



North Carolina Department of Health and Human Services

Beverly Eaves Perdue, Governor

Lanier M. Cansler, Secretary

Division of Mental Health, Developmental Disabilities and Substance Abuse Services

3001 Mail Service Center
Raleigh, North Carolina 27699-3001
Tel 919-733-7011 • Fax 919-508-0951
Leza Wainwright, Director

Division of Medical Assistance



2501 Mail Service Center
Raleigh, North Carolina 27699-2501
Tel 919-855-4100 • Fax 919-733-6608
Tara R. Larson Acting Director

March 2, 2009

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: Tara Larson 
Leza Wainwright 

SUBJECT: Implementation Update #54
DHHS Awards Replacement MMIS Contract
Routing of NEAs for Endorsement Withdrawal
CIS Providers 3 Year Re-Endorsement
CSS Tiered Rates
Posting CS SPA, Clinical Policy 8A & CSS
Calculating CS QP Standard
Professional Tx Services in Facility Based Crisis
Targeted Case Management Rates

CAP MR/DD Update
Crisis Services Update
Revised Record Mgt. and Doc. Manual
Revised PCP and PCP Instruction Manual
Revised ITR Form
Residential Tx Requests via ProviderConnect
Mental Health Provider – Claims Data
DMA PI Staffing Announcements

DHHS Awards Contract for Replacement MMIS

The N.C. Department of Health and Human Services (DHHS) has awarded a contract to Computer Sciences Corporation (CSC) to develop and implement a replacement Medicaid Management Information System (MMIS) in support of healthcare administration for multiple DHHS agencies.

Initially, the replacement MMIS will be used by the Division of Medical Assistance (DMA); the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH); the Division of Public Health (DPH); the Migrant Program for the Office of Rural Health and Community Care (ORHCC); and the Division of Health Service Regulation (DHSR). DMA will assume the administration of the N.C. Health Choice Program in 2010, and Health Choice claims processing and operational support will be part of the replacement MMIS multi-payer environment at start-up in 2011.

CSC will run the system and serve as the fiscal agent for DHHS and its divisions, providing operational support to manage provider and recipient call centers, prior authorization reviews conducted by EDS and other vendors, claims processing, pharmacy operations, medical policy reviews, and other administrative activities. CSC will be the fiscal agent for four years with one 1-year renewal option.

The DHHS Office of MMIS Services (OMMISS) will provide contract oversight and management for the implementation of the multi-payer replacement MMIS. OMMISS, together with staff from other DHHS divisions, will work closely with CSC on the total overall design, development, and installation of the system.

As part of the contractual agreement, responsibilities for Medicaid provider enrollment, credentialing, and verification, along with retrospective drug utilization review (Retro-DUR) functions will be assumed by CSC within 120 days.

DHHS and CSC recognize the importance of early and continued interaction with the provider community and are moving to facilitate that interaction as quickly as possible.

More information on early implementation activities and replacement system development will appear in future Implementation Updates and Medicaid Bulletins.

Routing of Notification of Endorsement Action (NEA) Submissions for Withdrawal of Endorsement

Due to continued problems with compliance, this is a republication of the guidance given in Implementation Update # 43 concerning the submission of Notification of Endorsement Action (NEA). **The endorsing agency must submit NEA letters to the Division of Medical Assistance via certified mail to: DMA Provider Services, 801 Ruggles Drive, Raleigh NC 27699-2501 or electronically to endorsement.dma@ncmail.net.** The endorsing agency shall copy DMH/DD/SAS at: endorsement.accountability@ncmail.net. This guidance is in accordance with DMH/DD/SAS Policy and Procedure for Endorsement of Providers of Medicaid Reimbursable MH/DD/SA services dated 12/3/2007. Please ensure that the NEA letters submitted to DMA are signed by the endorsing agency CEO for voluntary and involuntary withdrawals. Unsigned NEA letters will not be accepted by DMA.

Community Intervention Service Providers Three Year Re-Endorsement

Many Community Intervention providers began providing services in March 2006. For providers that received a three year endorsement, the end of the initial full endorsement period is approaching.

Business Verification

According to the Policy and Procedures for Endorsement of Providers of Medicaid Reimbursable MH/DD/SA Services (12/3/07), page 5, in order to request a new business verification timeframe providers must submit to the LME a letter of attestation. The letter of attestation must include:

1. Current business information
2. A copy of the national accreditation certificate
3. A report of any dissolutions, revocations, or revenue suspensions that have occurred over the past three years.

Attached is a standardized Re-endorsement Letter of Attestation that providers should use when they submit the above mentioned information to the LME in order to extend their business verification for three additional years. The attached letter of attestation and above mentioned information should be submitted to the LME that granted the provider's business verification.

Once the LME approves the provider's business verification for three additional years, the LME completes a Notification of Endorsement letter indicating the new effective business verification dates. The provider will be responsible for submitting the NEA to DMA.

If the provider does not submit a Re-endorsement Letter of Attestation to the LME, the LME must notify DMA by completing the NEA letter and note in the comment section that the business verification has expired and has not been renewed because of failure to submit the Re-endorsement Letter of Attestation. In this case, the LME will take the following actions:

1. Send a copy of the NEA to the provider via certified mail
2. Notify other LMEs statewide
3. Submit the NEA letter to DMA via electronic submission.

The three year re-endorsement process is based on the full endorsement date (not the conditional endorsement date or the enrollment date).

In the event of a denial the provider must wait six months before reapplying for business verification with any LME.

Site and Service Re-endorsement

In addition, site/service re-endorsement will require the submission of an NEA letter to the provider. LMEs should make a determination regarding compliance with service specific requirements for currently endorsed providers. This

determination should be as a result of monitoring activities or on-site endorsement reviews (based on monitoring reviews, post payment reviews, multiple plans of corrections, etc.) using service specific endorsement check sheets. An on-site endorsement review is not required; the LME will make the determination as to the need for an onsite review. It is the responsibility of the LME to initiate the site and service re-endorsement process and to generate the NEAs. Providers currently under an **approved** plan of correction may not be denied for that reason. If approved for re-endorsement, the LME should complete the NEA letter indicating an endorsement period of three more years. The provider will be responsible for submitting the NEA to DMA.

If re-endorsement is denied as a result of noncompliance with service specific requirements, the LME will indicate “denial” on the comment section and include the reason. The LME will take the following actions:

1. Send a copy of the NEA to the provider via certified mail
2. Notify other LMEs statewide
3. Submit the NEA to DMA via electronic submission

This process does not apply to CAP-MR/DD providers during their transition period to the new tiers.

Community Support Services – Tiered Rates (Repeat from IM #53)

The General Assembly enacted Session Law 2008-107 Section 10.15A(a)(b), which changes the payment methodology of Community Support services from a blended rate to a tiered rate based upon the individual qualifications of the staff providing the service. DMA submitted a State Plan Amendment to CMS for approval to implement these changes. **The SPA has been approved effective with date of service January 1, 2009.**

For dates of service December 1, 2007 through December 31, 2008, providers are instructed to apply secondary modifiers U3 or U4 to identify units of service provided by the qualified professional (QP) and non-qualified professional (non-QP) staff persons. Effective with date of service January 1, 2009, these two secondary modifiers will no longer be appropriate after date of service December 31, 2008, and have been replaced by eight new secondary modifiers effective with date of service January 1, 2009 (refer to the tables below).

Community Intervention Services (CIS) providers billing for Community Support services are required to apply these new secondary modifiers on claim submissions for procedure code H0036 in addition to the required primary modifier:

- H0036 HA – Community Support Child
- H0036 HB – Community Support Adult
- H0036 HQ – Community Support Group

The rates associated with the four levels of staff credentials have been approved by the Medicaid Rate Review Committee and CMS. Please note that these final rates represent a change from the proposed rates that were posted on the DMA web site.

H0036 HA - Community Support Child

Staff Level	Code	First Modifier	Second Modifier	Unit Rate
Qualified Professional - Licensed	H0036	HA	HP	\$22.04
Qualified Professional – Unlicensed	H0036	HA	HO	\$18.25
Associate Professional	H0036	HA	HN	\$10.29
Paraprofessional	H0036	HA	UB	\$ 5.92

H0036 HB - Community Support Adult

Staff Level	Code	First Modifier	Second Modifier	Unit Rate
Qualified Professional - Licensed	H0036	HB	HP	\$22.04
Qualified Professional – Unlicensed	H0036	HB	HO	\$18.25
Associate Professional	H0036	HB	HN	\$10.29
Paraprofessional	H0036	HB	UB	\$ 5.92

For H0036 HQ – Community Support Group, a separate set of modifiers will be necessary.

Staff Level	Code	First Modifier	Second Modifier	Unit Rate
Qualified Professional - Licensed	H0036	HQ	U8	\$ 7.09
Qualified Professional – Unlicensed	H0036	HQ	U7	\$ 5.87
Associate Professional	H0036	HQ	U6	\$ 3.31
Paraprofessional	H0036	HQ	U5	\$ 1.90

Authorizations for all Community Support services will continue at the aggregate level with payment at the detail level. Providers should not resubmit previously submitted prior authorization requests for CS services. The process of submitting a prior authorization request for CS services will not change.

Previously paid claims with a U3 or U4 secondary modifier for dates of service on or after January 1, 2009, will require a replacement claim to be filed with EDS. Please refer to the June 2007 Medicaid Bulletin for details on submitting replacement claims. Providers have until April 30, 2009 to submit replacement claims. After that time, automatic recoupments will be performed on claims paid with the U3 or U4 modifier for dates of service on or after January 1, 2009. It is recommended that providers separate all claim details for Community Support services for dates of service before or after January 1, 2009, to assure efficiency in payment.

Each claim for Community Support services will require the use of the two modifiers to be processed for payment. Primary modifiers HA, HB, or HQ must be placed in the first modifier position on the corresponding claim detail line. Secondary modifiers must be placed in the second modifier position on the corresponding claim detail line. **Payment of the claim is driven by the second modifier. Errors in entering the correct second modifier could result in recoupment upon audit of medical records.**

CMS-1500 Claim Examples

These examples are for illustration purposes only. Actual codes billed should reflect who rendered the services.

24. A. DATE(S) OF SERVICE						B.	C.	D. PROCEDURES, SERVICES, OR SUPPLIES			E.	F.	G.
MM	From DD	YY	MM	To DD	YY	PLACE OF SERVICE	EMG	(Explain Unusual Circumstances) CPT/HC PCS	MODIFIER	DIAGNOSIS POINTER	\$CHARGES	DAYS OR UNITS	
01	12	09	01	12	09	11		H0036	HA HO	1	73.00	4	
01	12	09	01	12	09	11		H0036	HA UB	1	47.36	8	
01	12	09	01	12	09	11		H0036	HA HN	1	41.16	4	
01	12	09	01	12	09	11		H0036	HQ U7	1	23.48	4	

Below are guidelines to assist providers in accuracy of claim submission:

- Providers should bill only one line each for primary and secondary modifier combination per date of service per client. If more than one staff person with same level of credentials provides services on the same date, these staff units should be rolled into one detail line.
- It is expected that any combination of staff and associated modifiers may be billed on the same date of service.
- The determination of staff qualifications is dictated by the staff credentials providing the service; not the actual intervention.
- No rounding of time is allowed for billable services; only round down when time does not reach a complete 15 minutes per individual staff rendering the service.
- The maximum of 32 units per week per adult client (H0036 HB) is applied to the combined total of all modifiers and units of service.

Posting of the Community Support SPA, DMA Revised Clinical Coverage Policy 8A, and Revised Community Support Service Definitions

These three documents are integrally connected. Their concurrent effective dates and postings on the web are meant to emphasize the fact that the revisions underscore the integrity of each of the independent documents while ensuring that the content among them all derive from the same source.

- **The Community Support State Plan Amendment (SPA)** was approved by CMS effective January 1, 2009. The draft SPA has been posted on the DMA Website since submission in June, 2008. Among other things, the SPA includes the range of allowable community support rehabilitative service activities, eligibility and continued service criteria, staff qualifications, utilization management requirements and documentation requirements. These requirements have been carried over and addressed in DMA Clinical Coverage Policy 8A and the revised service definitions (see bullets below). The SPA can be found at: <http://www.ncdhhs.gov/dma/csupport/>.
- **DMA Revised Clinical Coverage Policy 8A** describes policies and procedures that Local Management Entities and direct-enrolled providers must follow to receive reimbursement for covered enhanced benefit behavioral

health services provided to eligible Medicaid recipients. It sets forth the basic requirements for qualified providers to bill mental health and substance abuse services to Medicaid. One critical revision and as advocated by stakeholders is the consistency between DMA and DMH/DD/SAS policy and rules. Policy 8A includes the cross references the following manuals and rules thus giving the authority to set the requirements. The references were also included in the SPA submission:

- *Rules for Mental Health, Developmental Disabilities and Substance Abuse Facilities and Services*, APSM 30-1
- *DMH/DD/SAS Records Management and Documentation Manual*, APSM 45-2
- *DMH/DD/SAS Person-Centered Planning Instruction Manual*
- *N.C. Mental Health, Developmental Disabilities, and Substance Abuse Laws, 2001* (G.S. 122-C)

DMA Clinical Coverage Policy can be found at: <http://www.ncdhhs.gov/dma/mp/>

- **The revised Community Support Service Definitions** are posted as part of DMA Revised Clinical Coverage Policy 8A, which is described above. The service definitions are found in Attachment E of Policy 8A: <http://www.ncdhhs.gov/dma/mp/>

Calculating the Community Support Qualified Professional Standard

Beginning March 1, 2009, the state plan amendment (SPA) requires that Community Support providers meet a 35% qualified professional (QP) service measure, and then in September 2009, a 50% service measure, up from the 25% benchmark that has been in place. There are two measurements for LMEs to utilize to determine compliance:

1. Monthly reports that indicate the provider meets the 35%/50% benchmarks.
2. Three month aggregates to indicate that the average over three months meets the appropriate benchmark.

In order to facilitate the transition from 25% to 35% to 50%, while maintaining the integrity of the SPA requirements, and also to recognize the lag between service dates and paid claims dates, the following direction is provided:

1. Individual monthly reports will need to meet the requirements below:

a. December 2008	25%
b. January 2009	25%
c. February	25%
d. March	25%
e. April	35%
f. May	35%
g. June	35%
h. July	35%
i. August	35%
j. September 2009	35%
k. October	50%
l. November	50%
m. Ongoing	50%
2. For the months of March, April and May, if any monthly report does not indicate 35%, a Plan of Correction will be issued by the LME.
3. For the months of September, October, November 2009, if any monthly report does not indicate 50%, a Plan of Correction will be issued by the LME.
4. Aggregate reports for the following months, and the associated percentages must also be met:

a. December 2008, January, February 2009	25% aggregate
b. January, February, March 2009	25% aggregate
c. February, March, April 2009	25% aggregate
d. March, April, May 2009	25% aggregate
e. April, May, June 2009	35% aggregate
f. May, June, July 2009	35% aggregate
g. June, July, August 2009	35% aggregate
h. July, August, September 2009	35% aggregate
i. August, September, October 2009	35% aggregate
j. September, October, November 2009	35% aggregate
k. October, November, December 2009	50% aggregate
l. Ongoing	50% aggregate
5. Beginning with the three month period of April, May, June 2009, if any aggregate report does not indicate meeting the 35% benchmark, endorsement will be withdrawn.
6. Beginning with the three month period of October, November, December 2009, if any aggregate report does not indicate meeting the 50% benchmark, endorsement will be withdrawn.

Professional Treatment Services in Facility Based Crisis

Information was published in September 2008, via Implementation Update #48, that Facility Based Crisis Programs could not be billed and reimbursed for adults under the age of 21 years old. Through further advocacy with the Centers for Medicaid and Medicare (CMS), their decision was reversed, allowing Medicaid reimbursement for these services. The implementation of this service expansion will occur as follows:

- For Medicaid recipients age 18 through 20 years old, a new procedure code/modifier combination was implemented effective with date of service **March 1, 2009**.
 - Providers who are direct-enrolled for facility based crisis can be reimbursed for services rendered by billing S9484 with modifier HA.
 - The rate of reimbursement for S9484 with modifier HA is \$17.99 per unit (1 unit = 1 hour).
 - No more than 16 units can be billed and reimbursed per date of service.
 - No more than 480 units (30 days) can be billed and reimbursed within a calendar year.
 - All current policy applicable to S9484 with no modifier will apply to S9484 with modifier HA.
- For Medicaid recipients age 21 years old and older, S9484 with no modifier should continue to be billed for reimbursement.
 - The rate of reimbursement for S9484 with no modifier will continue to be \$17.99 per unit (1 unit = 1 hour).
 - No more than 16 units can be billed and reimbursed per date of service.
 - No more than 480 units (30 days) can be billed and reimbursed within a calendar year.
 - All current policy applicable to S9484 with no modifier remains in place.

The application of these separate procedure code/modifier combinations will allow DMA to assess the impact of the policy change. The Service Definition Review Work Group convened by DMA and DMH/DD/SAS will be asked to develop the endorsement and service definition criteria for Facility Based Crisis Services specific to Medicaid recipients under age 18. Further information will be communicated as this process unfolds.

Targeted Case Management Rates

The work group, that included representatives from the Targeted Case Management (TCM) provider community, has completed work on development of a new TCM rate for submission to the Center for Medicaid and Medicare Services. The work group reviewed accumulated cost and productivity data to develop a methodology in response to CMS's last direction for establishing a TCM rate.

The rate that was implemented on January 1, 2009 of \$18.75 per fifteen minute unit of service will remain in effect until CMS has reviewed and approved the methodology included in the state plan amendment (SPA). Once the SPA is approved the TCM rate will be set at the CMS approved rate.

CAP-MR/DD Update

Conference on Developmental Disabilities

Due to the current economic status the decision has been made to cancel the Conference for Developmental Disabilities. The Division of Mental Health, Developmental Disabilities and Substance Abuse Services is planning to provide training opportunities through web based and video methods over the next year. More information will be provided as the specifics of the trainings are confirmed.

Crisis Respite

DHHS has identified potential problems with the implementation of the Crisis Respite definition. Because of potential conflicts between the service definition and licensure requirements, implementing this service may result in providers being out of compliance with certain licensure provisions. Therefore, DHHS is recommending providers not implement the definition until the issues can be resolved. DHHS is working to resolve the problem and will provide updates as this work is completed. We are sorry for any inconvenience and appreciate your patience.

Money Follows the Person

In May 2007, the Center for Medicare and Medicaid Services awarded North Carolina a grant through Money Follows the Person Rebalancing Demonstration Program established by the Deficit Reduction Act of 2005. Services under this demonstration grant will end September 2011. North Carolina intends to use the funds to develop a roadmap for rebalancing the Medicaid long-term care delivery system. Staff from state agencies, providers, advocates and consumers have worked together to create this road map for operations – the Money Follows the Person Operational Protocol.

The goal is to move forward with a long term care system that provides an even greater array of home and community-based services and supports designed to promote choice and independence for individuals who are aging with care needs,

and/or have physical, mental, or developmental disabilities. The State intends to use Money Follows the Person funding to promote a long term care system in which individuals transitioning from nursing facilities and/or institutions have access to assistive technology, to increase the awareness and use of home and community based services through educational programs, and to offer more transitional services for individuals wishing to move back into the community.

Participants for Money Follows the Person (MFP) are those who have lived in an institution for the mentally retarded (state and private facilities) or nursing facility for at least six months; meet Medicaid eligibility criteria, and meet the criteria for enrollment in one of the Community Alternatives Programs (CAP) waivers (CAP/MR-DD Comprehensive, CAP/Choice, and CAP/DA) or in the Program of All-Inclusive Care for the Elderly (PACE). CAP/Choice is currently being piloted in four counties (Cabarrus, Duplin, Forsyth, and Surry), therefore, when CAP/DA is referenced in this document it is understood that CAP/Choice applies as well. The State intends to transition 304 individuals for the identified population groups. Recipients will be enrolled in a CAP waiver or the Program of All-Inclusive Care for the Elderly (PACE) on day one of the move into the community. Participants will have a full array of services and supports for successful community living.

Money Follows the Person demonstration project will be available statewide with a five county exception: Cabarrus, Davidson, Rowan, Stanley, and Union counties.

Attached are specific protocols for working with the CAP-MR/DD waiver programs and serve as guidelines for staff enrolling individuals in the MFP program. These documents include: *A Guide for Transition Planning for the Money Follows the Person Project, and Transition Protocol for Individuals Moving from State-Operated Developmental Centers and Community ICF-MR Facilities to the Community Using Money Follows the Person.*

MFP and waiver staff have conducted, and continue to conduct, presentations to various groups such as at conference settings (example, Association of Self Advocates, Guardianship conference) and trade associations (example, NC ICF Providers Association). MFP staff were invited to participate in a panel discussion with three states on transition barriers at the annual MFP conference held in Baltimore, MD March 2-4, 2009.

To date, three individuals have been enrolled in CAP/MR-DD. Additionally, there are 29 individuals on the MFP referral list for CAP/MR-DD who are in the planning stages of transitioning. Of these 32 referrals, two are scheduled to transition to the community (one CAP/MR-DD) by March 2, 2009.

Risk Identification Tool

The Risk Identification Tool and process is intended to assist individuals who receive CAP-MR/DD funding and their planning team with identifying potential areas of risk in the individual's life. The planning team has a responsibility to ensure appropriate supports are in place to maintain the health and safety of the individual while at the same time supporting the individual's choice while not promoting harm. The information gathered through the use of the Risk Identification Tool and process is used to inform the Person Centered Plan.

The implementation of the use of the Risk Identification Tool begins with Person Centered Plans due to be submitted in June 2009 for July birthdays. Case managers are responsible to work with the individual, guardian or legally responsible person and their planning team to complete the Risk Identification Tool and process and incorporate appropriate information gathered from the process into the Person Centered Plan. Please find in attachment four the instructions for completing the Risk Identification Tool and in attachment five the actual Tool.

Crisis Service Update

The Appropriations Act of 2008, House Bill 2436 included funding to expand the State's crisis service continuum. Several crisis services and programs were identified including, Mobile Crisis Teams, Walk-in Crisis and Immediate Psychiatric Aftercare (telepsychiatry), Systemic, Therapeutic Assessment, Respite and Treatment (START) teams, and the development of local community psychiatric hospital beds. These services play a critical role in the development of community infrastructure necessary to prevent psychiatric hospitalization and increase continuity of care for consumers between crisis services and appropriate ongoing services in the community. The following provides an update on the development of these programs.

Mobile Crisis Teams (MCT)

The legislation appropriated \$5,755,000 for 30 mobile crisis teams across the state. Mobile Crisis Management involves all support, services and treatments necessary to provide integrated crisis response, crisis stabilization interventions, and crisis prevention activities. Crisis response provides an immediate evaluation, triage and access to acute mental health, developmental disabilities, and/or substance abuse services, treatment, and supports to effect symptom reduction, harm reduction, and/or safe transition of persons in acute crises to appropriate supports/services. There are currently 25 teams that are operational; with the other five in different levels of development.

Walk-In Crisis and Immediate Psychiatric Aftercare

The legislation appropriated \$6,113,947 for walk-in crisis and immediate psychiatric aftercare to support the hiring of 30 psychiatrists and related staff. Out of this amount, the sum of \$1,650,000 was allocated in one time funding for the purchase of telepsychiatry equipment. Telepsychiatry is the use of electronic communication (two-way real-time interactive audio and video) between places of lesser and greater psychiatric expertise to provide and support psychiatric care when distance separates participants who are in different geographical locations. Telepsychiatry is appropriate in situations where on-site services are not available due to distance, location, time of day, or availability of resources. Its use is ideal for rural settings, other locations where professional services would not otherwise be readily available, emergency services, interim coverage when the psychiatrist/clinician is unavailable, or other situations which would prevent or delay service delivery. Following is a link to the DMH/DD/SAS website section which covers the use of telepsychiatry: <http://www.ncdhhs.gov/mhddsas/telepsyc/index.htm>.

Walk-in crisis and immediate psychiatric aftercare sites are designed to provide individuals in crisis with the most appropriate and least restrictive services available locally. These sites assess/triage individual's needs and provide for immediate intervention and referral to appropriate treatment resources. They also provide access to psychiatric care, including medication management, and they may link the individual with others determined to have clinical relationships with the individual, such as primary care physicians. A focus area for these clinics is to provide immediate psychiatric aftercare to individuals discharged from a psychiatric hospital or substance abuse facility pending appointment with their designated provider or for individuals in transition from one provider to another. Each of these sites should have telepsychiatry equipment available.

The Walk-in Crisis and Immediate Psychiatric Aftercare sites are in varying stages of preparation and operation (e.g., some sites are fully operational while others are in process of recruiting qualified staff).

Three Way Community Hospital Contract

The legislation appropriated \$8,121,644 to expand acute indigent care bed capacity across the state in local community hospitals. The goal of this funding is to increase the availability of community psychiatric beds by purchasing bed capacity in local hospitals; thereby working collaboratively with local, emergency departments and law enforcement agencies to divert short term admissions from the state psychiatric hospitals.

Community hospitals with psychiatric inpatient beds play an important role by providing immediate short-term, intensive crisis care for individuals close to home and their family and friends. Detailed admission requirements and expectations for these community hospital inpatient beds have been outlined in a three-way contract between the community hospital, the LME and DMH/DD/SAS. There has been a good response to this initiative and the DMH/DD/SAS, in partnership with the North Carolina Hospital Association have to date signed ten contracts expanding local community inpatient capacity by 70 beds, and continue to look at other potential contracts.

DMH/DD/SAS staff who work with the IPRS and EDS have recently issued a standard alert for a new procedure code only for those LMEs who are party to a three way contract. The procedure code for the contracted, inpatient hospital psychiatric services (YP821) has been implemented in IPRS. The effective date is dependent on the LME's specific contract. This procedure code is available only to LMEs that have established a three-way contract with a community hospital and the DMH/DD/SAS. LMEs with signed three-way contracts may begin billing claims using YP821 once they have an attending provider rate added by the DMH/DD/SAS Budget Office. This alert is consistent with the memo issued by Bill Scott, DMH/DD/SAS Budget and Finance Office Team Leader, on January 12, 2009 re: Procedures for Purchase of Local Inpatient Psychiatric Bed Days in SFY 2009.

Below is a list of community hospitals that have signed a three way contract to provide admission for indigent short term acute care in lieu of a state hospital admission. The LME who is the holder of a three way contract is responsible for authorizing admission for purposes of payment and works with the hospital as the care coordinator in working with other LMEs who may have an admission appropriate under the terms of the contract. The community hospital approves the hospital admission to the in-patient unit based upon clinical appropriateness.

3 Way Acute Care Indigent Contracts Between DMH, LMEs and Community Hospitals			
Community Hospital	Location	LME Contractor	# of Beds
Alamance RMC	Burlington, NC	ACR	8
Beaufort RMC	Washington, NC	ECBH	6
Brynn Marr Hospital *	Jacksonville, NC	Eastpointe	5
Catawba Valley RMC	Hickory, NC	Mental Health Partners	8

Coastal Plains	Rocky Mount, NC	Beacon Center	8
Duke Hospital	Durham	Durham Center	2
First Health	Southern Pines, NC	Sandhills Center	6
Forsyth Medical Center	Winston-Salem, NC	Centerpoint	8
Frye Hospital *	Hickory, NC	Mental Health Partners	5
Johnston Memorial	Smithfield, NC	Johnston County	14

The goal is to divert admissions from state hospitals to the above listed community hospitals when all of the following conditions are met: (1) Patient requires inpatient level of care; (2) Patient's financial status is indigent; (3) Patient is under commitment; (4) Patient would otherwise be admitted to a state hospital; (5) Referral information indicates that patient requires short-term stabilization

LEGEND: * Indicates six-month contracts for diverting any type of patient that meets admission criteria to a state hospital (when state hospitals are on delay status). This protocol is optimally utilized by the LME and the contracted community hospital, independent of the state hospital.

Any community hospital that is interested in entering into a three way contract may contact your community LME. Any LME interested in learning more about entering into a three way contract can contact Ken Marsh on the DMH/DD/SAS LME Team at 919-715-1294.

North Carolina Systemic, Therapeutic Assessment, Respite and Treatment (NC-START)

The legislation appropriated \$1,874, 243 for the START crisis model for developmental disabilities and an additional \$1,080,992 for start-up and ongoing support of respite beds that is a part of the START model. This funding allowed for the development of six teams, two for each region. Each of the six NC-START teams is now receiving referrals. These teams provide crisis prevention and intervention services for individuals with intellectual and/or developmental disabilities (I/DD) and behavioral health needs. The offices for the clinical teams are located in Concord and Asheville for the western region, Durham and Greensboro for the central region, and Wilmington and New Bern for the eastern region. Each of the regions has also submitted an application for licensure of their crisis respite home to the Division of Health Services Regulation (DHSR). The respite homes are located in Statesville, Franklinton, and New Bern. Dr. Joan Beasley, co-author of the START model is providing consultation and training to the clinical teams and respite staff monthly through scheduled days in the state as well as bi-monthly conference calls. The teams have worked collaboratively to develop standardized forms and a data collection template. The template will provide valuable information to the system as to the effectiveness and fidelity of the model in North Carolina.

The START model is being used in other states but on a local or regional basis. This is the first time the model is being used statewide, which has drawn national attention. In early February the DMH/DD/SAS presented NC's experience with implementation of the START model to the US Department of Health and Human Services, Office on Disability and representatives from several states.

The contact numbers for the teams are:

- NC-START West: 888-974-2937
- NC-START Central: 919- 865-8730 or 800-662-7119 x8730
- NC-START East: 252-571-9039

Because of the need for consumers in crisis to receive services as quickly as possible and the focus on effectiveness of the State's crisis services continuum, it is imperative that LMEs work with providers to eliminate potential and existing barriers to accessing any crisis service.

Revised Records Management and Documentation Manual (RMDM)

The revised Records Management and Documentation Manual (RMDM) has been revised based on the collection of more than one year's worth of comments and suggestions from the field, and also based on some new or changed requirements originating in legislation. In addition to legislation, the manual has also brought together information from DMA Clinical Policy 8A and the revised PCP format and instruction manual. *The revised RMDM is effective April 1, 2009.* The manual, appendices and a document that highlights the major changes can be found at: <http://www.ncdhhs.gov/mhddsas/statspublications/manualsforms/index.htm>.

Revised Person Centered Plan and Revised Person Centered Plan Instruction Manual

The revised Person Centered Plan format and the revised Person Centered Plan Instruction Manual have been posted on the web since December 1, 2008. As you know, the effective date of these documents was delayed due to some unmet legislative requirements, the details of which were posted on the web. The requirements have now all been met.

- **The PCP formats (Introductory and Complete) and the 2008 Instruction Manual are effective March 1, 2009** for all services which require a PCP, except for CAP-MR/DD service plans.

- **The effective date for CAP-MR/DD plans to be completed using the PCP format is for PCPs due for July 2009 birthdays.**

The PCP documents can be found at: <http://www.ncdhhs.gov/mhddsas/pcp.htm>.

In regards to the legislative requirements noted earlier, there is an additional document added and posted for use. The document is “**Notification of the Incomplete Checkboxes on the Person Centered Plan Signature Page.**” If the licensed professional who orders services does not complete the required check boxes, the qualified professional responsible for the PCP will need to submit this form to the Division of Medical Assistance, Program Integrity Unit. There are instructions for completion of the form posted with the document at: <http://www.ncdhhs.gov/mhddsas/pcp.htm>.

NOTE: Implementation Update #51 indicates that, “*The revised documents will have an effective implementation date of January 1, 2009; this means that any PCP annual review that is due in January of 2009 will need to be updated on the new forms. Revisions will not be subject to the new forms, only the annual plan.*”

- The new documents are now effective March 1, 2009.
- Any Introductory PCP, Complete PCP or PCP annual review that is due in March of 2009 will need to occur using the new format.
- It will also be necessary to use the new Update/Revision form for any reviews taking place in March 2009. The only significant change to this form is the signature page. **If a new service is added to a PCP as a result of a review and update/revision to the plan, Part 1, Section A of the Signature Page, with the new check boxes must be used.**

Revised ITR Form for Immediate Use for Submission of Prior Authorization Requests to Value Options

Please immediately begin to use the attached revised Inpatient Treatment Report (ITR) form to submit service requests for applicable behavioral health services. The form is available for download from the ValueOptions website at www.valueoptions.com/providers/Network/North_Carolina_Medicaid.htm.

The only change to the ITR was to the Level of Care section at the top left of page one:

- Changed RTC to PRTF/RTC
- Added Residential (Level II-IV excluding Foster Care)
- Added Foster Care
- Added Community Support Individual
- Added Community Support Group
- Added Community Support Team
- Deleted Group Home
- Deleted Halfway House

Submitting Concurrent requests for Level I and II (Family Type) Therapeutic Foster Care and Level II (Program Type) and Level III and IV Residential Treatment via ProviderConnect

Concurrent requests for Level I and II (family type) Therapeutic Foster Care (TFC) and Level II (program type) and Level III and IV residential treatment, may now be submitted via ProviderConnect. Make certain to select “Foster Care” for Level I and II (family type) Therapeutic Foster Care requests and “Residential Child Care” as the level of care for Level II (program type) and Level III and IV residential treatment requests.

Please note that because TFC providers are not directly enrolled and do not have a provider number, *concurrent* requests for TFC submitted via ProviderConnect will need to be submitted by the clinical home qualified professional using the clinical home provider number; in turn ValueOptions will make the authorization to the appropriate LME per the consumer’s county of eligibility in effect on the date of the review. LMEs can check the status of TFC requests via ProviderConnect. ValueOptions staff will call the Utilization Review Contact (UR) identified on the request and inform him or her of the authorization details, including which LME was authorized. ValueOptions will send the authorization letter to the LME.

Initial requests for Level I and II (family type) TFC and Level II (program type) and Level III and IV residential treatment should continue to be submitted via fax. *Concurrent* requests for Level and II (family type) TFC and Level II (program type) and Level III and IV residential treatment may still be submitted via fax. As above, ValueOptions staff will call the Utilization Review Contact (UR) identified on the request and inform him or her of the authorization details, including which LME was authorized. ValueOptions will send the authorization letter to the LME.

Directly enrolled providers must participate in webinar training before using ProviderConnect to submit service requests. Go to http://www.valueoptions.com/providers/Network/North_Carolina_Medicaid.htm and scroll down to “Provider Training Opportunities” to view the webinar schedule and register. Providers who previously completed webinar training

for submitting Community Support requests need not attend again as the only change to online request submission is selection of the appropriate Level of Care from the drop-down menu.

Mental Health Providers – Claims Data

Mental health providers needing Medicaid claims payment data to complete their cost reports will be able to request this data from EDS should they not be able to compile the information from their records.

Instructions for requesting this data along with the cost for each data request will be published by March 6, 2009 on the DMA Homepage under the Medicaid Provider Links. EDS will be able to generate the data for each unique Medicaid provider number for claims adjudicated within the past 24 months.

For those services billed through the LME, EDS will not be able to extract the data based upon the attending provider number. The provider will need to contact the LME for their claims data report.

Staffing Announcements from DMA Program Integrity Section

The Program Integrity section is responsible for Provider Medical Review, Home Care Review, Pharmacy Review, Behavior Health Review, Third-Party Recovery Section (TPR), Quality Assurance, and Special Projects Section.

DMA has four staffing additions to announce within Program Integrity-Behavior Health Review Section:

Patrick O. Piggott, MSW, LCSW, DCSW is the Chief of our newly created Behavioral Health Review Section. He is a licensed clinician with approximately 20 years of behavioral health experience in public, private, and private non-profit sectors. He has inpatient, outpatient, residential and community based experience. He comes from the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services in the State Operated Services Section. Patrick received his Masters of Social Work Degree from Virginia Commonwealth University in Richmond, Virginia and has been a Licensed Clinical Social Worker since 1999.

James Springer, MSW, LCSW is the Eastern Area Mental Health Program Coordinator with Program Integrity. He received a Masters of Social Work degree in 1997 and is a licensed clinical social worker. He has worked in the social work field for 18 years in various settings including a domestic violence shelter, psychiatric hospitals, Department of Social Services, correctional facility, chemical dependency treatment facility, mental health center, and an insurance company. He will be home-based in the Eastern Region.

Sherry Tabron, MSW, LCSW is one of the newly hired Central Area LCSW Analysts with the Behavioral Health Program Integrity Unit. Sherry is a licensed clinician with close to 20 years of experience in Mental Health service in both public and private sectors. Sherry received her Masters of Social Work Degree in 1987 from Virginia Commonwealth University and has been a Licensed Clinical Social Worker since 1993.

Francine Kirkpatrick-Karuba, MSW, LCSW is the Western Area Mental Health Program Coordinator with Program Integrity. She is a Licensed Clinical Social Worker. She graduated in 1987 from the University of North Carolina-Chapel Hill, School of Social Work Program, and has worked in the MH/DD/SAS field since. She started her career as the Willie M. Program Coordinator for the Western region. Francine left NC for a brief period and worked in western New York State developing continuums of care, single portal programs & a regional parent advocacy program for community mental health programs. Since her return to Asheville, NC, she has worked in the private sector, managing and developing a variety of programs, until joining the Behavioral Health Review Section. She will be home-based in the Western region.

These staff can be reached by calling our main number for Program Integrity at 919-647-8000.

For any questions concerning this change in billing procedures please contact EDS Provider Services at 1-800-688-6696 or 919-851-8888.

Unless noted otherwise, please email any questions related to this Implementation Update to ContactDMH@ncmail.net.

cc: Secretary Lanier M. Cansler
Allen Feezor
Dan Stewart
DMH/DD/SAS Executive Leadership Team
DMA Deputy and Assistant Directors

Christina Carter
Sharnese Ransome
Wayne Williams
Shawn Parker
Denise Harb