



## North Carolina Department of Health and Human Services

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### MEMORANDUM

**TO:** Legislative Oversight Committee Members  
Local CFAC Chairs  
NC Council of Community Programs  
County Managers  
State Facility Directors  
LME Board Chairs  
Advocacy Organizations  
MH/DD/SAS Stakeholder Organizations

Commission for MH/DD/SAS  
State CFAC  
NC Assoc. of County Commissioners  
County Board Chairs  
LME Directors  
DHHS Division Directors  
Provider Organizations  
NC Assoc. of County DSS Directors

**FROM:** Dr. Craigan L. Gray  
Leza Wainwright *lw*

**SUBJECT:** Implementation Update #58  
Extension for Provisionally Licensed Services  
Extension of Sunset Clause for Nurse Practitioners  
Prior Authorization for CPT Codes 99408/99409  
Updated Outpatient Prior Authorization Form  
Facility Based Crisis & Mobile Crisis MMIS Edits

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Record Retention and Disposition Guidelines  
Implementation of UM by LMEs

### **Extension of Coverage for Provisionally Licensed Providers Delivering Reimbursable Outpatient Behavioral Health Services Billed through the Local Management Entity**

The deadline for coverage of provisionally licensed providers delivering outpatient behavioral health services as a reimbursable service under Medicaid and state funds and billed through the Local Management Entity (LME) **has been extended to June 30, 2010**. The Division of Medical Assistance (DMA) and the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS) will continue to pay for services delivered by the provisionally licensed individuals listed above when billed through LMEs under HCPCS procedure codes H0001, H0004, H0005, and H0031 until that date. During the next six months, the Divisions will also evaluate the rates paid for these codes to ensure parity with rates for comparable CPT coded services.

As outlined in Implementation Update # 32, the LME may choose to provide this billing service on behalf of the provisionally licensed professional. If the provisionally licensed professional is employed by an agency, the agency must develop a contract directly with the LME to do this billing for them. If the provisionally licensed professionals work independently, they should contact their licensure board prior to developing a contract with the LME to ensure compliance with each profession's scope of practice.

In addition to providing outpatient behavioral health services billed through an LME, there are various other means for provisionally licensed professionals to obtain the clinical experience required by their licensing boards. These include:

- Providing outpatient services working with a physician using Medicaid’s “Incident To” policy (see the March 2009 Medicaid Bulletin).
- Providing enhanced behavioral health (Community Intervention) services as the Qualified Professional (QP) in order to receive family and community-based clinical experience.
- Serving as the licensed professional in the Intensive In-Home service.

**Extension of Sunset Clause for Nurse Practitioners who Provide Outpatient Behavioral Health Services**

DMA has extended the sunset clause for nurse practitioners who provide outpatient behavioral health services. DMA will allow nurse practitioners who possess an Advanced Certification in areas other than psychiatric nursing, and who have two years of mental health experience to enroll under this sunset clause. Under this clause, all nurse practitioners will be required to complete and submit the Advanced Psychiatric Certification to DMA Provider Services on or before June 30, 2015. Failure to complete the certification by June 30, 2015, will result in termination of participation in the N.C. Medicaid Program. It is DMA’s expectation that all providers will practice within the scope of their licensure, training, and practice competencies.

As a reminder, nurse practitioners must direct enroll with Medicaid to be eligible to provide outpatient behavioral health services to adults and children. Nurse practitioners may also provide services “incident to” a physician if they are employed in a physician’s office or a physician-directed clinic. However, all behavioral health practitioner services billed under “incident to” must meet the guidelines outlined in the May 2005 Special Bulletin, *Expansion of Provider Types for Outpatient Behavioral Health Services, Phase II*, and the article titled *Modification in Supervision When Practicing “Incident To” a Physician* published in the October 2008 Medicaid Bulletin. (The general Medicaid Bulletin and the Special Bulletin are available on DMA’s website at <http://www.ncdhhs.gov/dma/bulletin/>.)

**Prior Authorization for CPT Procedure Codes 99408 and 99409**

This is a clarification of the prior approval guidelines for provisionally licensed providers billing ‘incident to’ a physician outlined in the March 2009 and May 2009 Medicaid Bulletins (<http://www.ncdhhs.gov/dma/bulletin/>). In order to facilitate best practice and integrated care for clients, CPT procedure codes 99408 and 99409 do not require prior authorization. These codes are also used by physicians and other medical professionals for substance abuse assessments and screenings. ValueOptions will not process prior authorization requests submitted for these CPT codes.

**Outpatient Providers: Updated Outpatient Prior Authorization Form (ORF2)**

This is a reminder of current outpatient prior authorization and billing guidelines for outpatient behavioral health services outlined in the June 2009 Implementation Update/Medicaid Bulletin. ValueOptions has revised the current Outpatient Review Form (ORF2). Please see the ValueOptions website, [http://www.valueoptions.com/providers/Network/North\\_Carolina\\_Medicaid.htm](http://www.valueoptions.com/providers/Network/North_Carolina_Medicaid.htm), for the revised form.

Effective July 1, 2009, providers must use the revised ORF2 for prior authorization requests. Providers should pay special attention to these two fields on the revised form:

- Attending Provider Name/Medicaid #
- Billing Provider Name/Medicaid #

Both fields must be completed. Prior authorizations will be created for the Billing Provider/Medicaid Number. Providers must enter the Billing Medicaid Provider Number associated with the Billing National Provider Identifier (NPI) with which they will submit their claims (do not submit NPI on the ORF2).

Prior authorization requests for group providers will cover all providers under that Billing Medicaid Provider Number. Do not submit a new request for a provider that fills in should the primary provider be absent.

After September 1, 2009, ValueOptions will return any request as “Unable to Process” if it is submitted on the old ORF2 form or if the two fields noted above are not completed.

**Updated Edits for Facility Based Crisis and Mobile Crisis Services**

The Division of Medical Assistance has updated edits in the Medicaid Management Information System (MMIS) to by-pass third party commercial insurance and Medicare for Facility Based Crisis and mobile crisis services, since these services are not covered under those plans. Claims will no longer deny simply because the recipient has third party insurance and/or Medicare.

### **DMA Budget Initiative Web Page**

DMA will implement a number of changes in response to proposed legislated budget reductions. Providers will be notified of operational changes, and coverage and policy changes via the Medicaid Bulletin. These changes will also be listed on DMA's website at <http://www.ncdhhs.gov/dma/provider/budgetinitiatives.htm>.

### **CAP-MR/DD Update: Oral Nutritional Supplements (Supplement to Implementation Update #57, June 2009)**

Oral nutritional supplements **are covered for children under the age of 21 under Durable Medical Equipment (DME)**, when justification of medical necessity is provided. Oral nutritional supplements for children can be billed by providers enrolled as a Medicaid DME provider. All applicable guidelines can be located in the DME Policy 5A located on the DMA website, accessed by the provider link.

Oral nutritional supplements are **not** covered for adults (individuals over the age of 21) **under DME**. Adults who are receiving CAP-MR/DD services may receive oral nutritional supplements through regular Medicaid which are billed as "B" codes. The need for oral nutritional supplements shall be justified and documented on both the individual Person Centered Plan and the cost summary, either under Medicaid costs or in the comment section. The cost does not count against the \$135,000/\$17,500 yearly budget. A physician's order is required. Oral nutritional supplements **do not** require prior approval from the utilization review vendor. T1999 cannot be used for adults if the ordered nutritional supplement has an established B code.

Authorizations received previously are still valid and billing and payment should be honored if all requirements are met. For specific LME billing codes please refer to Implementation Update #57.

### **Standardization of Local Provider Monitoring Tool**

The Provider Monitoring Tool (PMT) was implemented on January 1, 2009 and is used by the LMEs for routine monitoring of local providers. Plans were to make revisions to the tool after it had been in use for six months. Posting and implementation of the revised PMT on July 1 has been postponed in order to make determinations in the areas discussed below.

- The PMT Workgroup (which consists of representatives from the LMEs, provider network, and DMH/DD/SAS staff) has made revisions to the tool in order to clarify certain key elements/sub-elements, to avoid duplication, and to further streamline the monitoring process. Revisions were made based on feedback and questions from the provider community and from LMEs administering the tool.
- A crosswalk of the PMT to national accreditation standards (CARF, COA, CQL, and The Joint Commission) has been developed to determine how the standards of each accreditation agency equate to the elements of the PMT.
- An analysis has been made of the relationship between national accreditation and provider performance as measured by performance on Medicaid audits and post-payment reviews, the results of complaint investigations, and the integrity of Medicaid billing.
- A survey of other states that have implemented deemed status for providers is underway in order to determine those elements of the process that have best ensured accountability in protecting the well-being of individuals receiving services.

In the coming weeks there will be discussions within the DMH/DD/SAS and in the PMT Workgroup related to the tool and the monitoring process as a whole to determine:

1. Ways to further streamline the process and reduce duplication in monitoring efforts.
2. The impact of national accreditation on the provision of quality services, how the accreditation process might enhance the administration of the PMT, and what type of deemed status could be granted to accredited providers.
3. How the Division of Health Service Regulation (DHSR) survey process for licensed facilities and the administration of the PMT might complement one another and where the PMT fits in terms of the local monitoring of those facilities.
4. How the Frequency and Extent of Monitoring Tool (FEM) might be recalibrated to give more weight to national accreditation and DHSR licensure.

The results of these discussions will further impact the PMT, most likely necessitating additional revisions; therefore, a decision has been made to postpone implementation of the revised tool until the above decisions have been made. LMEs should continue to use the standardized tool that is posted on the web in the interim.

Feedback and questions should be sent to [Provider.Monitoring@ncmail.net](mailto:Provider.Monitoring@ncmail.net)

## **Record Retention and Disposition Guidelines for Staff in the Central Office, State Facilities, LMEs and Provider**

### **Agencies**

Managing the life cycle of records is the responsibility of LME, and provider agency staff. Records management refers to: "...the application of efficient and economical management methods [for] the creation, utilization, maintenance, retention, preservation, and disposal of official records..." (GS §132-8.1). LMEs and providers are required to demonstrate compliance to the provisions of Chapters 121 and 132 of the NC General Statutes which govern the retention and disposition of public records.

The organization of the public mental health, developmental disabilities, and substance abuse service system has undergone a transformation in recent years, including the merger and consolidation of LMEs and a significant expansion of private provider agencies. It is necessary to update all record retention guidelines in light of these new realities. Toward this end, several projects are underway to meet this requirement.

Because the record types for human services are so different from the needs of other departments, specific schedules were developed and are being updated to reflect the record management needs of our present system. APSM 10-3 (June 1989) and APSM 10-4 (October 1986) address the additional record management needs for administrators and providers of mh/dd/sa services. The schedule for LMEs will be revised and a schedule that applies specifically to the mh/dd/sa provider network will be developed. Focus groups will be used to develop and fine tune these schedules. The first such focus group will convene at the upcoming NC Health Information Management Association (NCHIMA) Behavioral Health Section annual meeting in August. In addition, tools will be developed to assist all staff in carrying out this responsibility. LMEs and providers should continue to use the current retention schedules until the revised schedules are completed. These schedules can be accessed from the following links:

Schedule for State and Area Facilities (APSM 10-3):

<http://www.ncdhhs.gov/mhddsas/statspublications/manualsforms/aps/apsm10-3retentionupdated5-05.pdf>

Schedule for Central and Regional Offices (APSM 10-4):

<http://www.ncdhhs.gov/mhddsas/statspublications/manualsforms/aps/10-4apsm-recordretention1986.pdf>

Records management and records retention and disposition issues are coordinated by Cynthia Allen Coe who is a Registered Health Information Administrator (RHIA) on staff with the Accountability Team. Please direct questions related to these issues to her at [Cynthia.Coe@ncmail.net](mailto:Cynthia.Coe@ncmail.net) or at (910) 483-3869.

### **Implementation of Utilization Management by Local Management Entities**

N.C. Session Law 2008–107, Section 10.15(x), requires the Department of Health and Human Services to return the service authorizations, utilization reviews, and utilization management functions to the Local Management Entities. In the [March 2009 General Medicaid Bulletin](#), providers were notified that four LMEs had been selected to perform this function and that implementation was planned for July 1, 2009.

DHHS is continuing to work on transferring the utilization review functions to the LMEs to meet the intent of the legislation. However, due to factors such as the state of the economy, the magnitude of the required system changes, and other budget concerns, we do not anticipate being able to implement until January 2010.

Prior to implementation, there will be provider training and outreach. Providers will know the implementation plans well in advance of the effective date. DMA will use the [Medicaid Bulletins](#) and the [Implementation Updates](#) from DMH/DD/SAS and DMA to keep providers informed and up to date on activities.

Unless noted otherwise, please email any questions related to this Implementation Update to [ContactDMH@ncmail.net](mailto:ContactDMH@ncmail.net).

cc: Secretary Lanier M. Cansler  
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