PARTNERS
Behavioral Health Management

Provider Communication Bulletin #17

REVISED May 31, 2013 **(Initial Release: May 30, 2013)**

IN THIS BULLETIN:

From the Desk of the Medical Director

Beginning with Provider Communication Bulletin #17, Partners BHM's medical director will convey information as needed to the Provider Network through a series of memos.

To: Partners Behavioral Health Management Provider Network
From: J. Octavio Salazar, MD, MBA, DFAPA
Medical Director, Partners Behavioral Health Management
Re: What is Managed Care Really About?

Partners Behavioral Health Management communicates Provider Information through Provider Communication Bulletins, its website, www.PartnersBHM.org, and the "Monday Coffee Break" newsletter. If you have any questions regarding this Bulletin, please reference the subject contact, contact your provider specialist, or email questions@partnersbhm.org. All Provider Bulletins and training event information are posted at www.PartnersBHM.org.

It is difficult to deal with change of any kind, however, change is a fact of life. We face constant change in our lives in areas that are completely out of our control. Change occurs in a variety of ways, both personally and professionally.

Behavioral health practitioners have worked in an ever-changing environment for longer than a decade. Now, we are dealing with the need to adapt to new way of life called "Managed Care." We might be asking ourselves--"What is managed care? How can I work with it? How can I adapt to it? And how do I minimize the impact of it in my life and in my profession?"

I don't think that there is an easy or simple answer to all of these questions, however, let me try to offer some light on this new journey and phase in your professional life. If I could put in a few words what managed care is about, I would venture to say that it is focused around two major goals-- q*uality* and e*fficiency*.

Let's start with something that is very precious to us and it is quality. I believe that every behavioral health practitioner considers quality one of the main pillars or areas of foundation in his or her profession. However, there are different ways to address quality.

For some, quality could be the ability to offer services to consumers, or offer services in certain area or specialty, or simply, being available. For managed care, quality is focused toward following a *best practices approach to treatment*. Quality is providing an excellent initial assessment that builds the foundation for appropriate treatment. It is having access to clinically-developed narrative that contains information about disease symptoms and frequency, intensity and severity. It is learning what works to help an individual "get better" or what triggers are evident during a crisis episode. It is learning about a client's fluctuations and what causes them. It is addressing the different potential disorders that a client may present and the way they affect each other. It is considering the organic and psychological comorbidity. It is finding out if the consumer is affected by substance abuse in addition to other behavioral disorders. It is making a diagnosis that is congruent with the symptoms that the consumer is presenting and ordering medications, directly or through consultation, if indicated and that the medications are addressing the symptoms that have been described. It is addressing issues when the consumer is not responding to certain treatment approach, and changing to see if other approaches work better. It is the ability to realize that the consumer might not be benefiting from the intervention offered, and be able to reexamine what we are doing. It is being able to identify the disorder that the consumer is suffering by matching many of the symptoms the consumer is presenting to the diagnostic criteria found in the DSM IV-TR. It is offering a multidisciplinary approach to treatment that addresses biological, psychological and social issues. It is offering all available alternatives like therapy, medication, behavioral interventions, habilitative or rehabilitative interventions when indicated. It is seeking consultation with other professionals when you don't seem to be getting anywhere or referring the consumer to another level of care even if you don't offer it in your practice.

I can go on and on, but basically, if you are doing the things previously mentioned, you will sail through this new ocean called "managed care." You will get most of your services authorizations requests approved. You will do fine because you are offering the services in the way they are supposed to be offered. **You are delivering good quality services**. If you are not following this process, you might need to adjust your sails on the way and Partners BHM is here to help you move in that direction.

Let us briefly discuss efficiency. It means that the consumer will receive the right service, at the right time, in the right place for the proper duration, and at the right intensity. Not more, not less. When the symptoms start improving, then you adjust your intervention frequency or level of care to serve the

client appropriately. Managed care emphasizes a continuum of care so that consumers can move to a higher level of care when needed or a lower level of care when they are improving and can function more independently. One of the most helpful tools to use in making these decisions is the service definitions. If you are applying the service definitions conscientiously and matching your client's symptoms to the service definitions, you should not have a problem in getting your requests for services authorized.

Partners BHM's mission statement includes a sentence that states that the organization "ensures access to appropriate and individualized treatment which results in positive outcomes and ensures good stewardship of public funds." We are not able to accomplish our mission without you, the provider network. I hope reading this has been helpful to you, and welcome your feedback.

Partners BHM's Community Guide and Agency With Choice Providers

Partners BHM has published listings of Provider Agencies that will deliver Community Guide and Agency with Choice services. These services are for individuals with intellectual/developmental disabilities and are part of the NC Innovations Waiver.

To access the Community Guide listing, click here. To access the Agency with Choice listing, click here. The lists are located on the Partners BHM website in the NC Innovations category at "For Providers/Information & Documents".

Relative/Legal Guardian as Provider Process

As noted in Provider Communication Bulletin #15, providers employing a relative/legal guardian, living in the home of an adult (18 years or older) Innovations recipient and who is the direct support staff for that recipient, must comply with the Relative/Legal Guardian as Provider Process. This process was outlined at the April 9, 2013 Provider Forum and information about the process and forms can be located in the NC Innovations category on the For Provider/Information & Documents page, or by clicking here.

The Relative/Legal Guardian as Provider Process applies only to relatives/legal guardians who live in the home of the NC Innovations adult (age 18 or older) recipients. Partners BHM Relative/Legal Guardian as Provider (RAP) Committee will review provider requests to employ relative/legal guardians, to ensure that providers are following directives set forth in the *NC Innovations Technical Guide Version 1.0- June 2012* (located at http://www.ncdhhs.gov/dma/lme/Final_NC_Innovations_Manual_06252012.pdf) and to ensure that services are delivered in accordance with the Innovations Waiver Policy. NC Innovations services that can be provided by the relative/legal guardian include: Community Networking, Day Supports, Personal care, In-Home Skill Building Individual, In Home-Skill Building Group, Intensive In-Home Support, and Residential Supports.

Provider Network Management

June Provider Forum: Partners BHM's June Provider Forum will be held on Tuesday, June 11, 2013 and will start at 1 PM. The forum will be conducted via videoconference from the three regional offices. Please RSVP for the site where you will attend by noon, Monday, June 10.

- Partners BHM—Elkin, 200 Elkin Business Park Dr., Elkin NC 28621. Click here for Elkin.
- Partners BHM—Gastonia Board Room, 901 S. New Hope Rd., Gastonia NC 28054. Click here for Gastonia.
- Partners BHM—Hickory Multipurpose Room, 1985 Tate Blvd. SE, Hickory NC 28602. Click here for Hickory.

Notice To IPRS Providers : Partners' Provider Services/Contracts Department is in the process of reviewing IPRS Agreement Renewals. Providers will be notified if additional information is needed. The Provider Services/Contracts Department hopes to have all IPRS Agreement Renewals processed by the middle of June. If you have any questions, please do not hesitate to contact June Littlefield at 336-527-3202.

May Provider Forum: Handouts from the May Provider Forum can be accessed by going to http://www.partnersbhm.org/providers/provider-forms.aspx and expanding the "Provider Forums" category.

Do you have your current licensure information on file? It is the Provider's responsibility to ensure that Partners has current licensure on file for all Licensed Clinicians who provide services to Partners BHM consumers. Please send updated clinician licensure as it is renewed to Melena Wilmoth at mwilmoth@partnersbhm.org, or via fax to 336-527-8006. This will ensure that Alpha MCS has all the required and up-to-date data to allow claims to process, thus preventing denials.

Finance and Claims

Position Announcement: Effective June 1, Susan Lackey will begin serving as Partners BHM's Finance Director. Debbie Hatley, the current director, is moving into a part time position as the Associate Finance Director. Partners is in the process of interviewing a replacement for Susan's current position as the Financial Analysis Manager.

Proposed Fiscal Year 2013-14 Budget: Partners BHM has released its proposed Fiscal Year 2013-14 budget for public review. If you have questions or comments, please contact Anita Lingafelt, Clerk to the Board of Directors at alingafelt@partnersbhm.org or call 704-864-6324. To view the proposed budget, click here.

Utilization Management

Psychological Testing: All codes except 96118 are limited to a total of five hours (96118 is limited to eight hours). Testing requires pre-authorization after all unmanaged visits have been used and must include:

- Reason for the request;
- Completed Psychological Testing request form (located here or by going to the Utilization Management category on the For Providers/Information & Documents page); and
- Service order attached to the Service Authorization Request (SAR).

IPRS-Funded Day Treatment: Since July 2012, IPRS funds have not traditionally paid for Day Treatment during the summer months--Medicaid funds have paid for the service if determined as medically necessary. Partners BHM is willing to review situations on a case by case basis, and decisions will be based on medical necessity. Providers must have a current IPRS contact to request these services for a case that would be funded through IPRS. IPRS case approval will be contingent on availability of funds.

Retroactive Medicaid: If a provider has an IPRS authorization for dates that are now covered by Medicaid, providers will not need to submit a new SAR. Provides will need to send a SAR before the end date of the current IPRS authorization. The start date on the new SAR will be the day after the IPRS authorization expired and the provider should identify the appropriate funding source at that time. Providers can bill for services during the IPRS authorization period even if the funding source changed. Claims will be paid from the appropriate fund source since eligibility is determined at the time claims are submitted.

Partial Hospitalization: Partial Hospitalization is usually initiated when a consumer is discharging from an inpatient facility or in an attempt to avert an inpatient admission. When a new consumer is admitted, it may be difficult to get a Person Centered Plan (PCP) completed on the same day as an admission due to the urgency of the situation.

Partners BHM suggests that the Partial Hospitalization service provider submit the SAR on day of admission with clinical information listed in the justification area of the SAR. The provider will have two business days to submit a completed PCP with signatures. The PCP can be submitted by attaching it to the patient module without creating a new SAR. Once the PCP is uploaded, the SAR will be reviewed for medical necessity. The request can be approved back to the date the SAR was submitted.

Psychiatric Residential Treatment Facility: The Psychiatric Residential Treatment Facility service is a *planned service* and System of Care and Care Coordination must be involved in exploring all options prior to submitting an authorization request. Before the service can be authorized and delivered, a Care Review team meeting must be completed and the provider must attach the Signed Action Plan to the SAR when requesting this level of care. **PRTF requests should not be submitted as "expedited".** If a consumer is at great risk and requires immediate intervention, he or she should be evaluated for inpatient admission.

Outpatient Add-on Codes: 90875 is an add on code and does not require an authorization. It does not count against the unmanaged visits.
This code can be used by licensed staff with the following outpatient codes:

- Psychiatric diagnostic evaluation (90791, 90792)
- Psychotherapy (90832, 90834, 90837)
- Group psychotherapy (90853)

90833, 90836 and 90838 are add on codes for evaluation and management (E&M) codes, so no authorization is required and does not count against unmanaged visits. Only Physicians and Nurse Practitioners can use these codes.

If a provider submits a SAR, Utilization Management will enter an authorization although one is not required. This should not have a negative effect on claims.

Comprehensive Clinical Assessments: Comprehensive Clinical Assessments (CCAs) are required on many services when making an initial request. (Please refer to the benefit grids.) For **IPRS and Medicaid,** CCAs can only be completed by a fully or associate licensed staff person. That person must sign the CCA with his/her credentials. Partners has received assessments with SARs requesting Substance Abuse Intensive Outpatient Program (SAIOP) and Substance Abuse Comprehensive Outpatient Treatment (SACOT) that were completed by a CSAC or QSAP. These assessments are not considered CCAs and will not be accepted even when substance abuse services are being requested. If you do not attach an appropriate CCA when required, UM will put an alert in Alpha and the provider will have five calendar days to submit a CCA completed and signed by the appropriately licensed staff.

REVISED May 31, 2013--Outpatient Treatment Plans: Effective June 10, 2013, when an initial SAR is submitted for IPRS and Medicaid-funded basic benefits (individual, family or group therapy), a treatment plan (not a Person Centered Plan) and a service order signature must be submitted. This plan and service order is valid for one year. Both documents must be submitted with each initial request. The plan must be signed by the consumer and/or guardian and person completing the plan. The service order must be signed by a MD, NP, Psy.D, PhD, and Physician Assistant. The treatment plan must include at least one treatment goal. This requirement is outlined in the service definition from the Division of Medical Assistance. There is no set template for the treatment plan but the above criteria must be contained in the plan.

IPRS and Medicaid Funded Psychosocial Rehabilitation Services: Effective June 10, 2013 providers will not be required to submit an authorization request for Psychosocial Rehabilitation Services if the consumer receives 30 hours or less of the service in one week. The daily limit will be set at 10 hours to allow for evening activities. If the provider is planning to deliver more than 30 hours of service a week, a SAR and supporting documentation must be completed. This is reflected in updated benefit plans. When an authorization is required, it will be valid for one year versus the current 180 days.

Person Centered Plans for IPRS and Medicaid Funded Services: Effective June 10, 2013, all Person Centered Plans must include a service order signed by one of the following; the MD, NP, Psy.D, PhD, and Physician Assistant. Previously, PCPs for IPRS funded services have been accepted with a licensed clinician's signature. Those will not be accepted after June 1, 2013. This requirement is for MH/SA services. Individual Service Plans will continue to follow the same rules as before.

Therapeutic Leave for Group Living: Effective June 1, 2013, Partners BHM will allow up to 30 days of therapeutic leave for individuals residing in group living low/moderate/high settings. More details about any changes related to how a provider should bill these days will be communicated soon.

Therapeutic Foster Care: Effective June 10, 2013 concurrent authorization requests for Therapeutic Foster Care will be limited to 90 days per episode versus 180.

Benefit Grids: The Medicaid and IPRS Benefit Grids have been revised with a June 1, 2013 effective date and are available on the Partners BHM Website. Changes are highlighted.

- Medicaid Benefit Grid: http://www.partnersbhm.org/_formsandmanuals/Medicaid%20Services%20Benefit%20Grid.pdf

- IPRS Benefit Grid: http://www.partnersbhm.org/_formsandmanuals/IPRS%20Benefit%20Plan%20for%20Partners%20BHM.pdf

Partners Wants You to Know…

Web Updates: The following documents, along with those previously mentioned in this Bulletin, have been updated or added to the Partners BHM website in May:

Under About Us/More Information:

- Crisis Services Strategic Action Plan
- Who to Contact at Partners BHM
- System of Care—Care Review Request Form

Under For Providers/Information and Documents:

NC Innovations Category:

- NC Innovations Rates (replaces the Medicaid C Rate Schedule)
- Process for Procurement of NC Innovation Waiver Services
- Approved Contractor-Vendor List

Provider Information Category:

- Provider Specialist Assignments for Agencies and Licensed Independent Practitioners

Information for Hospitals Category:

- Inpatient Review Forms—Initial, Initial (Live Review), Continued Stay, Continued Stay (Live Review)
- Psychiatric Inpatient-Outpatient LIP Registration Worksheet

Utilization Management Category:

- LOCUS and CALOCUS scoring sheets
- ASAM Adult Scale and ASAM Score Sheet

Catawba County Care Reviews: The date/location/time for Catawba County Care Reviews will change effective June 2013. Care Reviews will be held the First Wednesday of each month beginning at 11 AM at Partners BHM-Hickory, 1985 Tate Blvd., Suite 529, Hickory NC. If you have questions or need to initiate a Care Review, please contact Kim Sorrell at ksorrell@partnersbhm.org or call 828-323-8049.

Cleveland, Gaston and Lincoln Adult Collaborative: Partners BHM's System of Care Department will host Adult System of Care Collaborative meetings in the Cleveland, Gaston and Lincoln county areas. Collaborative groups identify gaps in services, develop partnerships with agencies, promote resource development, offer technical assistance to providers to resolve service related issues, and help to ensure high quality services are delivered within the System of Care philosophy. Collaborative groups consist of community stakeholders with a vested interest in addressing needs of individuals in the community. The Collaborative Meeting dates are:

- Gaston – June 14, Partners BHM-Gastonia, Auditorium, 901 S New Hope Rd Gastonia NC, 28054 at 8:30 AM
- Lincoln – June 25, Christian Ministries of Lincoln County, 207 S. Poplar St. Lincolnton NC, 9 AM
- Cleveland – June 28 – Ollie Harris Center, Namon Board Room, 917 First St. Shelby, NC 28150, 9 AM

If you are interested in learning more about this group or attending, please contact Karen Creech, System of Care Adult Liaison, at Kcreech@partnersbhm.org or 704-772-4314.

DATE CHANGE! Wellness Recovery Action Planning: Partners BHM will be hosting six hour WRAP training at its Gastonia offices (901 S. New Hope Rd., Gastonia NC 28054) on Friday, June 14, 2013 from 9 AM-4PM. To register, contact Todd McLean at 704-842-6373 or by email tmclean@partnersbhm.org. This free training is limited to 25 participants. To learn more about Wellness Recovery Action Planning, visit http://www.mentalhealthrecovery.com/.

State News

Division of MH/DD/SAS Director Announced: On Tuesday, May 21, Secretary of Health and Human Services Dr. Aldona Wos announced that Dave Richard has been appointed as Director of the Division of Mental Health, Developmental Disabilities and Substance Abuse Services, effective May 28, 2013. Mr. Richard spent nearly 25 years as executive director of The Arc of North Carolina and has held leadership roles within The Arc of the United States. Prior to his role with The Arc of North Carolina, he served as executive director for The Arc of Delaware and The Arc of Louisiana. He earned his Bachelor of Science degree, with a major concentration in elementary education, from Louisiana State University.

NC Tracks News: On July 1, 2013, Computer Sciences Corporation (CSC) will become the new fiscal agent for the N.C. Department of Health and Human Services (DHHS). CSC will be implementing a new multi-payer system for N.C. DHHS, NCTracks**,** that will handle claims-processing and payment for DMA, DMH, DPH, and ORHCC. CSC has begun to pre-note the Electronic Funds Transfer (EFT) information submitted through the Currently Enrolled Provider (CEP) Registration. (For more about the CEP Registration process, see the April 2013 NCTracks Connections newsletter.) The EFT pre-note process involves submitting transactions to the bank routing code and account number provided in the CEP Registration to confirm that the EFT information provided is accurate. One zero dollar credit transaction will be submitted to your bank account for each NC DHHS Division for which you are authorized to provide services, including DMA, DMH, DPH, and ORHCC. If you serve recipients of services from more than one Division, you will receive multiple pre-note transactions.

If you have already completed your CEP Registration, there is nothing you need to do at this time. If you have not completed your CEP Registration, please do so right away. If you did not receive a CEP Registration letter in the mail, with an Authorization code to access the CEP application at www.nctracks.nc.gov, please call 1-866-844-1113. If there is a problem with the EFT pre-note process, a letter will be mailed by CSC to the provider. Claims cannot be paid without accurate EFT information. Claims for a provider with a failed pre-note will suspend for 45 days. If the bank account information is not corrected during that time period, the claims will be denied.

A Special Bulletin was published which provides key information about CSC and NCTracks that will be an important resource to providers beginning July 1, including:

- Contact information
- Hours of operation
- Checkwrite schedule
- AVRS functionality
- Information available on the new Provider Portal

It also includes reminders about important activities providers need to perform before July 1. All providers are encouraged to read the Special Bulletin. If you have any questions, please feel free to contact OMMISS provider relations at OMMISS.providerrelations@dhhs.nc.gov.