx;
  - Report to Strategic Alliance UR to 1000
  - Conflict of Interest report
    - Summary by agency of any staff who works for a MH/DD/SA agency.
    - The report must include:
      - Name of staff
      - Name of agency
      - Role in both agencies
      - Steps taken to assure that no conflict of interest happened or preferential treatment occurred.
    - Clinical staff may not conduct authorization activity
  - Report of clinical staff and license #. May only be NC license. Any activity conducted by non licensed or other state license is deducted from invoice
  - Report of inter-rater reliability results. Each agency must have policy and written procedure for inter-rater.



## *Reporting Examples*

### ■ Weekly

- Community support active authorizations
- Medicaid community support peer advisor referrals
- Denial and reduction overview
- Denial and reduction detail
- Turn around time/aging of authorization requests
- Customer service call statistics



## *Reporting Examples*

### ■ Monthly

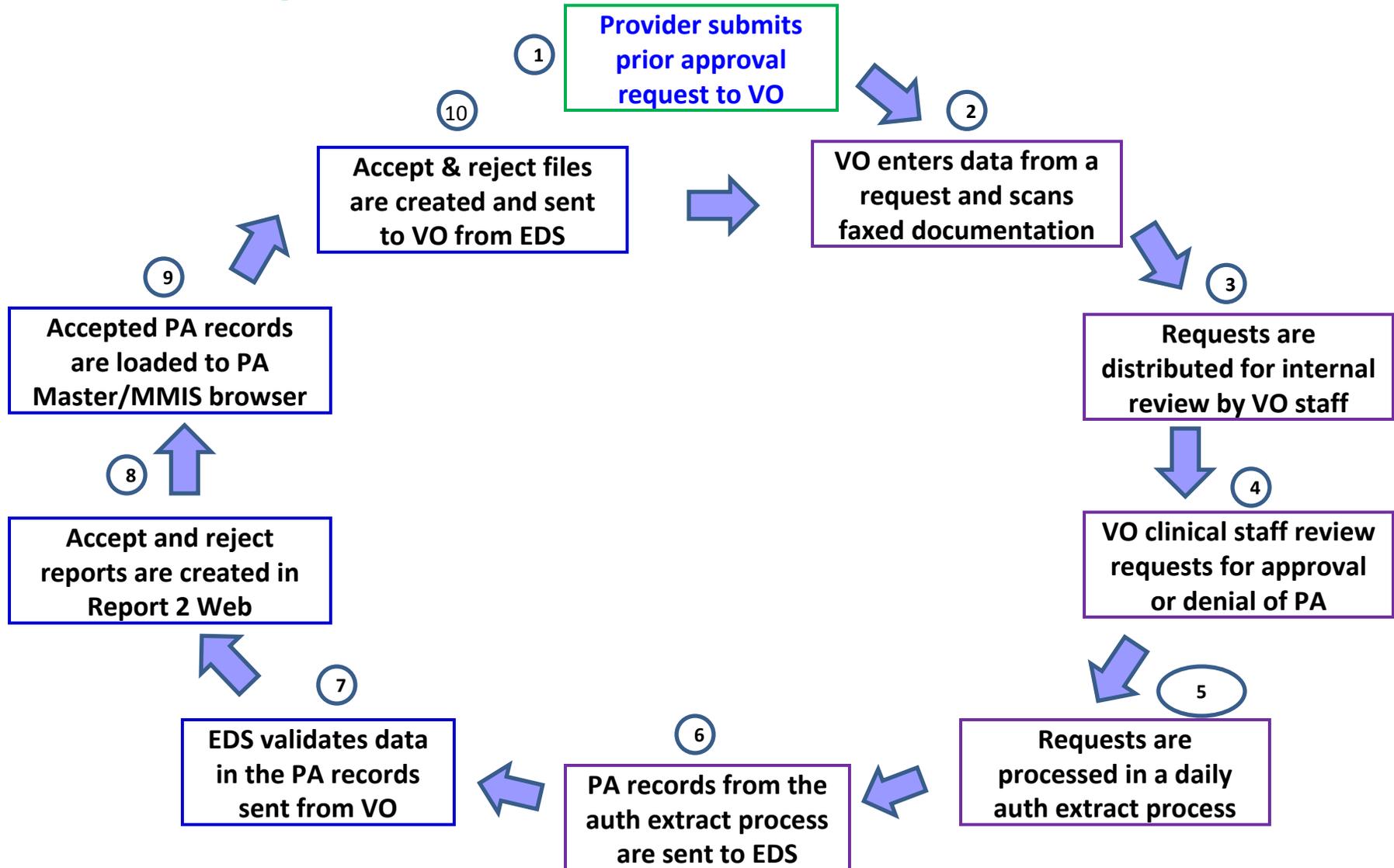
- Utilization by service code
- Utilization by service code and diagnosis
- Utilization by service code and age
- Number of submissions for authorization by method of submission
- CPT and HCPCs Code authorization by provider
- Authorization to denial ratio per contract reviewer
- Length of time from submission to authorization by method of submission
- Ratio of appeals to denials
- Comparison report from historical data to current data
- Report of referral patterns



## *Reporting Examples*

- AD Hoc
  - Reporting per provider; service; timeliness; appeals etc. at the request of the DHHS, DMA or DMH
- Trend Analysis
  - LME trends as well as service, utilization; provider; appeals, outcome of appeals, timeliness trends
- Daily
  - Depending on data transfer mechanism

# Current High Level PA Workflow from Provider to VO to EDS





## Current High Level PA Workflow from Provider to VO to EDS

1. A provider faxes an Inpatient Treatment Report (ITR) form or Outpatient Review Form (ORF2) form along with any required, additional documentation to Value Options through a dedicated fax line.
2. A data entry team reviews the documentation submitted for completeness. Incomplete documentation is returned to providers. The paper documentation is scanned and imaged in as attachments.
3. Once the data entry and imaging process is complete, the prior approval requests are queued and distributed amongst teams of Clinical Care Managers (CCM).
4. The CCM begins the process of reviewing a prior approval request. All questions or comments regarding the prior approval request are documented in notes within the IT system. Once the review process is completed, an authorization will be created for approval, denial, or void status.



## Current High Level PA Workflow from Provider to VO to EDS

5. Authorization entries that have been created or modified by the CCM staff are pulled in a daily authorization extract process. Authorizations letters are also processed and generated at this time. Authorization entries that have been created or modified by the CCM staff are pulled in a daily authorization extract process. Authorization letters are also processed and generated at this time.
6. All successful authorization entries that have successfully process through the daily authorization extract process are placed in an authorization file sent to EDS daily.
7. EDS receives the daily authorization file and performs a validation process of the records sent in the file.
8. A report of accepted records (HMKR9081) and a report of rejected records (HMKR9061) are generated in Report 2 Web production.
9. VO must work the rejected records daily so that the PA can be resubmitted to EDS. If the provider submits the claim prior to the rejected PA being corrected and resubmitted to EDS, the claim will deny for not PA on file.



## Current High Level PA Workflow from Provider to VO to EDS

9. All accepted records are loaded to the EDS PA Master File as either a new, added prior approval record or a change to an existing prior approval record.
10. A file of the accepted records and a file of the rejected records are placed on the secure File Transfer Protocol (sFTP) server for Value Options to retrieve on a daily basis. These files provide confirmation between the total number of records sent in a file versus the number of those records that were accepted or rejected.
  - ❖ All rejected records are reviewed and reworked by Value Options for submission on a future, daily authorization extract process.
  - ❖ Prior approval records placed on the EDS PA Master file are used in the process of adjudicating claims for behavioral health and substance abuse services that require the presence of prior approval on file.
  - ❖ VO receives and loads a daily provider file
  - ❖ VO receives and loads a weekly eligibility file



## *Prior Approvals-future (more to come)*

- 2 options being considered for submitting PA information to the fiscal agent
  - FTP files to EDS like VO does today; or
  - Key records into EDS PA Browser screens
- Pros/Cons



## CONTRACTS

- A contract will be executed with each LME selected
- Contract will be for 3 years with 2- one (1) year renewable options



## PENDING ACTIONS

- Relationship of management fees to UR payments
- Centralized location for data
- What defines 'catchment area'? County of eligibility or place of service delivery



# QUESTIONS AND ANSWERS