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**I. INTRODUCTION**

Medicaid is a health insurance program for low-income individuals and families who cannot afford health care costs. Medicaid serves low-income parents, children, seniors, and people with disabilities. The N.C. Department of Health and Human Services (NC DHHS) is responsible for administering the State's Medical Assistance Program (Medicaid, Title XIX) throughout the state. The Division of Medical Assistance (DMA) is the section of NC DHHS that manages the Medicaid program in the State of North Carolina and is specifically tasked with the daily logistics of delivering services to eligible participants. DMA has a budget of over \$9 billion, processing over 72 million claims per year.

NC DHHS, in response to General Assembly Session Law 2008-10 (HB 2436, Section 10.15(x)), is designated to oversee the implementation of this legislation that requires the Local Management Entities (LMEs) to provide utilization review of Medicaid-covered mental health, developmental disability, and substance abuse treatment services provided in North Carolina. The purpose of this document is to outline and define the requirements the LMEs must meet to be approved to provide utilization review services. The purpose for meeting these requirements is to assure Medicaid services provided by endorsed providers are appropriate and justified and that regulations required in the Medicaid State Plan per 42 CFR 456 are met.

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## II. DEFINITIONS

**Adverse Determination** – A determination to deny, terminate, suspend, or reduce Medicaid-covered services.

**ASAM** – American Society of Addiction Medicine.

**Appropriate Services** – Services deemed appropriate for authorization are those services which meet the criteria for medical necessity.

**CAP/MR-DD** – Community Alternatives Program for Individuals with Mental Retardation/Developmental Disabilities. Authorization of Service categories are:

**Initial Plan of Care (POC) Review and Authorization of Services** – shall be defined as review and authorization of CAP-MR/DD services contained in an individualized plan of care, including Targeted Case Management. These reviews typically occur only once in a lifetime at the initiation of CAP-MR/DD services or when a client may become decertified for this level of care then be reinstated (e.g. hospitalization, incarceration).

**Continued Need Review (CNR) and Authorization of Services** - shall be defined as Plan of Care service(s) reviews, including any discrete CAP waiver service(s) and Targeted Case Management, performed once annually on or about the anniversary of the birth month of the MR/DD recipient.

**Discrete CAP-MR/DD Service Review and Authorization** - shall be defined as the review of any provider request for change in services from the approved Plan of Care (POC) or Continued Need Review (CNR). This may entail changes in service units, type of services or selection of provider. Authorizations of both services by providers or the LME will be included in this category. This is also referred to as a cost revision.

**CON** – Certificate of Need.

**Concurrent Review** – After the LME has initially authorized a service, concurrent review follows the treatment as it is occurring and makes determinations about the medical necessity of continued care.

**Consumer** – An individual child or adult who receives mental health, developmental disability or substance abuse treatment services.

**Covered State Medicaid Plan Services** – Services covered under the North Carolina State Medicaid Plan. These are the service requests that will be reviewed by the LME.

**Criterion 5** – Criterion 5, as stated in 10A NCAC 22O.0113, is non-acute hospital service used as a transition service when, and only when, a recipient under the age of 17 is ready for discharge from inpatient care and there is a clear absence of appropriate community-based services for the recipient to return to.

**CPT** – (Physician's) Current Procedural Terminology Codes. Nationally standardized service definitions coded by the American Medical Association.

**CMS** – Centers for Medicaid and Medicare Services.

**CTCM** – Service request form for CAP/Targeted Case Management.

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## II. DEFINITIONS

**DHHS** – Department of Health and Human Services.

**DIRM** – the DHHS Division of Information Resource Management.

**DMA** – Division of Medical Assistance.

**DMH** – Division of Mental Health, Developmental Disabilities, and Substance Abuse Services.

**Early Periodic Screening, Diagnosis and Treatment (EPSDT) Review** – Defined as a review for services for recipients under the age of twenty-one (21) when the service(s) requested exceed unit or visit limitations or age exclusions as delineated in the service definitions or clinical coverage policies for the service or the requested service is not included in the North Carolina State Medicaid Plan but is coverable under 1905(a) of the Social Security Act..

**“Hands On”** – Clinical staff with the appropriate credentials must personally review each prior approval request. Automated approval without review by clinical staff is not acceptable.

**HCPCS** – HCFA Common Procedural Coding System. National codes assigned to the previously used state-created codes that are used for counseling and rehab option services.

**HIPAA** – Health Insurance Portability and Accountability Act of 1996.

**ITR** – Service request form, Inpatient Treatment Report.

**LME** – Local Management Entity.

**Maintenance of Service** – If an applicant or recipient currently receiving services requests a hearing before the effective date of an adverse determination, they will continue to receive Medicaid services at the level provided on the day immediately preceding the adverse determination or the amount requested, whichever is less, until a final agency determination is rendered on the appeal.

**Medical Necessity** – See **Section VII.A.** for a definition of medical necessity.

**Non-covered State Medicaid Plan Services** – Services covered under 1905(a) of the Social Security Act but not covered by the North Carolina State Medicaid Plan. These requests will be reviewed by the LME and forwarded to DMA for final review and decision.

**ORF** – Service request form, Outpatient Review Form.

**Outpatient Behavioral Health** – Behavioral health benefits including assessment, treatment (individual medical evaluation and management, including medication management, individual and group therapy, behavioral health counseling), family therapy, and psychological testing provided by direct-enrolled behavioral health practitioners for recipients of all ages.

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## II. DEFINITIONS

**Piedmont Behavioral Health** – The Piedmont Cardinal Health Plan (PCHP) administers all Medicaid-covered behavioral health services, substance abuse services, and services to persons with developmental disabilities in Cabarrus, Davidson, Rowan, Stanly, and Union counties. Services are also provided to mentally retarded/developmentally disabled individuals through the new Piedmont Innovations program, which replaces the Community Alternatives Program for MR/DD in these five counties.

**Person Centered Plan** – The person centered plan is a document that captures the services and natural supports required to meet the recipient's needs.

**Protected Health Information** – Defined in 45 CFR 160.103.

**PRTF** – Psychiatric Residential Treatment Facility.

**PI** – DMA Program Integrity Section.

**Prior Approval** – The process undertaken for the purpose of determining the appropriateness of a service for an individual before the service is delivered.

**QIO** – Quality Improvement Organization.

**Quality Assurance Monitoring** – Review of Medicaid covered services (excluding those services covered by other Program Integrity reviews).

**Representative** – For the purpose of an appeal of an adverse decision, the consumer may designate an individual to represent him/her in the process of appeal.

**Retrospective Review** – Reviews conducted after the service was rendered as a result of retroactive Medicaid eligibility when the service has been provided before the individual is determined to be Medicaid eligible.

**Service Provider** – The entity that is enrolled by DMA to provide medically necessary Medicaid covered services.

**Special Team Review** – Reviews requested by the State and conducted onsite to evaluate the needs of an individual or to monitor a program facility.

**State** – North Carolina.

**State Business Day** – Monday through Friday, 8:00 am through 5:00 pm, Eastern Standard Time with the exception of State Holidays as defined by the Office of State Personnel.

**Targeted Case Management (TCM)** – Case management is direct service designed to gain access for the recipient to medical, social, educational and other services. It consists of assessment, development of a care plan, referral and linkage to services, and monitoring and follow-up to assure service delivery and health safety of the recipient.

**Treatment Plan** – A plan of care, including person centered plans, based on comprehensive assessment, developed in partnership with an individual (or in the case of a child, the child's family) that outlines services to be provided to an individual.

## **II. DEFINITIONS**

**UM** – Utilization Management.

**UR** – Utilization Review.

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### III. LME REQUIREMENTS FOR PARTICIPATION

#### A. Divestiture

The LME must be fully divested of direct service provision before performing utilization management and utilization review for Medicaid-covered services. The LME **must not** provide any Medicaid reimbursable services.

#### B. Accreditation

The LME must be nationally accredited or able to demonstrate that an acceptable application for accreditation has been submitted to a nationally accredited body.

Evidence of a formal relationship with an approved accrediting body must be provided with the goal of achieving national accreditation.

Accreditation with any one of the following four national accrediting bodies is acceptable until January 1, 2012.

- National Committee for Quality Assurance (NCQA)
- Utilization Review Accreditation Commission (URAC)
- Commission on Accreditation of Rehabilitation Facilities (CARF)
- Council on Accreditation (COA)
- Council on Quality and Leadership (CQL)

By January 1, 2012, the LME must be accredited by NCQA or URAC to be eligible to perform or continue to perform Medicaid utilization management and utilization reviews.

The LME is required to attain Quality Improvement Organization (QIO) like-entity status with the Centers for Medicare and Medicaid Services. QIO-like entities must

- meet the requirements in Section 1152 of the Social Security Act and 42 CFR 475 and perform review functions specified under Section 1154 of the Social Security Act related to the performance of medical necessity and quality of care review
- be physician-accessed
- be able review cases and analyze patterns of care related to medical necessity and quality review
- have at least one individual who is representative of consumers on its governing body
- not be a health care facility, health care facility affiliate, or health care association

Refer to

[http://www.cms.hhs.gov/QualityImprovementOrgs/03\\_HowtoBecomeaQIO.asp#TopOfPage](http://www.cms.hhs.gov/QualityImprovementOrgs/03_HowtoBecomeaQIO.asp#TopOfPage) for additional information.

#### C. Financial

##### 1. Financial Resources

The LME must have the financial resources to meet all of the requirements for the provision of Medicaid utilization management and utilization review. No Medicaid start up funding is available.

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### III. LME REQUIREMENTS FOR PARTICIPATION

#### 2. Financial Statements

The LME must provide copies of the most recent two (2) years of independently certified audited financial statements of the organization. Audits should include: an opinion of a certified public accountant; a statement of revenue and expenses; a balance sheet; a statement of cash flows; and management letters. If the organization is too new to have audited financial statements, the LME shall attach copies of audited financial statements from each of the principal entities involved with the plan.

#### D. Legal Actions

If there have been any legal actions taken within the last two (2) years, or any legal actions pending against the LME, give a brief explanation and the status of each action.

The LME shall submit to DMA any information on any officer, director, agent, managing employee, or owner of stock or beneficial interest in excess of five percent of the applicant who has been found guilty of, regardless of adjudication, or who entered a plea of nolo contendere or guilty to any of the offenses listed in Section 435.03, F.S. The LME shall not contract with an applicant that has an officer, director, agent, managing employee, or owner of stock or beneficial interest in excess of five percent (5%) of the applicant, who has committed any of the listed offenses. In order to avoid a determination that the proposal is non-responsive, the LME must submit a corrective action plan, acceptable to DMA, that ensures that such person is divested of all interest and/or control and has no role in the operation and management of the LME.

The LME must provide the requested information or attest that no officer, director, agent, managing employee, or owner of stock in excess of five percent (5%) of the LME has committed any of the listed offenses. The LME must further attest that it will promptly notify DMA at any time it becomes aware of such an occurrence.

The State reserves the right to reject a proposal from an LME who has had a legal judgment made against one or more of such persons if the judgment made would materially affect the LME from performing its responsibilities under the contract.

#### E. Guardianship

The LME cannot act as a recipient's legal guardian. Guardianship must be transferred to another appointed individual or entity as determined by the clerk of superior court. The LME must submit a letter of attestation that no Medicaid recipients are wards of the LME at the time of contract execution.

#### F. Self-referral Prohibition

As mandated by NCGS 90-406, a health care provider must not make any referral of a patient to any entity in which the health care provider or group practice or any member of the group practice is an investor or may receive financial gains.

No invoice or claim for payment may be submitted by any entity or health care provider to any individual, third-party payer, or other entity for designated health

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### **III. LME REQUIREMENTS FOR PARTICIPATION**

care services furnished pursuant to a referral prohibited under NCGS 90-406. If any entity collects any amount pursuant to an invoice or claim presented in violation of NCGS 90-406, the entity must refund such amount to the payor or individual, whichever is applicable, within ten (10) working days of receipt.

Any health care provider or other entity that enters into an arrangement or scheme, such as a cross-referral arrangement, that the health care provider or entity knows or should know is intended to induce referrals of patients for designated health care services to a particular entity and that, if the health care provider directly made referrals to such entity, would constitute a prohibited referral under NCGS 90-406, shall be in violation of this law.

#### **G. Medical Malpractice/Liability Insurance**

During the term of the Contract, at its sole cost and expense, and through an insurance company or through a program of self-funded insurance, the LME must maintain professional liability insurance for itself and its professional staff with limits of at least (\$1,000,000) per occurrence and at least (\$3,000,000) in the aggregate.

The LME must furnish to DMA certificates evidencing this insurance coverage prior to commencing work and prior to the issuance of a purchase order. All certificates of insurance shall provide that the insurance company shall give DMA thirty (30) days written notice prior to cancellation or any change in the stated coverage of any insurance. The LME's insurance carrier must provide DMA with a waiver of subrogation for all policies.

#### **H. Automation**

The LME must have an automated system to capture and track service request information for utilization management and prior approval. The capability must exist to extract information from this system in a fixed length flat file with variable length fields and transmit it to the Fiscal Agent for prior approval processing and data reporting.

The system must be accessible remotely by DMA.

The LME must offer service providers the ability to check the status of their service request via a secured web connection.

The LME must be able to capture all documentation as outlined in this document in an electronic file. This includes the service request, supporting documentation, and all contacts made with the client via phone or mail and the outcome of the contacts. If documentation is only available in paper hard copy, the LME must have the ability to make an electronic image for immediate storage.

All service requests must be kept in an unalterable format to include a time/date-stamped field for integrity and audit purposes.

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**III. LME REQUIREMENTS FOR PARTICIPATION****I. Conflict of Interest**

The LME must not authorize services to be provided by any person who is also employed by the LME. The LME must not show favoritism to any provider and must avoid biased referral patterns.

**J. Services Billed Through the LME**

Provider services that are currently billed through the LME may be continued.

## IV. STAFFING REQUIREMENTS

### A. Minimum Requirements

The LME must, at a minimum, employ or contract with the following professional staff:

- A full-time Medical Director holding an unencumbered N.C. Medical License who is board certified in psychiatry. This position may not be divided among two or more individuals.
- A full-time Contract Manager who has a clinical background and who will coordinate Utilization Management with DMA.
- A full-time Director of Information Management Systems with a minimum of two (2) years experience in data management for a large health care contract covering a minimum of 100,000 lives.
- A full-time employee whose duties include being the Quality Improvements Manager.

On or before contract execution, the LME must submit an organizational chart specifying the FTEs per position and the Curriculum Vitas and background checks completed for the following key personnel: Chief Finance Officer, Chief Operating Officer, Contract Manager, Quality Improvement Director, Information Technology Director, Provider Relations Manager, Medical Director and Utilization Management Director.

The LME must, at a minimum, employ or contract with following clinical staff:

- A psychiatrist holding an unencumbered N.C. Medical License who is board certified or board eligible in child psychiatry.
- A physician holding an unencumbered N.C. Medical License who is board certified or board eligible in the American Society of Addiction Medicine (ASAM).
- A sufficient number of staff holding unencumbered N.C. Medical licensure or certification to support the functions described in this policy with expertise in each of the population groups serviced by Medicaid service in the LME catchment area.
- At least one staff must be available for each population group served.
  - ◆ Staff must be available who have special expertise with children and the elderly and have received training in cultural competency specific to key ethnic groups within their community.
  - ◆ Staff conducting CAP/MR-DD service authorization reviews or other developmental disability services reviews must meet the criteria for a qualified professional in developmental disabilities with a Bachelor's Degree in Human services and two (2) years experience with the relevant population.
  - ◆ Staff reviewing service authorization reviews for individuals with co-occurring disorders must have an advanced degree in one area and two (2) years experience in working with the co-occurring disorder.
- The following clinical staff who meet the criteria indicated in 10A NCAC 27G.0104 must review service authorizations for mental health services:
  - ◆ Licensed Psychologists
  - ◆ Licensed Psychological Associates
  - ◆ Licensed Professional Counselors
  - ◆ Licensed Marriage and Family Therapists
  - ◆ Licensed Clinical Social Workers

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## IV. STAFFING REQUIREMENTS

- ◆ Nurse Practitioners who are certified as an Advanced Practice Psychiatric Nurse Practitioner
- ◆ Certified Clinical Nurse Specialists who are certified as an Advanced Practice Mental Health Clinical Nurse Specialist.
- ◆ Certified Clinical Supervisors
- ◆ Certified Clinical Addictions Specialists
- The following clinical staff who meet the criteria indicated in 10A NCAC 27G.0104 must review service authorizations for substance abuse treatment services:
  - ◆ Certified Clinical Supervisor
  - ◆ Licensed Clinical Addiction Specialist
  - ◆ Certified Substance Abuse Counselor
- The following clinical staff must review service authorizations for CAP/MR-DD waiver services:
  - ◆ A Qualified Developmental Disability Professional with a Bachelors degree in the human services field and a minimum of two (2) years experience with mental retardation/developmental disability experience.
  - ◆ A Registered Nurse, or a staff nurse with a Bachelors of Science in Nursing degree or a Masters of Science in Nursing degree, with a minimum of two (2) years experience with mental retardation/developmental disabilities.

### B. Special Review Team

The LME must be able to comprise a Special Review Team to respond to requests from DMA to perform special team evaluations. The team must be comprised of a Ph.D. psychologist and a professional licensed or certified practitioner with expertise relevant to the disability of the individual for whom services are being reviewed (see **Section VIII.F.**). **Note:** The composition of the team may be amended with prior approval by DMA.

### C. Organizational Structure

The LME must specify the numbers of different professional staff that will be used to carry out the performance standards of the Medicaid utilization management and utilization review. The professional who will be assigned the responsibility for operational performance must be specified together with his/her resume. At the time of Contract Execution, the LME must submit an organizational chart specifying the FTEs per position and the Curriculum Vitas and background checks completed for the following key personnel: Chief Finance Officer, Chief Operating Officer, Contract Manager, Quality Improvement Director, Information Technology Director, Provider Relations Manager, Medical Director and Utilization Management Director.

### D. Hiring and Training

All staff must be hired and trained to perform utilization management functions and in all aspects of the LME's utilization management operations no later than thirty days prior to contract execution. For clinical staff, the LME will ensure a working knowledge of person centered planning and service definitions, due process procedures, and EPSDT. Additional training for the utilization management staff will be provided by the LME as procedures and work flow changes occur.

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## IV. STAFFING REQUIREMENTS

The LME will submit reports of all staff trainings as requested. This report, when requested, will include dates of training, the trainers and their credentials, subject matter covered, and staff in attendance. The LME must submit the report to the DMA's Contract Administrator and keep on file a plan for on-going staff training pertinent to:

- child and adult mental health
- developmental disabilities
- substance abuse
- disabilities caused by traumatic brain injury
- co-occurring disabilities
- due process
- EPSDT
- person centered planning
- service definitions and clinical coverage policies
- medical necessity criteria
- all procedures and processes outlined in this document

### E. Staff Qualification Verification

The LME must obtain and keep on file all relevant licenses and certifications of its practitioners. The LME must assure that licensure and certification is current.

Credentials must be provided by the LME to DMA for newly hired professional and clinical staff and then quarterly thereafter for all staff currently employed or contracted by the LME to provide utilization management functions.

The LME must report the credentialing information to DMA using the Staff Credentials Reporting Form (see **Attachment A**). The following information must be provided to DMA to allow for verification of the clinical staff's credentials:

- Licensure and certification documentation including, but not limited to
  - ◆ N.C. Licensure by the appropriate board or other licensing body.
  - ◆ Valid DEA or CDS certification, if applicable.
  - ◆ Board certification or eligibility, if the practitioner states that he/she is board certified or eligible on the application.
- Documentation of hospital privileges for individual or group practitioners providing hospital coverage, if applicable.
- Liability coverage in the amount required for participation.
- Malpractice and sanction history.
- Results of review of criminal background check for providers, owners and affiliates with five percent (5%) or more ownership.
- Results of review of individual clinical staff background checks, regardless of location.
- Assurance that provider is not excluded from participation by Medicare by the U.S. Office of Inspector General.

If the status of the LME's practitioners changes during the contract term, including loss of license or sanction, the LME must immediately inform DMA's Contract Administrator and suspend the employee's review functions until the reinstatement of the license in good standing. Failure to maintain licensure/certification will result in deductions from the LME's invoice.

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## **IV. STAFFING REQUIREMENTS**

### **F. Staffing Requirements for Adverse Action Determinations**

Service authorization reviews that result in an adverse action (denials, reductions, terminations, or suspension) based on the absence of medical necessity, must be made by appropriate clinical staff:

- If the service authorization request is for mental health services for a recipient aged 21 or older, the determination must be made by a psychiatrist holding an unencumbered N.C. Medical License who is board certified or board eligible in psychiatry.
- If the service authorization request is for mental health services for a recipient under the age of 21, the determination must be made by a psychiatrist holding an unencumbered N.C. Medical License who is board certified or board eligible in child psychiatry.
- If the service authorization request is for substance abuse treatment services for a recipient aged 21 and older, the determination must be made by a psychiatrist holding an unencumbered N.C. Medical License and who is board certified or board eligible in psychiatry or physician holding an unencumbered N.C. Medical License and who is board certified or board eligible in ASAM.
- If the service authorization request is for substance abuse treatment services for a recipient under the age of 21, the determination must be made by a psychiatrist holding an unencumbered N.C. Medical License who is board certified or board eligible in child psychiatry or physician holding an unencumbered N.C. Medical License and who is board certified or board eligible in ASAM.
- For mental health services reviewed under EPSDT criteria for a recipient under the age of twenty-one (21) that result in an adverse action (denials, reductions, terminations, or suspension) based upon the absence of medical necessity must be made by a board certified or board eligible child psychiatrist.
- For services related to developmental disabilities that result in an adverse action (denials, reductions, terminations, or suspension) based upon the absence of medical necessity must be made by a physician or licensed psychologist.

### **G. Subcontracts**

The LME must not subcontract with any entity to provide the utilization management functions outlined in the document. The LME may subcontract to individuals.

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**V. PROVIDER ASSISTANCE**

In addition to clinical staff, the Contractor must provide a staff representative who will handle provider complaints and problems, and must provide sufficient telephone lines and staff to ensure that providers have access to assistance.

**A. Call Center**

The Contractor must provide sufficient telephone lines and staff to ensure that calls are answered within five (5) rings.

**B. Provider Representative**

The staff provider representative must be readily available during working hours (Monday through Friday, 8:00 a.m. to 6:00 p.m.) to receive calls and take actions to solve problems.

- Calls must be returned within two (2) business hours of receipt.
- The staff provider representative must maintain a call log that, at a minimum, includes the following items:
  - ◆ Name of provider agency
  - ◆ Name and contact information of caller
  - ◆ Date and time of call
  - ◆ Nature of the problem/complaint
  - ◆ Disposition to Contractor representative(s)
  - ◆ Date and time of Contractor response
  - ◆ Resolution of the problem/complaint
  - ◆ Date and time of the resolution
  - ◆ Was inquirer satisfied with response process

**c. Provider Inquiry/Complaint Resolution Process**

The provider representative must respond to calls from service providers with an inquiry or a complaint. If the provider representative is available when the call is received, the nature of the complaint/inquiry will dictate if the provider representative can resolve the issue.

If the provider representative is not available, the service provider can leave a voice mail message, which will be returned by the provider representative within two (2) business hours.

If the provider representative can resolve the inquiry/complaint, action is taken to resolve the issue, and the provider is notified of resolution. If the provider representative is not qualified to respond to the inquiry/complaint, the provider representative routes the inquiry/complaint to the appropriate staff.

- For clinical inquiries/complaints, the call is routed to the Contractor's clinical supervisor.
- For non-clinical inquiries/complaints, the call is routed to the appropriate area.

If an inquiry/complaint is not resolved by the 25<sup>th</sup> day, the provider representative calls the service provider with the status of the inquiry/complaint, and the expected resolution date.

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**V. PROVIDER ASSISTANCE**

- If the expected resolution date is not met, the provider representative calls the provider with the status of the inquiry/complaint, and the expected resolution date.
- If the inquiry/complaint is met by the expected date, the service provider is notified of the resolution.
  - ◆ If the resolution is favorable, the inquiry/complaint is closed.
  - ◆ If the decision is not favorable, the issue remains unresolved or there is a concern regarding the Contractor's complaint process, then formal grievance/appeal procedures are given to the service provider.

**D. Provider Assistance Reports**

The Contractor shall:

- Capture data on average speed of answer, average hold time, call volume, and call abandonment rates. This data must be furnished electronically to DMA on a weekly basis through the Weekly Summary Inbound File.
- Capture data on provider complaints/issues and provide a trend analysis report to DMA on a quarterly basis related on issues and proposed solutions related to provider calls.

## VI. UTILIZATION MANAGEMENT

The LME is responsible for utilization management of Medicaid-funded behavioral health, developmental disability, and substance abuse treatment services by conducting the following activities:

- Authorization and re-authorization of **outpatient** behavioral health services provided by direct-enrolled mental health practitioners.
- Authorization, re-authorization, and concurrent reviews for the following **enhanced** (Community Intervention Services) behavioral health services:
  - ◆ Ambulatory Detoxification
  - ◆ Assertive Community Treatment Team
  - ◆ Child and Adolescent Day Treatment
  - ◆ Community Support Services
  - ◆ Diagnostic Assessment
  - ◆ Intensive In Home
  - ◆ Medically Supervised or ADATC Detoxification/Crisis Stabilization
  - ◆ Mobile Crisis Management
  - ◆ Multisystemic Therapy
  - ◆ Non Hospital Detoxification
  - ◆ Opioid Treatment
  - ◆ Partial Hospital
  - ◆ Professional Treatment Services in Facility Based Crisis Programs
  - ◆ Psychosocial Rehabilitation
  - ◆ Substance Abuse comprehensive Outpatient Treatment Program
  - ◆ Substance Abuse Intensive Outpatient Program
  - ◆ Substance Abuse Medically Monitored Community Residential Treatment
  - ◆ Substance Abuse Non Medical Community Residential Treatment
- Admissions and concurrent reviews for **inpatient** mental health and substance abuse treatment services, including **psychiatric residential treatment facility** services.
- Admissions and concurrent reviews for **residential child care treatment (Levels II through IV) facility** services.
- Authorization and concurrent reviews of services for recipients under the age of 17 provided under **Criterion 5**.
- Authorization, re-authorization, and concurrent reviews of Level I and Level II Family Type (**therapeutic foster care**) services.
- Authorization reviews for **targeted case management** services and **CAP/MR-DD** services including continued needs reviews and discrete change reviews.
- Authorization, re-authorization, and concurrent reviews of **out-of-state** services for recipients under the age of 21.

Additionally, the LME is responsible for utilization management of Medicaid-funded behavioral health, developmental disability, and substance abuse treatment services for the following types of reviews:

- Early Periodic Screening, Diagnostic, and Treatment (EPSDT) reviews
- Retrospective reviews
- Special team reviews
- Quality Assurance reviews

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## VII. UTILIZATION REVIEW COMPONENTS

### A. Medical Necessity

Medical necessity is defined as those procedures, products, and services that are provided to Medicaid recipients that are necessary and appropriate for the prevention, diagnosis, palliative, curative, or restorative treatment of a mental health or substance abuse condition when the procedure, product, or services are:

- Consistent with N.C. DHHS-defined standards, Medicaid clinical coverage criteria, and national or evidence-based standards verified by independent clinical experts at the time the procedures, products, or services are provided.
- Individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the recipient's needs.
- Able to be safely furnished, and no equally effective and more conservative or less costly treatment is available statewide (this should be linked with network development in the catchment area).
- Furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.
- Not for experimental, investigational, unproven or solely cosmetic purposes.
- Furnished by or under the supervision of a practitioner licensed (as relevant) under state law in the specialty for which they are providing service and in accordance with federal and state laws and regulations, the Medicaid State Plan, the North Carolina Administrative Code, Medicaid clinical coverage policies, and other applicable federal and state directives.
- Sufficient in amount, duration and scope to reasonably achieve their purpose.
- Reasonably related to the diagnosis for which they are prescribed regarding type, intensity, duration of service and setting of treatment.

### B. Medical Necessity Criteria

The LME must follow the medical necessity criteria delineated in the service definitions for a particular service and appropriate Medicaid clinical coverage policies to determine the appropriateness of the following services for eligible populations. Refer to the links listed below for access to the services definitions and clinical coverage policies.

- **Outpatient Behavioral Health Services**  
Medical necessity criteria are defined in Clinical Coverage Policy #8C (<http://www.ncdhhs.gov/dma/mp/>).
- **Enhanced (Community Intervention Services) Behavioral Health Services**  
Medical necessity criteria is defined in Clinical Coverage Policy #8A (<http://www.ncdhhs.gov/dma/mp/>).
- **Inpatient Behavioral Health Services**  
Medical necessity criteria are defined in Clinical Coverage Policy #8B (<http://www.ncdhhs.gov/dma/mp/>).

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## VII. UTILIZATION REVIEW COMPONENTS

- **Residential Child Care Treatment (Levels II through IV) Facility Services**  
Medical necessity criteria are defined in Clinical Coverage Policy #8D-2 (<http://www.ncdhhs.gov/dma/mp/>).
  - **Psychiatric Residential Treatment Facility Services**  
Medical necessity criteria are defined in Clinical Coverage Policy #8D-1 (<http://www.ncdhhs.gov/dma/mp/>).
  - **Criterion 5 Services**  
Medical necessity criteria are defined in Clinical Coverage Policy #8B (<http://www.ncdhhs.gov/dma/mp/>).
  - **CAP/MR-DD**  
Medical necessity criteria are defined in the CAP/MR-DD waiver (<http://www.ncdhhs.gov/mhddsas/cap-mrdd/>).
  - **Targeted Case Management**  
Medical necessity criteria are defined in the July 2005 Special Bulletin, *Targeted Case Management for Mentally Retarded/Developmentally Disabled (MR/DD) Individuals* (<http://www.ncdhhs.gov/dma/bulletin/>).
  - **Therapeutic Foster Care**  
Medical necessity criteria are defined in Clinical Coverage Policy #8D-2 (<http://www.ncdhhs.gov/dma/mp/>).
  - **Out-of-state Services**  
Medical necessity criteria are related to the specific service that is being requested.
- C. Early Periodic Screening, Diagnosis and Treatment Requirements**  
Service authorization requests must be reviewed under Early Periodic Screening, Diagnosis and Treatment (EPSDT) requirements if adverse action is to be taken on a request because the request exceeds policy limitations. If all EPSDT criteria are met, the service request should be approved even if policy limitations are exceeded. For further information see the guidelines published in the EPSDT Policy Instruction Update on DMA's website at <http://www.ncdhhs.gov/dma/epsdt/>.
- D. Residential Child Care Treatment (Levels II through IV) Facility Provider Enrollment Data**  
Authorization of Residential Child Care Treatment (Levels II through IV) facility services requires the LME to determine not only medical necessity but also to determine the appropriate State-created code to correspond with both level of care and provider enrollment information.
- DMA will provide the LME with an upload of the provider enrollment file each business day documenting the following information for the enrollment of residential treatment facility providers:
- bed capacity
  - approved treatment level
  - licensure date

## VII. UTILIZATION REVIEW COMPONENTS

- endorsement
- effective date of enrollment

The data also includes changes to an enrolled provider's bed capacity and approved levels of care.

The LME must use this data to confirm that the service provider is licensed and enrolled to provide the level of service being requested and to determine the appropriate State-created procedure code to indicate on the authorization request entered into the automated system and exported to the Fiscal Agent's system.

The service request must include a detailed description of the level of care that is being requested. The LME must determine the correct State-created code to assign to the authorization based on the HCPCS procedure code that identifies the level of care indicated on the service authorization request submitted by the service provider.

Following is a table listing the HCPCS procedure codes for residential child care treatment (Levels II through IV) and therapeutic foster care and the corresponding State-created codes.

<b>HCPCS Procedure Code</b>	<b>Service Description</b>	<b>State-created Code</b>
H0046 *	Level I Family Type	Y2347
S5145 *	Level II Family Type - Therapeutic Foster Care	Y2362
H2020	Level II Group Home	Y2363
H0019	Level III Group Home – 4 beds or fewer	Y2348
H0019	Level III Group Home – 5 beds or more	Y2349
H0019	Level IV Group Home – 4 beds or fewer	Y2360
H0019	Level IV Group Home – 5 beds or more	Y2361

\* These two RCC services are always billed using the LME's Medicaid provider number.

### E. Service Authorization Request Documentation

The service provider initiates the authorization/re-authorization process by completing and submitting the required Service Request Forms of Inpatient Treatment Report (ITR), Outpatient Review Form (ORF) or CAP/Targeted Case Management (CTCM) form. The ITR, ORF, and CTCM are the approved Service Authorization Request forms and must be used without modification.

Please refer to the ValueOptions website at:

[http://www.valueoptions.com/providers/Network/North\\_Carolina\\_Medicaid.htm](http://www.valueoptions.com/providers/Network/North_Carolina_Medicaid.htm)

for these forms and instructions.

## VII. UTILIZATION REVIEW COMPONENTS

The information that is provided on these forms includes, but is not limited to:

- the recipient's Medicaid identification number
- the recipient's diagnosis (DSM-IV, Axis I-V)
- date of initial assessment and/or subsequent assessments prior to referral
- history of previous treatment, including treatment response and dates of most recent hospitalization, if applicable
- reason/need for initial or continued treatment
- extent of danger to self or others/risk assessment
- substance abuse history, including types and amounts of substances abused, and the dates of initial use and most recent use, withdrawal symptoms, and vital signs from assessment
- medical problems, including medical history and medical problems that may exacerbate psychiatric symptoms or substance abuse problems
- medications that are currently prescribed, including the dosages, and medications to which the recipient has experienced adverse reactions
- the name of the recipient's primary care physician, (attending/referring physician) and Medicaid provider number
- demographic information
- information on custody/guardianship

For Criterion 5, the request must be submitted using the Criterion 5 Service Needs/Discharge Planning Status Form (see **Attachment B**).

The following documents must be submitted with the required form:

- If the service provider is requesting authorization for **enhanced** (Community Intervention Services) behavioral health services, a copy of the recipient's person centered plan is required with goals relevant to the requested service.  
**Note:** Depending on the applicable service definition, the service provider may submit either an introductory person centered plan or a complete person centered plan with the authorization request. If an introductory person centered plan is submitted, the service provider must submit the complete person centered plan prior to the end of the authorization period.
- If the service provider is requesting authorization for **outpatient** behavioral health services, the following documentation must also be included with the authorization request:
  - ◆ a written service order signed by a physician, Ph.D. psychologist, physicians assistant, or nurse practitioner**Note:** If the admission is to a **psychiatric unit within a general hospital**, a copy of the complete person centered plan is not required; only the Service Request Form is required.
- If the service provider is requesting authorization for admission of a recipient under the age of twenty-one (21) to a free-standing psychiatric facility (**hospital/psychiatric residential treatment facility**), the certification of need (CON) must also be included with the authorization request. This is available on line at <http://www.ncdhhs.gov/dma/provider/forms.htm> (see also **Attachment C**).
  - Certification of Need: Medicaid Inpatient Psychiatric Services Under Age 21  
OR

## VII. UTILIZATION REVIEW COMPONENTS

- Certification of Need: Psychiatric Residential Treatment Facility Service Under Age 21
  - ◆ a copy of the complete person centered plan
- If the service provider is requesting authorization for **CAP/MR-DD** services, a complete packet of documentation, including, but not limited to, the following documents are also required:
  - ◆ contact information for the recipient's case manager
  - ◆ a copy of the complete person centered plan, including crisis plan
  - ◆ a current MR2
    - for an initial request, the MR2 must be signed by the physician
    - for a re-authorization request, the MR2 must be signed by the LME and the qualified professional
  - Note:** The MR2 must be signed and dated prior to the date of the person centered plan.
  - ◆ the full NC SNAP document
  - ◆ psychological evaluation with the initial person centered plan, which includes adaptive functioning
  - ◆ supporting assessments
  - ◆ cost summary
- If the service provider is requesting authorization for **targeted case management** services, a complete packet of documentation, including, but not limited to, the following documents are also required:
  - ◆ a copy of the complete person centered plan

### F. Receipt of Service Authorization Requests

The LME must be able to accept secure transmissions from the service provider via surface mail, telephone, and secure electronic submissions to include e-mail, web-based, and fax. The ITR, ORF and CTCM are the approved Service Authorization Request forms and must be applied identically in all methods of acceptance. When the Vendor accepts electronic Service Authorization Requests, the provider must have an ID and password that uniquely identifies them. If the provider uploads the PCP, they must maintain the original signed forms on file.

### G. Timeframes for Response to Initial Requests for Service Authorization

The LME must use their best judgment within contractual guidelines based on level of need to determine the timeframe for response. Requests can be approved, denied, reduced, terminated or pending for additional information.

Requests are pending when there is inadequate clinical information to make a decision concerning the approval, denial or, reduction, of Behavioral Health services. The need for additional information is not explicitly for supporting the service as requested; it is for making an informed decision about the consumer's clinical needs. The LME will inform the service provider in writing using a letter format approved by DMA that additional information is required within fifteen (15) business days from the date of the notice. If the service provider does not submit the requested information or does not contact the LME prior to the due date to request a time extension (no more than an additional fifteen (15) business days can be granted), the request is denied in writing on day 16. The notice denial is sent to the service provider, recipient and/or legal representative.

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## VII. UTILIZATION REVIEW COMPONENTS

A written notification of the decision, including the parameters of the authorizations or details of the adverse action (denials, reductions or terminations) must be mailed to the recipient and/or legal representative and the service provider within one (1) business day of the decision.

### 1. **Emergent/Urgent Residential or Inpatient Admissions**

Emergent is defined as a life threatening or non-life threatening emergency requiring a face-to-face treatment/assessment within two (2) hours of the initiation of the request.

Service authorization requests that are identified as emergent require a response within four (4) business hours from receipt of a complete service authorization request.

It is recommended that the LME have a dedicated fax line for these requests to quickly identify them as Emergent/Urgent Residential or Inpatient Admissions.

### 2. **Routine**

Recipients with routine service needs require a response within five (5) business days from receipt of a complete service authorization request.

### 3. **CAP/MR-DD and Targeted Case Management**

Service requests for CAP/MR-DD waiver services or targeted case management services require a response within ten (10) business days of receipt of the complete service authorization request.

### 4. **Criterion 5**

Service requests for Criterion 5 require a response within five (5) business days.

### 5. **Out-of-state Services**

Service requests for out-of-state services require a response within five (5) business days.

### 6. **EPSDT**

Services reviewed under EPSDT guidelines require a response within fifteen (15) calendar days.

## H. **Timeframes for Response to Requests for Service Re-authorization**

The LME must respond to service requests for re-authorizations within five (5) business days of the receipt of a complete service authorization request except as follows:

- Requests for the re-authorization of hospital inpatient services require a response within one (1) business day of the receipt of a complete service authorization request.
- Requests for re-authorization of CAP-MR/DD services require a response within ten (10) days of the receipt of a complete service authorization request.

## I. **Timeframes for Response to Requests for Retrospective Reviews**

The LME must respond to a request for retrospective review within sixty (60) calendar days from the receipt of a complete request.

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## VII. UTILIZATION REVIEW COMPONENTS

### J. Recipient Eligibility

#### 1. Eligibility File

The Division of Information Resource Management (DIRM) will supply the LME with recipient eligibility information (see **Attachment D**), which is required for the processing of authorizations and claims. This information can be used by the LME to obtain the recipient's address to use on notices, to verify the date of birth, and to determine the county of eligibility. This information will be sent each business day. This file will identify the categories of enrollment for each recipient. The LME will not provide utilization review of recipients in categories for Family Planning Waiver (MAFD) and specific Medicare Qualified Beneficiaries (MQBB, MQBE and MQBQ).

#### 2. Cross Referenced Medicaid Identification Numbers

There are instances when a recipient may have more than one Medicaid identification (MID) number assigned to them. In most instances when this occurs, the numbers are cross referenced and both numbers will be sent to the LME on the eligibility file.

The cross-reference to the original MID number ensures that where the eligibility data indicates more than one MID number for the same recipient, the LME can identify the current MID number and authorize services using the correct MID number.

In circumstances where the recipient is a child whose identity must be protected because of an adoption, the recipient's original MID number is terminated and a new MID number is assigned. The new MID number is not cross referenced to the original MID number.

In this situation, or in any situation where the same recipient has two numbers that are not cross referenced, the LME must contact the DMA Eligibility Information System Unit and the DMA Medicaid Eligibility Unit by e-mail to verify eligibility and confirm the correct MID number.

The details of the request must be sent as a password-protected (the password is Medicaid) attachment by e-mail to [jonnette.earnhardt@ncmail.net](mailto:jonnette.earnhardt@ncmail.net) and [Carolyn.mcclanahan@ncmail.net](mailto:Carolyn.mcclanahan@ncmail.net).

If it is an error and the numbers should be cross referenced, the correction will be made by the local county department of social services. Once corrected, the MID number will be sent to the LME on the next eligibility file as cross referenced.

If it is correct and the MID numbers should **not** be cross referenced, the LME will be notified by DMA. The LME must manually move the authorizations to the new MID number based on date of service and effective date of the new MID number.

### K. Provider Eligibility

DMA's Fiscal Agent will supply the LME with provider enrollment information (see **Attachment E**), which is required for the processing of authorizations. This information will be used by the LME to verify the provider's address for use on service authorization request notifications; to verify the service provider's

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## VII. UTILIZATION REVIEW COMPONENTS

Medicaid provider number; to ensure that the service provider is active and in good standing with Medicaid; and to verify that the service provider is eligible to provide the treatment/service that is being requested. The provider eligibility database file will be sent to the LME each business day.

In addition, DMA will send a Comprehensive Withdrawal spreadsheet weekly which identifies providers that have lost endorsement and subsequent Medicaid enrollment. This spreadsheet will be the source of information when a Request for Authorization is received for a service already authorized to a different provider. If the provider is listed on this spreadsheet, then the Vendor may end date the authorization for the provider of record and enter the new authorization for a different provider. Only the Comprehensive Withdrawal spreadsheet shall be used in making changes for individual recipients. Any change related to provider enrollment will be transmitted through the routine provider eligibility data file.

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## VIII. TYPES OF UTILIZATION REVIEWS

All reviews must be performed by the LME clinical staff with expertise relevant to the nature of the recipient's disability for whom services are intended.

The clinical care manager may make recommendations to the treating clinician/service provider to reduce or modify services when a service authorization request does not meet medical necessity criteria. The clinical care manager may not threaten or use coercion to get the provider to accept the recommendation. If the treating clinician/service provider does not agree to the recommendation, the clinical care manager cannot deny the service request. Denials of service or recommendations to reduce or modify services must be forwarded to the appropriate physician or licensed psychologist for denial determinations.

Service authorization requests for recipients under the age of twenty-one (21) that exceed unit or visit limitations or age exclusions as delineated in the service definitions or clinical coverage policies for the service must be reviewed under EPSDT guidelines.

The LME may approve the request if all the EPSDT criteria are met even though clinical coverage policy criteria were not met. The LME must deny, reduce (change), or terminate the request if all the EPSDT criteria are not met.

The LME may refer a service authorization request to DMA if it is determined that a Medicaid-covered service other than the behavioral health, developmental disability, and substance abuse treatment services that are within the utilization management functions provided by the LME would more appropriately serve the recipient.

### A. Initial Reviews

Initial reviews are completed for requests of service where, typically, the recipient is new to the service being requested or the request is submitted after a break in service from the last date of authorized service.

**Note:** If a request for re-authorization of services for a recipient is submitted by a new service provider, it is considered to be an initial request.

### B. Concurrent Reviews for Re-authorization of Service

Concurrent reviews are required when:

- The service provider requests authorization for care beyond the dates of service that were initially authorized.
- The service provider requests a revision to the units of service that were initially authorized.

The purpose of a concurrent review is to determine if the authorized service continues to be appropriate at the current level and, if not, what alternative services are to be considered. The LME must assure that the least restrictive and most cost-effective service option that appropriately addresses the need, for which the original service was authorized, is being utilized.

Requests for re-authorization must be submitted to the LME prior to the end of the current authorization period. If a request for re-authorization is submitted AFTER the end of the previous authorization period, it will be handled as an initial request.

**Note:** If a request for re-authorization of services for a recipient is submitted by a new service provider, it is considered to be an initial request.

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## VIII. TYPES OF UTILIZATION REVIEWS

### C. **EPSDT Reviews**

EPSDT reviews are defined as reviews for service authorization requests for recipients under the age of twenty-one (21) when the service(s) requested exceed unit or visit limitations or age exclusions as delineated in the service definitions or clinical coverage policies for the service. As documented in the EPSDT requirements (42 U.S.C. 1396d(r) {1905(r)} of the Social Security Act), requests for services beyond the established limitations or exclusions must be considered if they are medically necessary to correct or ameliorate the condition.

Services reviewed under EPSDT guidelines require a response within fifteen (15) calendar days.

### D. **Requests for Non-Covered Services**

Requests for mental health or substance abuse treatment services for recipients under the age of twenty-one (21) that are not covered by Medicaid must also be reviewed and recommendations must be sent to DMA's Assistant Director for Clinical Policy and Programs Section for a final decision. The LME must notify the service provider in writing that the request was referred to DMA for disposition.

### E. **Retrospective Reviews**

#### 1. **Medicaid Eligibility**

Retrospective reviews may be performed if the recipient did not have Medicaid at the time the service was provided but obtains Medicaid eligibility with an effective date that encompasses the dates that the service was provided. The LME must verify with DMA the date that the eligibility was entered into the Recipient Eligibility file to assure the authenticity of the provider request.

The LME must make a decision within 60 calendar days of the receipt of a complete request.

The records must be submitted with the Service Request Form and the authorization documentation specific to the service (see **Section VII.E.**) being requested. Any authorization information from a different vendor or LME that may have been applicable during the period of services to be reviewed should be included with the request.

Where Medicaid eligibility was approved after the service was provided, authorization for inpatient, outpatient or enhanced services typically should not exceed 365 days from the date of eligibility (depending on the authorization increments delineated in the service definition or clinical coverage policy for the service). However, there may be circumstances that require additional time for determining eligibility.

Additional retrospective reviews for enhanced services may be requested by DMA due to provider or client specific situations.

#### 2. **Provider Transfers**

Exceptional circumstances may occur where an LME requests concurrent authorization of services to transfer a client to a different service provider without individual review of client information.

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## VIII. TYPES OF UTILIZATION REVIEWS

When this request is made, DMA will coordinate with DMH and the responsible LME for submission of client transfers to a different provider. A spreadsheet of individual client changes will be provided and transfer of authorization based upon historical review of medical necessity will occur. Following this initial transfer, concurrent review standards will apply.

### F. Special Team Reviews

DMA may request the LME must perform an on-site special team evaluation. These monitoring reviews will be conducted for various reasons. A review may be requested to evaluate the needs of an individual or to monitor a program within a facility.

At a minimum, the team must be comprised of a licensed psychologist and a licensed or certified practitioner with expertise relevant to the disability of the individual for whom services are being reviewed. Additional professional team members may be used as needed to effectively represent the multiple needs of an individual, or the multiple services provided by a program.

**Note:** The composition of the team may be amended with prior approval by DMA.

Written results of the visit must be communicated to DMA within ten (10) business days of the completion of the review.

### G. Quality Assurance

#### 1. Quality Assurance Reviews

The LME must perform quality assurance reviews for Medicaid reimbursable services. The sample size will be selected based on the size needed for a valid review of the service. These services must be individually reviewed with the sample size selected by the nature of the service. Medical records must be requested for each service reviewed and criteria applied as directed by DMA. The LME is responsible for sending a Notification Letter to the provider requesting the needed documents for the time period to be reviewed (See **Attachment M**).

Each month, DMA will pull a statewide sample of forty (40) records for CAP/MR-DD waiver services. The LME must conduct record reviews for the identified recipients that are assigned to the LME's catchment area and send the reviews to DMA.

The LME must forward all relevant documentation to DMA concerning any identified problems. DMA's Program Integrity Section will then be responsible for any subsequent review or disposition of the problem.

#### 2. Quality of Care Complaints

If at any time a clinical care manager becomes aware of circumstances that may be a quality of care issue (adverse incident), the LME must notify DMA of the complaint using the Notification of Quality of Care memo template (see **Attachment F**).

The following information must be indicated on the memo:

- Name of recipient
- Recipient's MID number

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## VIII. TYPES OF UTILIZATION REVIEWS

- The dates of service the recipient was under the clinical home provider's care
- The name and address of the service provider
- The service provider's Medicaid provider number
- The type of service provided by the provider
- The dates of service for the service provider
- The name of the individual making the complaint
- A summary of the complaint

The completed Notification of Quality of Care memo is sent to the Chief of DMA's Behavioral Health Services Unit for disposition.

A summary of quality of care complaints is provided by the LME to DMA on a quarterly basis (see **Section XXI.B.1.**).

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## IX. Authorization Process

The LME cannot authorize services for dates of service prior to the receipt of the authorization request unless the request meets the criteria for a retrospective reviews (see **Section VIII.E.**).

The LME will use the established authorization period for initial authorizations and re-authorizations indicated in **Attachment G.**

The Contractor shall accept secure transmissions from the service provider via surface mail, telephone, and secure electronic submissions to include e-mail, web-based, and fax. The ITR, ORF and CTCM are the approved Service Authorization Request forms and must be applied identically in all methods of acceptance. When the Contractor accepts electronic Service Authorization Requests, the provider must have an ID and password that uniquely identifies them. If the provider uploads the PCP, they must maintain the original signed forms on file.

The LME's UM medical director must ensure that authorization reviews are conducted by appropriate staff with experience relevant to the disability of the individual for whom services are being reviewed (see **Section IV.**). At any point during the authorization process the service provider may request to speak to the physician rendering an adverse decision.

### A. Administrative Denials

#### 1. Unable To Process – No Appeal Rights

For all recipients, there is required information to meet the standard of a valid request for services. The following information is mandatory: the recipient's name, address, Medicaid identification number, date of birth, the provider's Medicaid provider number and contact information, date of request, and the service requested must be indicated on the request form. This information may be garnered through the Recipient Eligibility file, Provider Enrollment file and the materials submitted by the provider directly to the UR Vendor.

In addition to the required information listed above, the following must be submitted to the LME to be able to process the request for authorization:

- The signed Request for Authorization form (ITR, ORF, CTCM) .
- The signed applicable Person Centered Plan (introductory or full).
  - Signatures must be present for the recipient, legally responsible person (if applicable), person responsible for the plan and clinician signing the service order indicating medical necessity;
  - Signatures can not be dated in excess of one year from the start date of the request; and
  - Signatures must be updated in conjunction with the review of Action Plan/Goals.
- The service order checkboxes which designate whether or not the clinician completed a face-to-face interview and reviewed the assessment must be checked for MH/SA recipients; and
- The Person Centered Plan contains information in the following sections to be considered a complete plan for review: Action Plan/Goals, page 2 of the Crisis Plan and the Observation and Assessment page.

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## IX. Authorization Process

Requests for authorization for the same service that is currently authorized to another provider for the same time period may be returned as Unable to Process based upon criteria identified in **Section X.A.**

Any request for authorization that is determined to be an identical duplicate to a request already received may be returned as Unable to Process based upon criteria identified in **Section X.A.**

If the vendor determines that the request does not meet the standards for a valid request, then,

- The clinical care manager does NOT review the request for medical necessity.
- The vendor documents the request as Unable to Process.
- A written notification must be mailed to the service provider within one (1) business day.

### 2. Unable to Process – With Appeal Rights

When a request for authorization is received for an individual who is not a current Medicaid recipient, as validated from the Recipient Eligibility file, the request may be returned to the provider. When a Request for Authorization is received which exceeds the benefit limit for the following services, it may also be returned as Unable to Process:

- CAP-MR/DD Cost Summary indicates a request in excess of \$17,500 for the Supports Waiver; or
- CAP-MR/DD Cost Summary indicates a request in excess of \$135,000 for the Comprehensive Waiver.

If the vendor determines that the individual does not meet the standards for Medicaid eligibility then,

- The clinical care manager does NOT review the request for medical necessity.
- The vendor documents the denial.
- A written notification must be mailed to the service provider and the recipient and/or his/her legal representative within one (1) business day.
- Appeal rights are provided as a part of the specialized denial letter to the recipient.

All other Requests for Authorization are forwarded to clinical staff and if necessary, are to be pended to request additional information as specified in Initial and Concurrent Reviews and listed under in **Section IX.E.**

### B. Initial and Concurrent Authorization Reviews

The authorization process is initiated when the service provider submits a completed Service Request Form to the LME. The LME must respond within the timeframes specified in **Section VII.G.** The LME reviews the form to verify that the request includes the required information and documentation.

The clinical care manager reviews the clinical information indicated on the Service Request Form and the treatment/service plan submitted with the form to determine if medical necessity is met for the requested service.

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## IX. Authorization Process

If the clinical care manager determines that medical necessity is met:

- The clinical care manager authorizes treatment/service and documents the approval.
- A written notification of the approval documenting the parameters of the authorization must be mailed to the service provider within one (1) business day.

If the clinical care manager determines that medical necessity is met but the request exceeds the allowable amount or duration, the age of the recipient determines the UR procedure:

For children under age 21:

- The LME clinical care manager reviews the request using EPSDT criteria. If the service authorization request meets the EPSDT criteria, the clinical care manager authorizes treatment/service and documents the approval
- A written notification of the approval documenting the parameters of the authorization must be mailed to the service provider within one (1) business day.

OR

- The clinical care manager determines that medical necessity is not met using EPSDT criteria.

For individuals age 21 or older:

- The clinical care manager authorizes treatment/service within the maximum benefit allowed and documents the approval.
- A written notification of the approval documenting the parameters of the authorization must be mailed to the service provider within one (1) business day. Although the request is not approved as submitted, it meets the maximum allowable benefit for that individual. No appeal rights are issued.

OR

- The clinical care manager reviews the medical necessity of the request as presented and determines that medical necessity is not met.

Thereafter, regardless of the recipient age, the clinical care manager:

- Contacts the treating clinician/service provider to discuss revising the treatment/service request.
- If the treating clinician/service provider agrees with the revisions, the clinical care manager documents the discussion in the record.
- The service provider must obtain approval from the recipient for the revised treatment/service plan.
- The authorization request is pended until the service provider verbally notifies the clinical care manager of the recipient's approval. This must be received within fifteen (15) business days.  
**Note:** If the recipient's approval is not obtained the request must be denied, reduced, terminated, or suspended on day 16.
- Upon receipt of the recipient's approval, the LME documents the record.
- A written notification of the approval documenting the parameters of the authorization must be mailed to the service provider within one (1) business day.

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## IX. Authorization Process

If an agreement to revise the treatment/service plan to meet medical necessity cannot be reached, the clinical care manager completes the Clinical Peer Review Form (see **Attachments H. and I**) and the case is forwarded to the LME UM medical director for **peer review**. If it is determined through peer review that medical necessity is not met, the LME must deny, reduce, or terminate the service.

- The LME must notify the treating clinician/service provider by telephone on the day the adverse action is completed.
- A detailed written notification of the action (see **Section X.**) must also be sent to the service provider and the recipient and/or his/her legal representative the treating clinician/service provider within one (1) business day.
- The LME must post the adverse action notice to the DMH/OAH secure website.

Note: When Concurrent Requests for authorization result in a denial or reduction of services, the LME will issue an authorization for a notification period of 30 days. Maintenance of Service (MOS) may also be applicable if the denial or reduction is appealed.

### C. Requests for Additional Units

Following an Initial or Concurrent Authorization, a provider may request additional units of service within the original authorization period to meet unforeseen client circumstances. When this occurs, the provider must clearly identify the request as such on a new ITR, ORF or CTCM and include new information which supports the medical necessity of the request. The LME must evaluate these requests as a separate review and issue a new authorization or adverse determination letter notifying the recipient of the decision.

### D. Additional Requirements for Service Specific Authorizations

#### 1. Inpatient Behavioral Health Services, Including Psychiatric Residential Treatment Facility Services

The service facility contacts the LME for authorization prior to admission. Contact may be initiated by the service facility by telephone; however, the service facility must follow up the verbal contact by submitting a Service Request Form. The LME must respond within the timeframes specified in **Section VII**. The LME reviews the form to verify that the request includes the required information and documentation.

If the service facility is requesting authorization for admission of a recipient under the age of 21 to a free-standing psychiatric facility (**hospital/psychiatric residential treatment facility**), the LME requests a CON (<http://www.ncdhhs.gov/dma/formsprov.html#bh>) from the service provider.

If the clinical care manager determines that medical necessity is met

- The clinical care manager verifies that the CON is properly executed.
- The clinical care manager authorizes treatment and documents the approval.
- A written notification of the approval documenting the parameters of the authorization must be mailed to the service provider and the recipient and/or his/her legal representative within one (1) business day.

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## IX. Authorization Process

Where applicable, if the CON is not received or is not properly executed, the authorization is pended. The Contractor sends the standard notification requesting additional information however the due date is 30 calendar days, rather than 15 days as for other services, to meet federal regulations for CON certification.

**Note:** If the CON is not received or it is improperly executed, the request must be denied, reduced, terminated, or suspended on day 31.

### 2. Residential Child Care Treatment Facility Services and Therapeutic Foster Care

The LME must confirm that the service provider is licensed and enrolled to provide the level of care that is being requested for the recipient and must indicate the appropriate State-created procedure code on the authorization.

### 3. Criterion 5 Services

When a recipient under the age of 17 meets discharge criteria but placement is not available in the community, the recipient's treating clinician/service provider must request continuation of service under Criterion 5.

The service provider must submit the Criterion 5 Services Needs/Discharge Planning Status Form with a copy of the discharge plan attached to the form.

The LME must respond within the timeframes specified in **Section VII.G.**

If the request for Criterion 5 is incomplete (e.g., missing discharge plan)

- The LME notifies the service facility that correct information is required
- The authorization request is pended until the service provider notifies the clinical care manager of the recipient's approval. This must be received within fifteen (15) business days.

**Note:** If the recipient's approval is not obtained the request must be denied, reduced, terminated, or suspended on day 16.

If the request for Criterion 5 is complete, the LME clinical care manager reviews the request and determines if placement is available or appropriate.

If the LME clinical care manager determines that placement is not available or appropriate

- Criterion 5 is certified for the dates of service until discharge and an authorization letter is issued.
- The letter is sent to the legal representative(s) advising them of the recipient's eligibility for Criterion 5.
- The clinical care manager faxes a continued stay form to the facility on the day that the request is approved.
- A written notification of the approval and the continued stay form must be mailed to the service provider within one (1) business day.

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## IX. Authorization Process

### 4. CAP/MR-DD and Targeted Case Management

Authorization may be requested for initial or concurrent services or if a recipient's eligibility is suspended (e.g., hospitalization, incarceration) and is then reinstated. If a CAP-MR/DD recipient is referred for Level of Care (LOC) review during an active authorization period, this may result in the termination of CAP eligibility and will be communicated from the LOC vendor for data entry by the LME.

The UR Vendor must determine from the client eligibility file which Waiver applies to the individual and apply the associated financial thresholds. Clients using the Support Waiver are indicated by a C2 indicator and may be authorized for services up to \$17,500 as reflected on the Cost Summary. Clients in the Comprehensive Waiver are indicated by CM on the eligibility file and may receive from \$17,500 to \$135,000 in services. The vendor may deny any service requests up to the \$135,000 limitation.

If the vendor approves a request for funding that exceeds \$100,000, the vendor must submit this request to DMH for additional review. The request is pended until DMH completes their review and approves or denies the Plan of Care. The results of the DMH review are communicated to the vendor for entry into the data system and issuance of the approved authorization letter. For denials, the responsibility for due process notification and appeals lies with DMH.

Concurrent reviews for re-authorizations of CAP/MR-DD services and targeted case management must be performed once annually on or about the anniversary of the birth month of the recipient. In addition to the standard documentation requirements for Requests for Authorization, the provider must submit a Cost Summary for CAP-MR/DD recipients.

If the review results in a determination that medical necessity may be met by reducing or authorizing alternative treatment services,

- The clinical care manager contacts the treating clinician/service provider to discuss revising the treatment/service plan.
- If the treating clinician/service provider agrees with the revisions, the clinical care manager documents the discussion in the record.
- The service provider must obtain approval from the recipient for the revised treatment/service plan.
- The authorization request is pended until the service provider notifies the clinical care manager of the recipient's approval. This must be received within fifteen (15) business days.

If it is determined that medical necessity is not met or an agreement to revise the treatment/service plan to meet medical necessity cannot be reached, the case is referred to the LME UM medical director or licensed psychologist for peer review. If the LME UM medical director or psychologist agrees that medical necessity is not met, the LME must deny, reduce, or terminate the service.

### 5. Out-of-State Services

The authorization process is initiated when the service provider submits a completed Out-of-State Placement Packet

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## IX. Authorization Process

(<http://www.ncdhhs.gov/mhddsas/statspublications/manualsforms/forms/forms-outofstplacement.pdf>) to the LME. The LME must respond within the timeframes specified in **Section VII.G**. The LME reviews the form to verify that the request includes the required information and documentation listed in **Section VI.E**.

The LME clinical care manager reviews the clinical information and determines if medical necessity is met based on approved Medicaid criteria and policy.

If the clinical care manager determines that medical necessity is met

- The LME contacts the service provider to determine if there are alternative facilities in North Carolina appropriate to meet the needs of the recipient.
- If there are no appropriate facilities in North Carolina, the LME contacts the DMA Behavioral Health Services Unit with the recommendation to approve the service.
- DMA issues written approval to the LME upon verification through DMH that the out-of-state provider meets enrollment criteria, has agreed to the assigned rate of payment, has agreed to accept the recipient, and has been assigned a Medicaid provider number.
- The clinical care manager authorizes treatment and documents the approval.
- A written notification of the approval documenting the parameters of the authorization must be mailed to the service provider within one (1) business day.

If the clinical care manager determines that medical necessity is met but the provision of service out-of-state does not appear to be appropriate, the LME contacts DMA to consult on the authorization request.

- If DMA directs the LME to approve the service, then care can be authorized.
  - ◆ DMA issues written approval to the LME upon verification by DMA that the out-of-state provider meets enrollment criteria and has been assigned a Medicaid provider number.
  - ◆ The clinical care manager authorizes treatment and documents the approval.
  - ◆ A written notification of the approval documenting the parameters of the authorization must be mailed to the service provider within one (1) business day.
- If DMA concurs with the LME, the LME must deny, reduce, or terminate the service.
  - ◆ The LME must notify the treating clinician/service provider by telephone on the day the adverse action is completed.
  - ◆ A detailed written notification of the action must also be sent to the service provider and the recipient and/or his/her legal representative the treating clinician/service provider within one (1) business day.
  - ◆ The LME must post the adverse action notice to the DMH/OAH secure website.

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## IX. Authorization Process

### E. Services Approved through Retrospective Reviews

Upon receipt of the Service Request Form and the medical records, the clinical care manager determines if medical necessity has been met. Retrospective reviews must be completed within the timeframes specified in **Section VI.I**. The LME must verify with DMA the date that the eligibility was entered into the Recipient Eligibility file to assure the authenticity of the provider request.

If the LME determines that the request does not include the required information for processing authorizations,

- The LME does NOT review the request for medical necessity.
- The LME documents as Unable to Process.
- A written notification must be mailed to the service provider within one (1) business day.

If the clinical care manager determines that, based on Medicaid criteria, medical necessity is met, the requested service authorization is approved.

- The clinical care manager documents the approval.
- A written notification of the approval documenting the parameters of the authorization must be mailed to the service provider within one (1) business day.

If the clinical care manager cannot determine medical necessity for all or a portion of the stays, the clinician completes the Clinical Review Form (see **Attachments H and I**) and the case is forwarded to the LME UM medical director for **peer review**.

If the peer review results in a determination that medical necessity was met, then the care is authorized.

- The clinical care manager documents the approval.
- A written notification of the approval documenting the parameters of the authorization must be mailed to the service provider within one (1) business day.

If the peer review determines that medical necessity is not met, the LME must deny any portion or all of the services rendered.

- A detailed written notification of the action must be sent to the service provider and the recipient and/or his/her legal representative the treating clinician/service provider within one (1) business day of the decision.
- The LME must post the adverse action notice to the DMH/OAH secure website.

## **X. DISPOSITION OF AUTHORIZATION REQUESTS**

### **A. Unable to Process – No Appeal Rights**

There are three conditions that meet the criteria for returning a Request for Authorization to the provider with no action taken. These are:

#### **1. Improper/Invalid Request**

When a service provider’s request for authorization does not contain the required data elements to be considered a proper or valid authorization request, the request must be returned to the service provider. These notifications do not require the LME to issue appeal rights to the recipient.

For all recipients, the recipient’s name, address, Medicaid identification number, date of birth, the provider’s Medicaid provider number and contact information, date of request, and the service requested must be indicated on the request form.

In addition to the required information listed above, the following must be submitted to the LME to be able to process the request for authorization:

- A signed Request for Authorization form (ITR, ORF, CTCM)
- The signed applicable Person Centered Plan (introductory or full).
  - Signatures must be present for the recipient, legally responsible person (if applicable), person responsible for the plan and clinician signing the service order indicating medical necessity;
  - Signatures can not be dated in excess of one year from the start date of the request; and
  - Signatures must be updated in conjunction with the review of Action Plan/Goals.
- The service order checkboxes which designate whether or not the clinician completed a face-to-face interview and reviewed the assessment must be checked for MH/SA recipients; and
- The Person Centered Plan contains information in the following sections to be considered a complete plan for review: Action Plan/Goals, page 2 of the Crisis Plan and the Observation and Assessment page.

If any of this information is not present, the LME returns the request to the service provider as Unable to Process.

The LME must issue a letter of return using a letter format (see **Attachment K**) approved by DMA.

<b>Type of Review</b>	<b>Notice</b>	<b>Description</b>
Initial Review Concurrent Review Retrospective Review	DMA 3503 MH	Request was returned to provider with no action taken

These types of notifications do not require the LME to issue appeal rights to the recipient and may be completed by administrative staff.

#### **2. Services that are Currently Authorized to Another Provider**

The LME may not authorize a service for a recipient during any active authorization period for this same service with another service provider.

## X. DISPOSITION OF AUTHORIZATION REQUESTS

The LME must receive the completed Discharge from Treatment Form from the service provider with the active authorization. If the LME receives a request for services from a provider for a recipient with an active authorization for that service, the Vendor must review the Comprehensive Withdrawal spreadsheet to determine if the provider is listed. If the provider is not listed on the spreadsheet, the service request will be returned to the provider for administrative reasons.

The LME must issue a letter of denial using a denial letter format (see **Attachment K**) approved by DMA.

Type of Review	Notice	Description
Initial Review Concurrent Review Retrospective Review	DMA 3503 MH	Request was returned to provider with no action taken

These types of notifications do not require the LME to issue appeal rights to the recipient and may be completed by administrative staff.

In situations where there is controversy regarding the legitimate provider of services and there is an appearance that medical necessity is present, the UR vendor should contact their LME staff (Customer Services, Provider Relations) for a determination. The LME will inform the UR Vendor by sending an email with their determination of the correct provider for authorization. If this cannot be resolved, then contact DMA who will coordinate the determination of client choice and associated dates of service and inform the UR Vendor.

### 3. Duplicate Requests

If it is determined that the authorization request is a duplicate of a request already received and:

- If no action has been taken on the initial request, return the duplicate request and indicate that no action was taken because the request was a duplicate and that action on the original request will be forthcoming.
- If the request has been reviewed and approved, return the duplicate request to the provider and indicate that no action was taken because the request was a duplicate.
- If the request has been reviewed, adverse action taken, and the recipient's appeal rights have not expired, review the request to see if additional information is contained in the request that would change the adverse decision. If there is no change in the adverse action, return the duplicate request to the service provider indicating that the initial decision stays; no appeal rights should be granted.

Type of Review	Notice	Description
Initial Review Concurrent Review Retrospective Review EPSDT Review	DMA 1058	If the recipient is under appeal rights, return the request to provider with no action taken

## X. DISPOSITION OF AUTHORIZATION REQUESTS

These types of notifications do not require the LME to issue appeal rights to the recipient.

If the appeal rights have expired, review the request as a new request. If the decision continues to be that the service is denied, reduced or terminated, the LME must issue an adverse notice and associated appeal rights.

Type of Review	Notice	Description
Initial Review Concurrent Review Retrospective Review EPSDT Review	DMA 2001, 2001E, 2002, 2002E	If the recipient's appeal rights have expired and adverse action is taken.
Recipient Appeal Request Form	DMA 2003	Allows recipient to request a hearing with the Office of Administrative Hearings

The decision for denial, reduction or termination may only be made by staff specified in **Section III.F**.

### B. Unable to Process With Appeal Rights - Ineligible Recipient

When a Request for Authorization is received for an individual who is not a current Medicaid recipient, as validated from the Recipient Eligibility file, the Request may be returned to the provider. When a Request for Authorization is received which exceeds the benefit limit for the following services, it may also be returned as Unable to Process:

- CAP-MR/DD Cost Summary indicates a request in excess of \$17,500 for the Supports Waiver; or
- CAP-MR/DD Cost Summary indicates a request in excess of \$135,000 for the Comprehensive Waiver.

The LME must issue a letter of denial informing the recipient and service provider that the service authorization request was denied and the reason for the denial. The LME must use a letter format approved by DMA. These reviews may be completed by administrative staff and require that appeal rights are issued.

Type of Review	Notice	Description
Initial Review Concurrent Review EPSDT Review Retrospective Review	DMA 2001 DMA 3503 MH	Request was denied due to lack of Medicaid Eligibility or Request exceeds the CAP-MR/DD Waiver Eligibility Indicator
Recipient Appeal Request Form	DMA 2003	Allows recipient to request a hearing with the Office of Administrative Hearings.

## X. DISPOSITION OF AUTHORIZATION REQUESTS

### C. Requested Service Exceeds Maximum Policy Guidelines

If the clinical care manager determines that the request exceeds the maximum allowable amount, duration or combination between services, the clinician may reduce the request to the maximum as follows:

1. When a request is received that exceeds the allowable **authorization period** for that service (**see Attachment G**), the clinical care manager may automatically authorize the maximum authorization period if medically necessary. This applies to all recipients and no appeal rights are issued.
2. When a request is received for an Adult age 21 and older that exceeds the maximum allowable **amount of service**, the clinical care manager may reduce the authorization to the maximum allowable units if medically necessary. No appeal rights are issued.

NOTE: Any authorization as noted above that is less than the maximum allowable must go through peer review.

NOTE: When a request is received for a Child under age 21 that exceeds the maximum allowable **amount of service**, the request is reviewed under EPSDT to determine medical necessity.

A written notification of the approval documenting the parameters of the authorization must be mailed to the service provider within one (1) business day. Although the request is not approved as submitted, it meets the maximum allowable benefit for that individual. No appeal rights are issued.

Initial Review Concurrent Review Retrospective Review	DMA 1059	Request was approved for maximum time allowed by service definition or clinical coverage policy.
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### D. Approval

If the requested service is determined to be medically necessary, the LME authorizes care issuing a written authorization/decision letter to the service provider within one (1) business day.

The LME must issue a letter of approval using a letter format (see **Attachment K**) approved by DMA that is appropriate to the request.

Type of Review	Notice	Description
Initial Review Concurrent Review Retrospective Review	DMA 3504	Request was approved as meeting medical necessity criteria.
Initial Review Concurrent Review EPSDT Review Retrospective Review	DMA3504E	Request was approved as meeting medical necessity criteria (clinical and EPSDT) for recipient under the age of 21.
Initial Review Concurrent Review Retrospective Review	DMA 1059	Request was approved for maximum time allowed by service definition or clinical coverage policy.

## X. DISPOSITION OF AUTHORIZATION REQUESTS

### E. Pended Requests

When a service provider's request for authorization contains the required data elements for a valid authorization request, however there is inadequate information to make a determination of medical necessity, the request is pended and the LME notifies the service provider that additional information is required to complete the service authorization review.

The request for additional information must be made by telephone and followed by a written information request within one (1) business day.

The LME must request additional information using a letter format (see **Attachment K**) approved by DMA.

Type of Review	Notice	Description
Initial Review Concurrent Review EPSDT Review Retrospective Review	DMA 3501	Additional information required to determine if service meets medical necessity for a recipient 21 years of age and older.
	DMA 3501E	Additional information required to determine if service meets medical necessity criteria (clinical and EPSDT) for recipient under 21 years of age.

If the provider does not respond to the request within fifteen (15) business days following the issuance of the request by submitting the needed information or requesting a time extension, the LME must deny the request for lack of information. The LME must issue a letter of denial informing the recipient and service provider that the service authorization request was denied due to the service provider's failure to provide the additional information. The LME must use a letter format (see **Attachment K**) approved by DMA.

Type of Review	Notice	Description
Initial Review Concurrent Review EPSDT Review Retrospective Review	DMA 2001A	Request was denied due to failure to provide additional requested information
Recipient Appeal Request Form	DMA 2003	Allows recipient to request a hearing with the Office of Administrative Hearings.

These types of notifications require the LME to issue appeal rights to the recipient, however, they may be completed by administrative staff.

### F. Revisions to the Original Request Resulting in a Change in Service

The LME may discuss with the service provider an alternative volume, duration or combination of services from that which was requested.

The service provider is responsible for reviewing the changes with the recipient and/or his/her legal representative and, if appropriate, with the recipient's treating clinician. If the recipient or legal representative agrees to the recommended service alternative, the service provider must submit a revised person centered

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## X. DISPOSITION OF AUTHORIZATION REQUESTS

plan with the consent of the recipient/legal representative indicated (by signature) in the person centered plan along with an authorization request, if indicated, for the alternatives service(s) discussed and/or a referral to an appropriate service provider for the alternative service. If the agreement is for an alternative amount of the same service requested, then revised documentation is not required.

The LME must retain documentation of the agreed upon changes in the requested services for review by DMA, the recipient/legal representative, and applicable service provider.

The LME must issue an authorization letter reflecting this change of service using a letter format (see **Attachment K**) approved by DMA.

If an agreement cannot be reached, the service authorization request is denied and appeal rights are issued. The decision for denial reduction or termination may only be made by staff specified in **Section III.F**.

### G. Denial/Reduction

The LME may deny, reduce or terminate a request for services if it is determined that:

- medical necessity criteria is not met for the specific service requested
- medical necessity criteria is not met for the volume or duration of the specific service requested
- the services would be ineffective
- a more cost-effective alternative that otherwise satisfies the standards for medically necessary services is available
- the services exceeds benefit limits (if 21 years of age or older only)
- the service provider failed to provide a complete authorization request form or failed to provide additional information as requested or
- other administrative reasons.

Authorization requests that are denied due to lack of medical necessity must be issued by appropriate clinical staff as defined in **Section III.F**.

In the event that the recipient has medical issues involved with the presenting problems, the recipient's treating medical practitioner must be consulted prior to issuance of any denial or recommendation of alternative service.

If the denial is appealed, the LME will issue Maintenance of Service authorization within the timeframes designated by the appeal process.

The LME must document the following information in the review record for authorization requests that are denied due to lack of medical necessity:

- specific service units and/or time period denied
- the reason for the denial and
- any alternative services that are recommended based on evidence-based treatment standards.

The LME must notify the individual and/or his/her legal representative (if any) by trackable mail with return receipt requested; the provider by regular mail or courier; and DMA electronically as specified by DMA.

## X. DISPOSITION OF AUTHORIZATION REQUESTS

The LME must issue an adverse notice using a letter format (see **Attachment K**) approved by DMA within the timeframes designated by the appeal process.

Type of Review	Notice	Description
Initial Review EPSDT Review	DMA 2001	Request was denied.
	DMA 2001E	Request reviewed under policy and EPSDT criteria and denied under EPSDT.
Concurrent Review EPSDT Review Retrospective Review	DMA 2002	Request was denied.
	DMA 2002E	Request reviewed under policy and EPSDT criteria and denied under EPSDT.

An explanation of the individual's appeal rights and a statement of the manner in which the individual may appeal the adverse determination must be included in the letter. An appeal request form must be included in the letter to the recipient and/or his/her legal representative. The appeal request form shall not be included in the provider's mailing.

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## **XI. NOTIFICATION OF ADVERSE ACTIONS**

### **A. Recipient Notices**

When an adverse decision is made to deny, reduce (change), terminate, or suspend a Medicaid applicant's or recipient's services, the recipient and/or his/her legal representative, where applicable, must be notified in writing by trackable mail of the decision.

The reason for the adverse action must be stated clearly in the notice and it must be specific to the recipient. For example, if medical necessity is not met, the clinician must state why medical necessity was not met.

The citations that support the decision must be specific [for example, 8A (3.1)(e)(3)]. It is not acceptable to cite only policy 8A. If the recipient is under 21 years of age, specify both the EPSDT and clinical coverage policy criteria that are not met.

The LME must complete all of the highlighted section in the header portion of the Recipient Hearing Request Form and mail it, along with the general information sheet about the hearing process and appeal form, to the recipient or guardian. Should the recipient be under 21 years of age or adjudicated incompetent, the notice must be mailed to the recipient's legal representative.

**Note:** The appeal information sheet and request form must be one page documents. Neither document can spill over to a second page and the documents cannot be duplexed.

While DMA would prefer that the name of the clinician making the decision appear on the notice, it is permissible to use a more generic signature such as Prior Approval Unit, LME.

When the LME mails the notice to the recipient and/or his/her legal representative the notice will also be posted to the DMH/OAH secure website.

### **B. Notice Format**

The notices provided are specific to DMA. The LME must customize the notices for their use. The notices must be reproduced on the LME's letterhead.

In the body of some of the notices, DMA's mailing address and telephone numbers are provided; the LME must insert appropriate contact information. All highlighted, bracketed information, and examples must be completed and customized to the individual recipient. No other changes should be made to the notices.

Information that is not applicable to the recipient must be removed from the notices.

The Spanish translation on page 1 of the DMA 2001, 2001A, 2001E, 2002, and 2002E must be maintained in the footer on that page. DMA will supply all required translated documents as they are approved.

Use of translated documents should be based upon a review of various sources of information including client eligibility data, PCP documents and Request for Services Form. When there is evidence that the recipient may require translated

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## **XI. NOTIFICATION OF ADVERSE ACTIONS**

documentation, the UR Vendor should err toward inclusion and mail both the English and translated documents.

### **C. Date of Notification**

If the adverse action is related to an initial request for services, the date of the notice is the date the notice is mailed. This cannot be the date the notice is picked-up by the mailing vendor unless the notice is mailed that day as well. The effective date is the day the notice is mailed.

If the adverse action is related to a re-authorization request, the effective date of the adverse action is 30 days from the date the notice is to be mailed.

### **D. Tracking Notifications**

In regard to mailing the notice, a trackable system must be used to mail the notices. If the notice is returned, the LME must provide for retention, security, and destruction of the notice in accordance with all applicable federal and state laws, rules, and regulations.

### **E. Notification Audits**

At a minimum, ten percent (10%) of the notifications generated as the result of an adverse action (denial, termination, reduction) must be audited by the LME on a monthly basis to verify the accuracy and timely notification of adverse actions.

The audit is used to verify that:

- the adverse determination letter was generated;
- the appropriate adverse determination letter was used;
- the adverse determination letter accurately reflected the decision of the LME's UM medical director, including decision, alternative recommendations when indicated, denial reason, and supporting citation;
- the adverse determination letter was appropriately addressed per the DMA provided consumer and provider demographic information; and
- MOS was posted accurately and within two business days as the appeal progressed through the various phases/stages.

The LME must report the findings of the audit to DMA on a monthly basis (see **Section XVII.C.**). DMA reserves the right to audit notifications as it deems necessary to assure quality.

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## **XII. HEARING AND APPEALS**

### **A. Filing for a Hearing with the Office of Administrative Hearings**

The recipient, legal representative, or a spokesperson designated in writing or verbally by the recipient or his/her legal representative have the right to appeal to the Office of Administrative Hearings (OAH).

To file the request, the Recipient Hearing Request Form (DMA 2003) (see **Attachment L**) must be completed, signed, dated, and faxed or mailed to **both** DHHS and OAH as specified on the form. The request must be filed within 30 days of the date the notice was mailed. The recipient's case will commence as soon as the completed recipient hearing request form is **received and filed** with OAH **AND** DHHS.

Refer to **Attachment M** for the Medicaid Recipient Fair Hearing Timeline.

### **B. Hearing Process**

Once the request for hearing is filed, the recipient, legal representative or spokesperson will be contacted by OAH or the Mediation Network of North Carolina to discuss their case and to be offered an opportunity for mediation in an effort to resolve the appeal. The Contractor shall participate in the mediation process.

If mediation resolves the case, the hearing will be dismissed, and services will be provided as specified by the Mediation Network of North Carolina. If the offer of mediation or the results of mediation are not accepted, the case will proceed to hearing and will be heard by an administrative law judge with OAH. The recipient, legal representative or spokesperson will be notified by mail of the date, time, and location of the hearing.

The administrative law judge will make a decision and will send that decision to Medicaid for a final agency decision. The recipient, legal representative or spokesperson will receive a written copy of both the administrative law judge's decision and Medicaid's final agency decision. If the recipient or legal representative does not agree with Medicaid's final agency decision, a judicial review in superior court may be requested. The hearing process must be completed within ninety (90) days of receipt of the completed Recipient Hearing Request Form.

### **C. Responsibilities of LME For Appeals and Hearings**

The LME must maintain and store all relevant documentation, which includes, but is not limited to:

- pertinent medical records to substantiate the adverse decision
- provider records of prior and concurrent treatment
- any LME records
- a written narrative of the LME's reasons to deny services to an individual, including citations to support the decision
- copies of the adverse notice and Recipient Hearing Request Form

The LME will be notified when a request for hearing has been received. If the recipient is eligible for MOS, the LME will enter the MOS within 2 Business days. The Contractor shall participate in all mediations and hearings.

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## **XII. HEARING AND APPEALS**

A clinical care manager may represent the Vendor in all mediations and modifications to the original decisions within the parameters of their authority. Participation in the mediation may be tape recorded only with the acknowledgement and agreement by all individuals.

A child/adolescent psychiatrist if the recipient is under 21 or an adult psychiatrist if over 21 or a physician or licensed psychologist for developmental disabilities only must represent DMA at the OAH proceedings. The only exception is when the decision for denying the service is based exclusively on Federal Regulation or DMA policy. In these instances, a clinical care manager may represent the Vendor in court proceedings.

Other qualified staff members must be available for reviews, interviews and testimony for mediation and hearings. Representation during mediation includes

- explaining why the adverse decision was made
- offering acceptable compromise options
- reviewing any new information presented, and changing the previous decision if necessary
- accepting or rejecting the mediator's resolution to the case
- entering the mediator's order into the authorization system if mediation resolution accepted
- notifying the provider of the outcome

Additionally, if the case goes to hearing, the LME is expected to testify, and, if the case goes to judicial review, the LME must provide information as requested by either the DMA Appeals Coordinator or Attorney General.

The LME will be notified regarding the final agency decision and/or judicial review.

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### **XIII. Maintenance of Service**

A recipient is entitled to MOS if he/she had been receiving services the day the decision was made and as long as he/she remains otherwise Medicaid eligible, unless they give up this right, for the pendency of the appeal. **This right to receive services applies even if the recipient changes providers.**

Initial requests for services are not subject to Maintenance of Services, with one exception. In the event the service has been previously authorized and there is no more than a 10-day gap between authorizations, the client may receive MOS. This application of MOS occurs only after receipt of a Request for an Appeal.

A new service request for the service under appeal is not required until the appeal is completed. However, the services must be provided in accordance with all federal and state applicable laws and rules and regulations. Services will be provided at the same level the recipient was receiving the day before the decision or the level requested by the provider, whichever is less. The services that continue must be based on the recipient's current condition. If the recipient loses his/her appeal, he/she may be required to pay for the services that continue because of the appeal.

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## **XIV. Quality Improvement and Performance**

### **A. Objectives**

The LME must have a quality improvement plan in place to monitor and assure the accuracy of their authorization decisions and the ongoing application of appropriate parameters, regulations, and policies in a consistent manner between clients, services, and service providers.

The LME must monitor the application of clinical best practices and the use of the least restrictive and most cost-effective service option that appropriately addresses the clinical need for which the services were requested.

The results of utilization review decisions will be the shaping of service delivery to Medicaid recipients. Expected outcomes will reflect the following in aggregate:

- Reduction in hospitalization utilization.
- Reduction in child residential services.
- Reduction in out of state authorizations.
- When child residential services are required, the majority will be served in Therapeutic Foster Care family setting.

#### **1. Quality Improvement Plan**

The quality improvement plan must have a senior staff person responsible for the management, tracking, and reporting of quality improvement activities. There shall be evidence that senior management has reviewed and responded to results of the quality improvement activities.

#### **2. Clinical Care Criteria**

The LME shall apply DMA approved clinical care criteria related to best practices based on current treatment protocols and national standards (e.g., SAMHSA, American Psychiatric Association, etc.) for all major diagnoses and treatment modalities. These clinical care criteria must support appropriateness of care decisions by the LME and must be made available to DMA.

#### **3. Monitoring**

The LME is expected to monitor performance, timeliness, accuracy, provider relations and services, and system performances and to develop improvement plans when indicated to maintain compliance with requirements and best clinical practices. The plan shall be responsive to trends in performance that indicate a need for staff training, new policy development, and increased resources.

#### **4. Required and Targeted Performance Improvement Plan**

DMA will mandate performance improvement strategies for deficiencies related to Performance Measures as well as for any emerging patterns of problem performance. DMA will notify the vendor that a required plan is to be submitted. The LME shall submit their plan within 15 business days of receipt of this notification and DMA must approve the plan within 15 business days of receipt. Extension of these timeframes may occur as negotiated. DMA reserves the right to require immediate corrective action for any problems that could result in potential harm to recipients.

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## **XIV. Quality Improvement and Performance**

The LME is expected to independently identify and correct performance problems. DMA will monitor the effectiveness of the interventions. Resolution of the performance issue is expected to be accomplished within 45 days of the approved plan. DMA may accommodate reasonable requests for extensions for completion, depending on the nature of the issue.

Required and Targeted Performance Improvement will be initiated prior to any financial penalties or withhold of payments.

### **B. Performance Measures for DMA**

#### **1. Treatment Patterns**

The mapping of diagnosis and previous treatment patterns to the appropriate authorization of community based services will be reviewed quarterly. The LME shall report to the Division any significant trends from the previous quarter and other historical data that may facilitate the provision of appropriate, cost-effective services to persons with Mental Health, Substance Abuse or Developmental Disability treatment needs.

#### **2. Erroneous Decisions**

Erroneous decisions are defined as authorizations and denials that violate an officially promulgated federal or state regulation, policy or directive. In cases of erroneous decisions, the LME shall reimburse DMA for the total cost to DMA of the service(s) provided in error.

#### **3. Record Review**

On a quarterly basis, a random sample of cases will be selected by DMA from the LME's database and the LME shall send DMA copies of all documentation on the sample cases.

This review may include but is not limited to the following:

- If the LME approves/authorizes an admission/service based on an incorrect/invalid CON, the LME shall reimburse DMA for the payments made to the provider
- If the LME approves/authorizes a service based on incomplete information per DMA requirements, i.e., lack of service orders or unsigned PCP, the LME may be subject to repayment for the total cost to DMA of the service(s) provided in error:
- In cases of erroneous decisions, the LME may be subject to repayment for the cost to DMA of the service(s) provided in error.
- DMA reserves the right to sample as many services as it deems necessary to assure quality.

#### **4. Timeline for Review of Services**

Reviews of authorization requests shall be completed according to the timeline associated with the level of client acuity for services.

The performance standard shall be that 93% of reviews and related documents for authorization requests received that meet DMA's

requirements for a complete request shall be completed and within the applicable Emergent/Urgent Residential or Inpatient Admissions, or

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## **XIV. Quality Improvement and Performance**

Routine **turnaround time (TAT)** period. However, periods of time during which an authorization request is pended by LME for receipt of additional information from a provider, or other third party shall be excluded from the compliance calculation.

Penalties for non compliance with the 93% standard for Emergent/Urgent Residential or Inpatient Admissions, or Routine service requests shall be:

- 87% to 92% = 1% reduction in reimbursement of Invoice for services in the applicable TAT category
- 81% to 86% = 2% of Invoice for services in the applicable TAT category
- 75% to 80% = 4% of Invoice for services in the applicable TAT category
- 69% to 74% = 8% of Invoice for services in the applicable TAT category
- 63% to 68% = 12% of Invoice for services in the applicable TAT category
- 62% to 57% = 16% of Invoice for services in the applicable TAT category
- 51% to 56% = 20% of Invoice for services in the applicable TAT category
- 50% or less = 25% of Invoice for services in the applicable TAT category

The LME shall report weekly the average TAT for all reviews for all services in each TAT category (Emergent/Urgent Residential or Inpatient Admissions, or Routine).

### **5. Review of Inpatient Services**

Telephone shall be used for inpatient hospital reviews. Telephone reviews shall generally be completed during the initial contact but shall in no event be completed more than four (4) business hours after the provider's initial contact with the LME. If the provider does not have the necessary information at the time of the initial telephone call, the LME shall complete the review within four (4) business hours after the LME receives the final information. The LME shall attain this standard of completing telephone reviews at least 97% or more. Compliance shall be monitored by DMA via audits. Any variations from these standards may result in a reduction in reimbursement of 1% per event per invoice.

### **6. Electronic Submissions**

The LME must keep a log of all electronic submissions and shall acknowledge receipt of those electronic communications by return e-mail or fax, depending on method of submission.

### **7. Notification**

Notification of the LME's approval shall be mailed to the appropriate parties within one (1) business day to the service provider. The LME shall attain this standard of communicating notifications at least 93% or more. Compliance shall be monitored by DMA via LME reports and audits. Any variations from these standards may result in a reduction of 1% per event per invoice.

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## **XIV. Quality Improvement and Performance**

### **8. Adverse Notification**

In the event of an adverse determination, notification of the LME's decision shall be mailed to the service provider and to the individual and/or his/her legal representative within one (1) business day. The correct DHHS standardized adverse decision notices with appeal rights shall be sent to the recipient and/or his/her legal representative by trackable mail with return receipt requested. Providers shall be sent a copy of the adverse decisions by regular mail or courier. In situations of controversy regarding the receipt of this communication, the LME may be required by DMA to resend authorization letters to specific providers or clients by trackable mail. The LME shall attain the standard of communicating adverse notifications at least 97% or more. Compliance shall be monitored by DMA via LME reporting, consumer or provider complaints and audits. Any variations from these standards may result in a reduction of 5% per event per invoice.

### **9. Telephone Access**

The LME shall ensure there are a sufficient number of telephone lines and staff so that all calls can be answered within five (5) rings at least 93% of the time. DMA will sample this standard through random phone calls to the LME. The LME shall capture data on average speed of answer, average hold time, call volume, and call abandonment rates. This data must be furnished electronically to DMA on a weekly basis through the Weekly Summary Inbound File. Any variations from these standards may result in a reduction of 1% per event per invoice.

### **10. Provider Relations**

The provider representative must be able to return all provider calls received Monday through Friday between 8:00 am and 6:00 pm within two (2) business hours of receipt.

The LME shall monitor and document this response time and report to the Division any deviations greater than 93%. Any variations from the 93% standard may reduce the total invoice amount by up to 5%.

### **11. Audits**

The LME shall conduct internal random audits to assess inter-rater reliability of review staff and whether reviews have been conducted in full accordance with established procedures and criteria. Audit results shall be sent to DMA on a quarterly basis.

### **12. Clinical Care Manager Certification/Credentials**

Reviews conducted by a clinical care manager who is not licensed/certified/credentialed in North Carolina will be subject to a reduction per event per invoice

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## XV. PRIVACY AND SECURITY

### A. **Records and Confidentiality**

The LME is required by state and federal law to maintain the confidentiality of all medical records. As a business associate, the LME is entitled to all of the service provider's medical records needed for this contract to which DMA itself is entitled under its contract to reimburse providers for services. Records received by the LME must be shared with only DMA or with other parties approved in writing by the individual or guardian and DMA.

### B. **HIPAA Standards**

The LME must comply with all HIPAA standards according to the federal HIPAA Privacy and Security guidelines. Please refer to the summary found in <http://www.dhhs.gov/ocr/privacysummary.pdf> at [http://www.cms.hhs.gov/EducationMaterials/04\\_SecurityMaterials.asp](http://www.cms.hhs.gov/EducationMaterials/04_SecurityMaterials.asp).

### C. **N.C. Identity Theft**

The LME must comply with all standards of the N.C. Identity Theft legislation (NCGS 132-1.10 and NCGS 75-65).

### D. **Mishandled Protected Health Information**

The LME agrees to report to DMA (i) any use or disclosure of electronic protected health information or other protected health information not provided for by the Business Associate Agreement of which it becomes aware; and (ii) any security incident of which it becomes aware.

These incidents, as well as any "security breach" as defined by N.C. Identity Theft legislation, must be reported on the HIPAA Breach Report (see **Attachment N**). The completed form must be submitted as an attachment by e-mail to [DMA.Privacy.Official@ncmail.net](mailto:DMA.Privacy.Official@ncmail.net).

### E. **Business Associate Requirements**

The LME will sign and abide by the standard DHHS Business Associate Agreement for HIPAA business associates. These requirements include

- The LME agrees to not use or disclose protected health information other than as permitted or required by the contract or as required by law.
- The LME agrees to use appropriate safeguards to prevent use or disclosure of the protected health information other than as provided for by this contract.
- The LME agrees to mitigate, to the extent practicable, any harmful effect that is known to the LME of a use or disclosure of protected health information by the LME in violation of the requirements of this contract.
- The LME agrees to report to DMA (i) any use or disclosure of electronic protected health information or other protected health information not provided for by the Business Associate Agreement of which it becomes aware; and (ii) any security incident of which it becomes aware.
- The LME agrees to ensure that an agent to whom it provides protected health information received from, or created or received by the LME on behalf of DMA agrees to the same restrictions and conditions that apply through this contract to the LME with respect to such information.

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## **XVI. CONFIDENTIALITY**

The LME is required by state and federal law to maintain the confidentiality of all medical records. The LME is entitled to the entire service provider's medical records to which DMA itself is entitled under its Contract to reimburse providers for services. Records received by the LME must be shared only with DMA or with other parties approved in writing by the individual or guardian and DMA.

- The LME agrees to not use or disclose Protected Health Information other than as permitted or required by the contract or as required by law.
- The LME agrees to use appropriate safeguards to prevent use or disclosure of the Protected Health Information other than as provided for by this contract.
- The LME agrees to mitigate, to the extent practicable, any harmful effect that is known to the LME of a use or disclosure of Protected Health Information by the LME in violation of the requirements of this contract.
- The LME agrees to report to DMA any use or disclosure of the Protected Health Information not provided for by this contract of which it becomes aware.
- The LME agrees to ensure that any agent to whom it provides Protected Health Information received from, or created or received by the LME on behalf of, DMA agrees to the same restrictions and conditions that apply through this contract to the LME with respect to such information.
- The LME agrees to provide access, at the request of DMA, to Protected Health Information in a designated record set to DMA or, as directed by DMA, to an individual in order to meet the requirements under 45 CFR 164.524.
- The LME agrees, at the request of DMA, to make any amendment(s) to Protected Health Information in a designated record set that DMA directs or agrees to pursuant to 45 CFR 164.526.
- Unless otherwise prohibited by law, the LME agrees to make internal practices, books, and records, including policies and procedures and Protected Health Information, relating to the use and disclosure of Protected Health Information received from, or created or received by the LME on behalf of, DMA available to DMA, or to the Secretary of the U.S. Department of Health and Human Services or his/her designee, in a time and manner designated by the Secretary of the U.S. Department of Health and Human Services, for purposes of the Secretary of the U.S. Department of Health and Human Services determining DMA's compliance with the Privacy Rule.
- The LME agrees to document such disclosures of Protected Health Information and information related to such disclosures as would be required for DMA to respond to a request by an individual for an accounting of disclosures of Protected Health Information in accordance with 45 CFR 164.528, and to provide this information to DMA or an individual to permit such a response.

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## **XVII. SECURITY**

### **A. Desktop and Laptop Computers**

All desktop and laptop computers must be secured to minimize unauthorized access and to reduce the opportunity for introduction of computer viruses.

- Each laptop's hard drive must be entirely encrypted such that if the laptop is lost or stolen, the information on the laptop would not be accessible by a non-owner.
- Each desktop and laptop must have an agency approved screen saver with a screen lock that engages after the keyboard and/or the mouse have been idle for a period of three (3) minutes or less.
- Each desktop and laptop must be turned off when not in use for an extended period of time or shall be powered down into a suspended status, except as specifically authorized by the agency security administrator.
- Anti-virus software must be installed on each desktop/laptop computer, and designated staff shall make certain that the desktop/laptop has the most current anti-virus software and appropriate patches installed.
- No modems or wireless communication devices shall be used in desktop or laptop computers, except as specifically authorized by the agency security administrator.
- No passwords shall be stored in clear text on desktop/laptop systems.
- Shared system-wide applications may not contain stored passwords that enable applications to be run without entry of the password each time the application is launched.
- Wireless systems must be approved by the agency security administrator and must have encryption capabilities enabled.
- Desktops/laptops that contain confidential information must be configured so that they cannot be booted from a floppy disk or a CD ROM.
- Critical data files must be backed up, and if confidential data is backed up, the backup media must receive appropriate security.
- Only standard approved software shall be installed on the desktop/laptop with any exceptions being pre-approved by the agency management and reviewed by the security administrator.
- Default settings for applications such as e-mail, calendar, and Internet access tools must be set to support a secure environment.
- Security audits must be performed internally on a regular basis to ensure compliance with the standard requirements.

### **B. Electronic Mail**

The LME must send all PA and UM/UR related e-mails using a secured, encryption enabled e-mail method, such as ZixMail.

To reduce unauthorized access to (e-mail) systems all e-mail services must adhere to the security requirements G.S. §147-33.110.

### **C. Configuration**

- All services and operations must be disabled except those that are expressly permitted (e.g., Web based mail, FTP, remote administration) and only the minimal Internet services required shall be installed.
- Default accounts and groups must be disabled or removed.
- The service banner must not report the mail server and operating system type and version.

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## **XVII. SECURITY**

- The mail server must be configured to use encrypted authentication of passwords or other authentication data.

### **D. Firewall/Mail Relay**

The mail server must be protected by a firewall that controls all traffic between the Internet and the server.

- Incoming and outgoing messages must be scanned for viruses at the firewall or mail relay. If attachments are allowed on the e-mail service, the mail server administrator must filter potentially dangerous attachment types (e.g., .vbs, .ws, .wsc file extensions) at the mail server or mail gateway and conduct virus scans on allowed file types.
- The firewall (or router that is acting as a firewall) must block all access to the mail server from the Internet except those ports that are required to operate the e-mail server.

### **E. Intrusion Detection System (IDS)/Intrusion Prevention System (IPS)**

- IDS/IPS must monitor network traffic to and from the mail server and must monitor changes to critical files on the mail server (host-based or file-integrity checker).
- A firewall, in conjunction with IDS/IPS, must block IP addresses or subnets that the IDS/IPS reports are attacking the organizational network.
- IDS/IPS must be configured to log events and the logs must be maintained for at least three months.
- IDS/IPS must be updated with new attack signatures at least weekly.

### **F. Other Security Requirements**

- Secure worksite – ID badges, restrictive entry, and account for people coming and going after hours via a signed logbook. Use of back doors shall be restricted to authorized personnel only.
- Data at rest – if the LME has a server room, it must be locked with restricted entry. A log must be maintained and signed by each individual entering the room, showing the date and time of each entry to the server room.
- Portable data devices – if data devices are portable, they may not be removed from the premises unless encrypted (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 must be encrypted and labeled as confidential.
- Passwords must be used on all applications.
- Passwords may not be shared, except with authorized support technicians
- All workforce must be trained to know the rules for HIPAA and NC Identity Theft. Statements must be signed indicating that they have received this training, understand it, and accept responsibility.
- All workforce must be trained to know the rules for HIPAA and NC Identity Theft. Statements must be signed indicating that they have received this training, understand it, and accept responsibility.

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## **XVIII. STATEWIDE ARCHITECTURE**

All systems must comply with the North Carolina statewide architecture requirements. Policies can be found at <http://www.ncsta.gov/>.

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## **XIX. DISASTER RECOVERY**

The LME must have a documented Disaster Recovery plan that has been implemented and, at a minimum, is tested annually. It must include, but not exclusively, the following items:

- Daily backups of software and production data files on all servers on both host and local area network systems.
- A verification and audit program must be used to confirm that the system backups are complete and accurate.
- If tapes are used for system backups, they must be rotated regularly to ensure the physical integrity of the tapes and to minimize tape parity error problems.
- Backup files transported offsite at a minimum of a twice-per-week schedule.
- Backup software and data maintained at an offsite location at least 50 km (30 mi.) from the primary site.
- Offsite location that has been tested to replicate the current working environment to provide full recovery within a period of 24 hours using the backups described above.
- Personnel trained to service beneficiaries, with controlled access to the clients' data, must either be present or have access to the backup site.
- Data traffic automatically rerouted to the backup site in the event of a disaster at the primary site.
- In case of a disruption in a service center, all telephone calls are to be automatically rerouted to the backup service center or alternate site.
- Communication plan, succession plan, and escalation process in the event of a disaster.
- Training of the workforce to assure familiarity with the plan.

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## XX. DATA PROCESSING

### A. General Requirements

While each LME will have their own unique automated utilization management system, it is necessary that these systems capture certain required information and standard elements. This is needed to ensure consistency of reporting statewide. Each LME will send a daily (Prior Approval) PA file to the Fiscal Agent. It will include prior authorization information and reporting information. Each LME will submit to the Fiscal Agent a weekly summary report which will contain summary information that is not captured on the daily file but is needed for reporting purposes. Each of these files is explained in more detail below. DMA will be the final arbitrator of any disputes about the specifications and methods for Fiscal Agent interface by LME.

In situations where issues arise, DMA, DIRM and the Fiscal Agent staff may evaluate the LME's data system to identify issues or barriers in data transfer. Joint assessment and problem-solving will occur to assure efficient and effective data system interface. Appropriate LME personnel will be engaged to meet this objective and may include both central operations and local data systems staff.

DMA retains privilege to access needed LME technical staff and IT systems according to the circumstances and situations presented for operations of these requirements.

DMA will provide written notification to the LME of all system change requirements no less than thirty (30) days prior to the effective date of operation.

### B. Prior Approval Process

In order for a provider to be paid for a service that requires prior approval, there must be an approved prior approval record on the Fiscal Agent's PA master file.

#### 1. Daily PA File

For LMEs to create a prior approval record on the PA master file, the LME must transmit this information by 2:00 p.m. daily to the Fiscal Agent in a fixed length flat file with variable length fields. Refer to **Attachment O** for *the LME PA Authorization Inbound/Outbound File Layout*.

The file layout indicates whether a field is required or optional. Also there is a column that defines each field.

When the Fiscal Agent receives the daily PA file, the Fiscal Agent's system validates the data before loading it to the PA master file. An accept and reject file will be sent to the LME's secure mailbox. The LME will be responsible for retrieving the files.

Refer to **Attachment O** for a copy of the *LME PA Authorization Inbound/Outbound File Layout*.

Any errors that are found will be sent back to the LME on the Reject file with an error code which identifies the error. Refer to **Attachment P** for the *PA Authorizations Error Codes*. The reject file will be available for the LME to pick up the next business day.

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## XX. DATA PROCESSING

The LME must work the reject file within three (3) business days and resubmit the prior approval request. It is critical that this be accomplished timely. If the provider files the claim before the rejected prior approval is resubmitted, the claim will deny for no PA on file.

Any variations will be processed directly with the fiscal vendor then referred to DMA for problem-solving as necessary. DMA staff will have full access to LME's IT system as needed for this purpose.

The LME must ensure that all transmissions are cataloged and maintained for the life of the Contract.

### 2. **Overlapping Authorization Dates**

Prior approvals with overlapping dates are not allowed. The LME must ensure that these are not sent to the Fiscal Agent on the PA file.

### 3. **Unmanaged Units of Service**

Prior Approval of services with unmanaged units or pass-through have a start date following the unmanaged units or the date of the request for services, with one exception. Authorization for Mobile Crisis services must include the unmanaged units for the total authorization. This occurs upon each initial PA.

### 4. **Authorization Record Transmissions**

Authorizations are transmitted using three types of Records – Add, Change and Void.

- Add – This record type identifies a prior authorization record that is being submitted to the Fiscal Agent for the very first time. A prior approval record must be added on the Fiscal Agent prior approval file before it can ever be changed or voided on the Fiscal Agent prior approval file.
- Change – This record type is to be used when an update needs to be made to a previously created or previously submitted prior authorization record. The resubmission of the existing prior authorization record will now have a Change record type.
- Void – This record type is to be used when a previously created prior authorization record was created in error regardless of status and already sent to the Fiscal Agent. The Void record type will identify prior authorization records that were created due to administrative errors caused by the Vendor.

Rules for the use of these record types must be followed to effectively transmit Prior Authorizations and ensure accuracy of information.

### 5. **Summary PA File**

The LME must send summary PA data to the Fiscal Agent on a weekly basis in a standard file format. The cutoff for data for this file is 11:00 a.m. Thursday and file must be sent by 2:00 p.m. every Thursday. Refer to **Attachment Q** for the *Weekly Summary Inbound/Outbound File Layout*.

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## XX. DATA PROCESSING

When the Fiscal Agent receives the PA Summary data file, the Fiscal Agent's system validates the data. A reject file will be sent via secure FTP to the LME the next business day. Refer to **Attachment Q** for a copy of the *Weekly Summary Inbound/Outbound File Layout*.

Any errors that are found will be sent back to the LME on the Summary Reject file with an error code which identifies the error. Refer to **Attachment R** for a list of the *Weekly Summary Error Codes*.

### C. Data Collection

Information obtained in each paper, telephone, and electronic review performed by the LME must be documented by the reviewer and entered into the LME's database. All documentation must be available in an electronic record. It is the responsibility of the reviewer of record to complete the required data elements before a review is completed and a recommendation is made to DMA.

Compliance will be audited quarterly by the LME's Director of Information Management Systems. All results of internal audits must be submitted to DMA on a quarterly basis. The audits must, at a minimum, address issues listed in the Performance Standards as well as internal continuous quality control measures adopted by the LME.

### D. Front-end Editing

In order to ensure the highest degree of accuracy of PA data into the DMA PA master file, there are certain front end edits that need to be implemented at the onset of PA data entry by the LME. If any of the edits fail, the PA should not be allowed to progress further through the system. The LME needs to provide edits including but not limited to the following information:

- Recipient MID, DOB, Name as compared to the Eligibility file.
- Provider Medicaid eligibility and service eligibility as compared to information on the Provider file.
- Valid diagnosis code.
- Not a duplicate.
- No overlapping dates with a current authorizations for the same service level.

### E. Data Ownership

The LME agrees that data provided by DMA to the LME is owned by DMA and shall only be used for the sole purpose of supporting the statement of work of these requirements. All data created in any form as part of these requirements shall become the property of DMA and shall be accessible by DMA at any time. All data associated with this Contract shall be transferred to and accepted by DMA prior to final payment to LME at the end of the Contract. Under no circumstances shall the LME share data with any other entity without prior written authorization by the DMA Contract Administrator or designee.

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## XXI. REPORTING

The LME must provide reports of collected data that will assist DMA in managing its system of care for recipients with behavioral health, developmental disability, and substance abuse treatment needs. Data may be requested by DMA in a frequency, form, and format necessary to meet its operational needs.

Data must be able to be transferred electronically and developed in Microsoft Access or Excel.

### A. Ad Hoc Reports

Ad hoc reports will be requested by DMA on an as needed basis. There will be instances where the report information will be needed the same day it is requested. Typically, ad hoc reports will be required within 1 to 2 days of the request.

### B. Quarterly Reports

#### 1. Quality of Care Incident Summary Report

The LME must submit a summary report (see **Attachment S**) on a quarterly basis of all quality of care complaints that were reported to DMA (see **Section VIII.G.2.**).

#### 2. Staff Qualification Verification

Refer to **Section IV.E.** for information on staff qualification verification.

#### 3. Significant Trends

The LME must report to DMA any significant trends from the previous quarter and other historical data that may facilitate the provision of appropriate, cost-effective service to recipients with mental health, substance abuse, or developmental disability treatment needs (see **Section V.D.**).

#### 4. Internal Compliance Audits

Results shall be submitted to DMA Contract Administrator according to the schedule identified under Performance Measures for DMA (see **Section XX.C.**).

#### 5. Provider Assistance Reports

Capture data on provider complaints/issues and provide a trend analysis report to DMA on a quarterly basis on issues and proposed solutions to provider calls.

### C. Monthly Report on Adverse Determination Letter Audit

The LME must submit a monthly report documenting the results of audits on the accuracy and completeness of notifications to recipients on service requests that resulted in an adverse action. The report must indicate how the errors identified in the audit were resolved (see **Section XI.E.**).

### D. Weekly Operations Reports

The Contractor shall submit weekly reports with the Timeline for the Review of Services, Telephone Access as identified in Section 3.16, Performance Standards, Summaries of UM Activity including numbers of approvals, denials, recipients, etc.

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## XXII. INVOICING

### A. Service Reviews

The quantities of reviews are defined by service and reflect a complete transaction for a specific client for a specific provider. This entails both approvals and denials. Those requests for services that are returned as Unable to Process and Voided Authorizations are excluded from the invoice.

When an authorization is approved based on medical necessity for a specific point in time, the activity should be invoiced. For example, both the original authorization of units and a request for additional units may be invoiced for the same client, provider and dates of service – the dates the transactions are sent to EDS would be different, indicating there were two review events. If a change is made to an existing authorization based upon a data entry error, miscalculation of units, etc, these types of corrections may not be invoiced.

Denials may be invoiced however the entry of MOS units associated with the denial is not considered a separate transaction. The denial and MOS actions should be invoiced only once. This applies to the data entry of OAH decisions – since there is no decision concerning medical necessity, this new authorization directed by the Final Agency Decision should not be invoiced.

1. Authorizations for CAP-MR/DD services are billed under three **types** of reviews rather than through specific services. The Initial Plan of Care review is typically a one time review and associated with the release of new CAP-MR/DD allocations and should be billed once per recipient. The Continued Need Review (CNR) is an annual review for each individual and includes Targeted Case Management services for that individual. This should be invoiced once per year regardless of the number of services authorized. The Discrete Service Reviews or Revisions will be the most frequent authorization or denial transaction. Each Service Authorization may be invoiced separately only for Discrete Service Reviews. This includes changes in providers, additional units, etc. Discrete Service Reviews shall be invoiced for a maximum of three or less services submitted simultaneously. If four or more services are submitted simultaneously for revision, the vendor should invoice this at the rate of a CNR.

Targeted Case Management is only to be invoiced when provided as a “stand alone service”. When there is a change in Targeted Case Management for a CAP-MR/DD recipient following the CNR, this should be invoiced as a discrete service review.

2. Retrospective Reviews are to be invoiced only for reviews related to recipient eligibility or under special circumstances where DMA has submitted written request for a client specific review. This category excludes the transfer of clients between providers. Separate rates are established for retrospective reviews for Inpatient, PRTF and Child Residential Services. Any other service requested for retrospective review should be invoiced at the routine rate for that service.
3. EPSDT, Out of State, Quality Assurance, Special Team Reviews and Court Proceedings have individual rates associated with these activities which are separate from the type of service reviewed.

## XXII. INVOICING

- EPSDT Reviews are designated for children under 21 where the key factor in approving a service is based upon EPSDT policy application. Denials may not be billed under this rate. This entails:
  - ◆ Any Out of State approval for Level III RCC services
  - ◆ Any service approved that specifically overrides clinical policy limitations as follows:
    - Authorization of MH/SA services for individuals that have a sole diagnosis of developmental disability;
  - ◆ Any combination between services that are not typically allowed as follows:
    - Authorization of both Targeted Case Management and Child MH/SA periodic service (CS-Individual, IIH, MST);
    - Authorization of CS-Individual service in addition to IIH or MST for transition purposes;
    - Authorization for more than one Day Service for transition purposes;
  - ◆ Services targeted to adults and approved for children under age 18; and
  - ◆ Special requests from DMA Clinical Policy identified under Non-Covered Services Requests.

**Note:** EPSDT Reviews are **not** to be invoiced for the following authorizations:

- Adult and Child Services for individuals between the ages of 18 and under age 21 should be invoiced under the standard service rate unless they meet one of the criteria above; and
- Child services that exceed established limits, such as 8 hours per week of CSS, are to be invoiced as a routine review.
- Out of State Reviews are designated when the client receives an approval or denial for service based upon medical necessity. It does not reflect any provider enrollment issues that may occur when DMA processes the provider. Any potentially incomplete reviews due to DMA provider enrollment will be excluded from invoicing.
- Quality Assurance Reviews are initiated by DMA and invoices should reflect the agreed upon quantity of recipients, regardless of the number of providers or services reviewed.
- Special Team Reviews will be based upon a documented request from DMA.
- Court Proceedings are the participation in mediation or hearing activities to support the clinical UR decision made.

The total invoice amount should be a summary of transactions from the PA File, CAP-MR/DD services and these additional categories for payment.

### B. Submitting Invoices

The LME must submit invoices with supporting documentation on a monthly basis. The invoice with supporting documentation must document all LME

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## XXII. INVOICING

activities from the previous month. The invoice must be submitted to DMA within ten (10) calendar days following the end of each month. The invoice must be in the DMA approved format/form, signed and dated by a responsible company official, and include the correct purchase order number. Refer to **Attachment T** for a copy of the invoice format.

The invoice must include the following information:

- The date range for the invoice.
- The quantity of each type of review.
- The rate for each type of review.
- The cost for each type of review and the total cost for all reviews.
- LME contact information including name, e-mail address, and phone numbers in case of inquiries regarding the initial invoice or supporting documentation.
- Invoice number.
- Invoice date.
- Tax ID number.
- Page numbers ( i.e., page 1 of 3).

The invoice shall be accompanied by two (2) copies of documentation supporting the invoice. The supporting documentation must be electronic in nature and contained on Read Only computer media, CD, or DVD data disk(s). The supporting documentation must be in Microsoft Excel format and password protected for personal health information. The totals for services and cost contained in the supporting documentation must equal the cost and number of services submitted in the invoice.

Invoices are sent by e-mail and on paper to the DMA Contract Administrator and to the designated representative of DMA's Contracts Monitoring Section. The invoice must be received and signed for by DMA's Contract Administrator or his/her designated representative.

All monthly invoices shall be directed to:

Chief of Behavioral Health Services  
 Division of Medical Assistance  
 1985 Umstead Drive, Kirby Building  
 2501 Mail Service Center  
 Raleigh NC 27699-2501  
 Phone (919) 855-4260  
 Fax (919) 733-2796

Contract Administrator  
 Division of Medical Assistance  
 1985 Umstead Drive, Kirby  
 Building  
 Raleigh NC 27603  
 Phone (919) 855-4150  
 Fax (919) 715-8486

DMA will review the invoice and documentation. Every effort will be made to pay the invoice, less any deductions, net thirty (30) days from the date the invoice arrives.

DMA's invoice reviewers shall be permitted, at their discretion, to ask for and review additional documentation. DMA's invoice reviewers will be permitted to review documentation and/or computer databases at DMA's offices or at the LME's offices, or elsewhere as deemed appropriate by DMA.

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## XXII. INVOICING

### C. Issue Resolution

DMA will attempt to resolve any questioned charges with the designated contact person. Unresolved questions of individual charges that do not appear to be appropriate and are not yet resolved, will be listed and submitted to the LME for response.

Invoices and supporting documentation dates must be congruous. The Performance report must match dates and data from invoices. Weekly documents may be provided to DMA but invoices must be modified and reissued for changes.

Issues related to invoice charges may be addressed by the LME as follows:

- In writing, submit additional documentation in support of the questioned charges.
- In writing, ask to withdraw the charges and reduce the invoice by the amount of the questioned charges.

### D. Reduction of Reimbursement to LME Based on Performance

The LME shall submit performance reports according to the frequency specified in **Section XIV**. The LME may deduct the amounts warranted by the performance reports with explanation of all adjustments incorporated into the invoice. DMA will analyze the reports and inform the LME of any reductions quarterly.

If there is a disagreement in the application of deductions, DMA will schedule an informal meeting within fifteen (15) days to discuss any contested tentative penalty. DMA will issue its final decision with fifteen (15) days of the conclusion of the informal hearing.

Performance targets based upon service outcomes are assessed. Any payments, withholding or deductions will be assessed quarterly following receipt of data reports and may be applied retroactively to the previous 12-month aggregate payments.

### E. Payment

Request for payment is via monthly invoice from the LME to DMA. Payment is based on unit price per review.

Payment to the LME is made after the invoice is reconciled and audited. DMA will pay only those items that are verified and approved on the invoice. All charges that are unsupported or not verifiable will be deducted from the invoice.

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## XXIII. OTHER REQUIREMENTS

### A. Meetings

At DMA's request, the LME shall meet with DMA at the DMA's offices in Raleigh, North Carolina or another mutually agreeable site to discuss problems encountered by the LME, to review progress, and/or to discuss approaches to problems. Anticipated frequency of meetings/conference calls is monthly.

### B. Contract Administrator

The LME shall designate a single Contract Administrator to be the primary contact with DMA, for all issues regarding this Contract. The LME's Contract Administrator, or coverage designee during absences, shall be available by phone, facsimile, or e-mail at any time during business hours, 8:00 a.m. to 6:00 p.m.

### C. Travel

The LME shall be responsible for all travel expenses incurred by the LME.

### D. Testing

The LME must participate in extensive testing of the PA file and the summary file for implementation as well as any time there are changes to either of these files.

The LME must allow DMA to review testing of their internal system changes required to meet the standard requirements for reporting.

### E. Record Release

All records must be released as requested to DMA and its agents including, but not limited to:

- Medicaid Investigation Unit
- Attorneys General
- Office of Inspector General
- Centers for Medicare and Medicaid Services

### F. Provider Training

The LME shall be responsible for training service providers on its prior approval policies and procedures and on clinical care criteria to assure effective and efficient request for services. The LME is responsible for ongoing training and technical assistance to service providers on both an individual and group basis to assure effective performance and continued access to services for Medicaid recipients.

### G. Payment for Services by Providers

Circumstances arise where a provider's enrollment number may change, typically due to change in ownership or merger between companies. When this occurs the LME may charge the provider to institute a change to existing authorizations with a terminated provider number. If a provider wishes to have the LME make changes to the provider number on an authorization without having to submit a new authorization request, the LME will charge the provider \$9.70 for each authorization changed. This fee will cover the cost of making these changes, since changing a provider number on an authorization requires voiding the old authorization, building a new authorization with the new provider number, attaching relevant inquiries and reviews into the inquiry, documenting the basis of the activity, and creating and mailing an authorization letter to the provider that corresponds to the new authorization. The requested changes will be completed

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### **XXIII. OTHER REQUIREMENTS**

within ten (10) business days after the receipt of the payment. Any requests for reasons other than those cited must be routed through DMA for approval.