Provider Communication Bulletin #25
November 27, 2013

IN THIS BULLETIN:

November 22 Provider Alert

The following topics were sent via email in a Provider Alert issued on November 22.

Business Associate Addendum--URGENT Action Requested: Providers who have not signed and returned the recent Business Associate Addendum that was emailed to each organization's contact during October and November, MUST return a signed Business Associate Addendum (BAA) for each contract they have with Partners Behavioral Health Management. If you have not submitted the completed BAA, please do so immediately. You can access a copy of the BAA by clicking here. Submission of this revised document is required in order to stay in compliance with the MCO contract.

Please return the signed BAA to:
Contract Department
200 Elkin Business Park Drive
Elkin, NC 28621

Should you have a question, please call Partners' Contracts Department at 1-877-864-1454, option 4, option 2.

Attention Innovations Waiver Providers--Submission of "Failure to Provide Back-Up Staffing Incident Reports (Level I)": Effective immediately, "Failure to Provide Back-up Staffing" Reports are to be sent to the **attention of Marsha Johnson via fax at 704-884-2696.** This change is *only for the back-up staffing reports that Innovations Waiver service providers sent to Kathleen Meriac*. The DHHS Quarterly Level I Report will continue to be directed to the Consumer Relations Department.

Provider Feedback Survey

Partners BHM is conducting a Needs Assessment and Services Gaps Analysis to assess the behavioral health needs of the citizens in the regions it serves. To assist with this process, we are asking you to participate in the Provider Feedback Survey. The survey period has been extended and will close on December 2. The survey should take between 7-10 minutes to complete. Results from all completed surveys will be tabulated and used to complete the Partners BHM Needs Assessment and Services Gaps Analysis. When completed, a Summary of the Online Provider Survey results and the Final Report will be posted on the Partners BHM website for review.

Questions regarding the Provider Feedback Survey:

Q: Why does the survey request some financial information?

A: The intent of these questions is to help understand the size and expansion capabilities of the organization.

Customer Services

Enrollment Request Submitted By Contract Providers:

1. In order not to impede timely access to services, **ALL** contract providers will be expected to complete the AlphaMCS consumer enrollment **correctly, IN ENTIRETY (two pages)** and submit to the MCO within **SEVEN calendar days,** for **State Funded** consumers in the following instances:
    a. Whenever the consumer walks into the provider's office/agency requesting services and the contract provider initiates services. The enrollment should be completed, dated and submitted on the first date of service.
    b. Whenever the consumer calls the provider directly and the provider initiates services by offering the consumer an appointment.
2. **Consumers with Private Insurance, Medicare, TriCare, NC Health Choice, etc. are not eligible for Enrollment in the IPRS/State-Funded Health Plan.** Provider requests for consumers with other payer sources to be enrolled in IPRS/State-Funded Health Plan will be denied. As noted in Provider Communication Bulletin #23, providers are expected to monitor alternative funding sources.
3. All Enrollment Requests must be submitted to Partners within seven calendar days of assessing and enrolling the consumer. Enrollment Requests:
    a. Must be complete
    b. Must contain a diagnosis, target pop and all SA details when applicable
    c. Must have a matching screening date, admission date and start date of diagnosis and target pop.
    d. Failure to submit a complete and accurate enrollment within seven calendar days of the screening/admission date may affect payment for delivery of services rendered. **NO EXCEPTIONS.**

4. Provider Requests for Enrollment *may not* be back dated to cover dates of service when the consumer was not officially enrolled because the provider did not submit the enrollment in a timely manner and/or within seven calendar days of the first date of service.
5. If the Enrollment Request is submitted to Partners BHM via AlphaMCS after seven calendar days of the SCREENING/ADMISSION date, the date that the Enrollment was submitted to Partners will be considered the EFFECTIVE DATE of IPRS/State-Funded coverage. NO EXCEPTIONS
6. Providers *may not* back date the ADMISSION DATE on a Request for Enrollment to cover dates of service after a consumer becomes ineligible for Medicaid coverage and before the consumer was appropriately enrolled in an IPRS/State-funded Health Plan.
7. The SCREENING DATE and the ADMISSION DATE of the Provider Enrollment Request should match and should be the date that the provider completed the comprehensive clinical assessment (screening) and admitted the consumer.
8. Admission date should match screening/intake date and **may not** precede it.
9. Enrollment Requests/State benefits will be made effective the date of admission when the date of admission matches the screening date AND the Enrollment has been submitted to Partners within seven calendar days.
10. If the Enrollment Request is submitted to Partners seven days after the screening/intake date, the State benefits will be made effective the date that the request is submitted to Partners.
11. The provider should always thoroughly check AlphaMCS for the consumer and an enrollment before submitting a **NEW enrollment request. If an AlphaMCS number is found, ALWAYS check to see if the consumer has an effective date for STATE and/or MEDICAID insurance**.
12. Providers may now search AlphaMCS, for referred or previously seen consumers, by only **one parameter**, such as
    a. Entering a birth date only
    b. Entering First Name, Last Name only
    c. Entering DOB, or SSN or insurance policy number only
13. "UNKNOWN" **may NOT be entered to answer any question on the enrollment.**
14. ALWAYS Include **ADMISSION date**. **Admission date should be the same as the Date of Screening and should never be prior to the Date of Screening**
15. Intake assessments are to be completed by licensed clinicians. The enrollment information may be keyed in to AlphaMCS by a Qualified Professional, however, the name entered into the enrollment form as the person who completed the enrollment should be the name of the licensed clinician who completed the assessment and determined the diagnosis. It must include his/her professional credentials.
16. Make sure information in the fields match each other, such as "presenting problem by consumer age/disability >target pop>diagnosis." For example--if the consumer is a child make sure presenting problem, consumer age/disability is checked for a child, and that a child target pop is indicated on the Additional Clinical Information on page 2)
17. Always enter a diagnosis and a target pop on the Additional Clinical Information on page 2
18. If the "in need of detox" question is checked **yes** - you **MUST** also document
    a. at least one withdrawal symptom **and**
    b. at least one SA diagnosis
19. If a substance abuse diagnosis is entered then **the drug of choice details must be entered in full**
20. If a **poly** substance abuse/dependence diagnosis is entered **at least three substances and the drug of choice details must be entered in full.**
21. Should you have an Enrollment Request returned requesting additional information and Partners has entered a note in the "comment" section, you are **NEVER** to delete the note entered by Partners. If you need to enter a reply note, please feel free to enter your reply under the note

entered by Partners staff. **ONCE NOTES ARE ENTERED BY PARTNERS BHM OR THE PROVIDER, THEY ARE NEVER TO BE DELETED.**

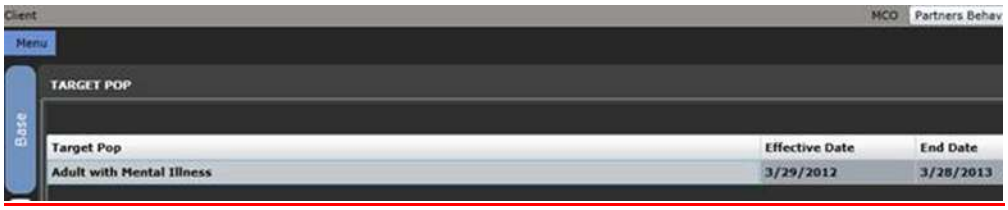
Training on the Enrollment process is available to all Providers. Please contact the Partners BHM Help Desk at HelpDesk@partnersbhm.org or 704-842-6431 to request training.

Update Requests Submitted By Contract Providers:

1. **All requests for changes to a currently enrolled consumer's record should be made by submission of an Update Request via ALPHA.**
2. Prior to the submission of an Update Request to change a Target Pop, please check AlphaMCS to ensure that the consumer has a State Insurance effective date with no end date. See instructions for Target Populations located in this Bulletin.
3. If the consumer is not showing in AlphaMCS as actively enrolled to the IPRS/State-Funded Health Plan, you must submit an Enrollment Request
4. **Provider Update Requests submitted for consumers who have a payer source other than IPRS or Medicaid B will be denied, *unless* the consumer is already receiving an IPRS service that was previously approved by the Partners Utilization Management Department.**
5. When submitting an update request for a change of name and/or Social Security Number, providers are responsible for making sure that the name and/or Social Security number on the update request matches the consumer's Social Security Card prior to requesting an update of a consumer's name in AlphaMCS. The provider should notify Partners BHM via a note in the Update Request when they have completed this verification process. Otherwise, Partners will return the Update Request for verification.
6. When submitting an Update Request for a change in the consumer's Date of Birth, providers are responsible for verifying that the Date of Birth requested on the Update Request matches the Date of Birth on a valid NC identification care, Driver's License or Birth Certificate. The provider should notify Partners BHM via a note in the Update Request when they have completed this verification process. Otherwise, Partners will return the Update Request for verification.

Target Population:

1. Target Pop must always be documented on all enrollments to State Insurance on the Additional Clinical Information on page 2.
2. Always enter an end date for the target pop.
3. ASTER & AMI Target Pops may be end dated 2099.
4. Crisis Target Pops should never extend more than 14 days.
5. PRIOR to submitting an update request for a Target Pop, ALWAYS check AlphaMCS to see what target pop is in AlphaMCS and the dates already entered. The Target Pop dates that you request should not, in any way, overlap dates that are already in AlphaMCS. For example, if there is already a Target Pop is in ALPHA with an effective date of Dec. 15, 2012 with an end date of Dec. 14, 2013 and you need to extend the end date. You cannot extend the end date by entering a new "overlapping" Target Pop with a start date of November 20, 2013 and an end date of Nov. 19, 2014. See #8, item c, on the next page.
6. Prior to adding or updating a Target Pop for a consumer, the provider should **ALWAYS** search AlphaMCS under Menu > Patient Search > Clinical Tab > Target Pop Tile… to see what Target Populations are already entered in AlphaMCS.



7. If the Target Population that the consumer needs **is not** found under the AlphaMCS Target Pop Tile, the provider will need to enter the appropriate target population with an appropriate effective date and end date.
8. If the Target Population that the consumer needs **is** found under the AlphaMCS Target Pop Tile:
    a. The provider will need to check to see if the Target Pop has an appropriate end date.
    b. The effective date of the Target Pop found in AlphaMCS will **ALWAYS** remain the same and the provider will not make any changes to the effective date.
    c. If the end date of the Target Population needs to be adjusted, the provider will create a new target pop entry with the same effective date that is documented in AlphaMCS for that target pop, and will then enter a new end date. **For example:** In the above screen shot if the provider needed to extend the end date of the existing AMI target pop, they would create a new entry with an effective date of 3/29/2012 and an end date of 3/28/2099.
    d. NOTE: sometimes a target pop may be entered in AlphaMCS more than once because it has already been extended. For example

Target Pop	Effective Date	End Date
Adult with Mental Illness	3/29/2012	3/28/2013
Adult with Mental Illness	3/29/2013	3/28/2014

    In this instance, if you needed/wanted to extend the target pop out further, you would use **the most current effective date or 3/29/2013** rather than 3/29/2012.

9. **End Dates** - Target Pops should be end dated in 2099 whenever appropriate. **ASTER, AMI & ADSN Target Pops may all be end dated in 2099**. **CDSN may be end dated out to the day prior to the child's 18th birthday.**

10. **Concurrency Issues** - When you view AlphaMCS and note that a consumer is already in the AMI Target Pop, you are cautioned about trying to also enter the consumer in the AMCS (MH Crisis) unless the AMI Target Pop has an end date prior to the start date of the AMCS (MH Crisis) Target Pop. The consumer may not be in both AMI and AMCS concurrently. In this instance, it is preferable that you just leave the AMI Target Pop and extend the end date if necessary as the AMI Target Pop will cover more services.

11. If a Target Pop with an incorrect effective date has been submitted and approved and needs to be corrected, the provider must request correction of the Target Pop via an additional update request. The provider can note this in the comment section of the update request.

Utilization Management

Authorization Information:

- **ADVP** and **Day Activity** authorizations will be up to six months (180 days).
- **Outpatient services**: End date all requests for December 31, 2013. New unmanaged visits start January 1, 2014. If an authorization is entered for days past December 31, 2013 at this point, the unmanaged visits may not be available
- For **S9484 Facility Based Crisis and Three-Way hospitals**: AlphaMCS can only allow one initial authorization without review per year per consumer. Partners BHM is working with Alpha to determine if there is a solution for this issue. Until then, providers will need to submit a SAR for subsequent admissions after the first seven of days when authorization was not required.
- **Site selection:** *It is very important that providers delivering the same service in multiple sites select the correct site when entering a service authorization request.* If the site you need to select is not available, check and make sure that site is listed in your contract. Utilization Management cannot correct this for providers. There may be problems with claims processing if you select the wrong site on the SAR and bill with the correct site.

Rescinding a SAR--Instructions for Providers**:**

1. Filter for the SAR
2. Make note of reviewer to whom the SAR is currently assigned
3. Expand the SAR menu to number 3
4. Click "Rescind" button to activate "Update" button
5. Click "Update" button to open the SAR and make corrections
6. Note in the SAR justification to return to reviewer to whom it was previously assigned. Put this reviewer's name in your comments.
7. Submit the SAR
8. Provider should not attempt to rescind a SAR after a decision has been made

AlphaMCS Code Changes: Some services will now be grouped together in AlphaMCS. When the provider enters a SAR, there will be changes to the drop down box "**Procedure Summary Group".** Select the Procedure Summary Group code based on information below. The provider can then use the next drop down box to pull in the individual code being requested.

Providers will see the following changes:

- **Grouped under Day Services:** ADVP; Sheltered Workshop; Community Respite; Day Activity; Developmental Day; Day Supports; Hourly Respite; Long Term Supports; Developmental Therapies, Supported Employment.
- **Grouped under Residential**: Adult Residential and Child Residential
- **Grouped under Outpatient Evaluation**: All assessment codes, 90761, 90792, H0001; H0031; T1023; YP836; YP830
- **Grouped under Outpatient**: All psychological testing including developmental testing; ECT (90870); SAIOP; SACOT; add on code 90875,90839 and 90840 Crisis Therapy codes
- **Grouped under Outpatient Therapy**: **All individual, family and group therapy**. (*Outpatient providers can now select the Procedure Summary Group "Outpatient Therapy", BUT **do not** select a specific procedure code; this will allow a provider to use authorized units across all the outpatient therapy codes.)*

- **Grouped under Crisis Services:** Facility Based Crisis (S9484 and YA369); 23 hours Observation chair; Mobile Crisis; Crisis Behavioral Consultation
- **Detox:** All detox codes are grouped under Detoxification Services
- **E&M Codes:** All 99xxx codes regardless of place of service will now be grouped under Physician Services

Services for individuals enrolled in Medicare/Third Party Insurance and Medicaid:

- If a person has Medicare or another third party payer as their primary insurer and receives Medicaid, *some* enhanced services may be paid for by Medicaid. If the enhanced service is covered due to this scenario, the provider does not need to receive a denial from Medicare or other third party payer in order to offer the service. However, *authorization requirements for each service still apply*.
- The **services not covered** under this scenario are Partial Hospitalization, TFC, PRTF, Diagnostic Assessment, Outpatient Therapy and Inpatient treatment. Medicare and/or third party insurance is the primary payer for these services
- Consumers with Medicare Qualifying Benefits (MQB) are not covered by Partners BHM.

Finance and Claims

MEDICAID TOP 5 DENIALS OCTOBER 2013	PROVIDER RECOMMENDED ACTION STEPS
Duplicate Claim	Claim has previously been submitted and adjudicated. Do not refile.
Service is not authorized	Verify Service Authorization for consumer. Contact Utilization Management.
Claim received after billing period	Write off charges as non-billable. Do not rebill.
Client has other covered insurance (COB)	Check Insurance and COB tiles. Check DOS for accuracy. Resubmit only if incorrect.
Patient not enrolled on the date of service.	Verify that all patient information is correct on claim. Check the existence of a patient insurance.

Partners Wants You to Know…

Provider Site Questionnaire: Beginning next week, Partners BHM's Provider Specialists will be contacting agencies and licensed independent practitioners for completion of a questionnaire. The questionnaire, to be completed by each company site where services are rendered, will help Partners enhance its provider information directory and search tool for individuals in the Partners BHM catchment, and allow staff to more effectively refer individuals to available providers and specialists. If you have any questions regarding this process, please contact your Provider Specialist.

Information presented at the November 8, 2013 Provider Forum is available on the Partners BHM website on the "For Providers/Information and Documents" page. Simply expand the Provider Forum Information to access the PDF.

December Provider Forum: Partners BHM will host Provider Forums via videoconference on Tuesday, December 10. The forum will begin at 1 p.m. Click here for more details and to RSVP.

Website Updates: The following items have been updated on the Partners BHM website:

- *Care Review Request Form*, located on the "System of Care" Department page and on the "About Us/More Information" page.
- *Relative/Legal Guardian as Provider Process*, located on the "For Providers/Information & Documents" page, in the NC Innovations category.
- A new page*, Intellectual and Developmental Disabilities*, is located under "About Us/Departments."

Partners-Sponsored Trainings

All Partners Training Academy opportunities are posted on the Calendar at http://www.partnersbhm.org/calendar/.

Training participants are asked to please arrive at least 10 minutes prior to the start to the training to allow for check in.

Effective Person Centered Planning Documentation: *The remaining sessions of this training are full. If you are interested in being added to the waiting list, email Janet Noblett at* jnoblett@partnersbhm.org.

Gold Star & Self-Audit/Self Disclosure Training: Want to learn more about Gold Star, the new tool used for provider monitoring? Partners BHM is sponsoring Gold Star Monitoring Training and Self Audit/Self Disclosure Process. The training will be presented by the members of the Provider Network and Compliance Department staff. Provider agency staff are strongly encouraged to attend this training.

This training will improve providers' understanding and awareness of initial/Implementation and Routine Gold Star Monitoring, as well as the self-audit and disclosure process. Objectives are:

- How to define Provider Monitoring
- The language of Provider Monitoring and Gold Star Monitoring
- Importance of monitoring from the Beneficiary's perspective
- How to prepare for Provider monitoring and the tools used
- What to expect for follow up from a Provider Monitoring
- What self-auditing and disclosure means
- The benefits of self-auditing and disclosure
- The Provider Self-Audit and Disclosure process

If you have any questions regarding this training, please contact Janet Noblett at 704-884-2596 or by email at jnoblett@partnersbhm.org. This training will be held via videoconference from Partners BHM's three regional offices. To register for this training, click here.

An Introduction to Child and Family Teams: A Cross-System Training from the Family's Perspective: ***This training is currently full. If you are interested in future sessions, please contact Janet Noblett at jnoblett@partnersbhm.org.***

Supports Intensity Scale Training: The Supports Intensity Scale® (SIS®) is an assessment tool that measures practical support needs of a person with Intellectual/Developmental Disabilities. The DDTI

training will provide participants the opportunity to gain an understanding of the use of the SIS® as well as other assessments and incorporating the SIS® results and other assessment information into the Individualized Service Plan. The training will also focus on using the assessment information to create Long Range Outcomes. **This training is open only to Provider Agencies who are members of the Partners BHM Provider Network.**

This training will be held Wednesday, December 11 from 10 a.m.-4:30 p.m. (check in begins at 9:30 a.m.). The training will be conducted live in Gastonia and videoconference to Elkin and Hickory regional offices. ***Training participants will be required to pre-register at the DDTI website. Go to http://ddti.unc.edu/DDTI_calendar.asp and then choose the December 11, 2013 SIS training to register for any of the three locations.*** The event duration is six hours. After completion of the event, a certificate will be emailed to attendees for five contact hours.