Provider Communication Bulletin #33
July 15, 2014

IN THIS BULLETIN:

State-Funded Services/IPRS Enrollment Criteria

Partners would like to thank its provider community for working with us as we returned to a 'capped-contract' funding model for Fiscal Year 2014-15 State-Funded/IPRS services. We have also reviewed procedures regarding who will be eligible for enrollment in State-Funded/IPRS Services. Partners understands the need to identify enrollment parameters so providers can appropriately manage the needs of individuals they serve.

Effective July 1, 2014, the following criteria apply for State-Funded/IPRS enrollment:

- As noted in Partners' Provider Communication Bulletin #29 (March 26, 2014), effective July 1, 2014, Partners resumed enrolling those individuals who are Medicare or Medicaid eligible, but whose services are not part of the Medicaid or Medicare benefit package, in IPRS services.
- We will continue to exclude from IPRS enrollment any **new individuals** who receive third-party insurance benefits, even if the service provided is not part of that insurance carrier's benefit package. A 'new individual' is defined as an individual not enrolled in IPRS as of July 1, 2014.
- Individuals who are currently enrolled in IPRS services may receive a change in services (step-up or step-down) without impact on their IPRS enrollment status. The appropriateness for the requested service will be evaluated by UM through the usual and customary processes.
- Please remember that beginning August 1, 2014, UM will review target populations (target pops) based on State Benefit Plan criteria and DSM-5 diagnose criteria. If the target pop is determined not appropriate, the request cannot be processed. A correct Benefit Plan (target pop), would need to be selected and the SAR resubmitted.

State Communication Bulletin # 143—NCTOPPS 2014-2015 User Tools and Guidelines

The NC Division of MM/DD/SAS released Communication Bulletin #143 titled, "NCTOPPS 2014-2015 User Tools and Guidelines" (find all DMH/DD/SAS bulletins here) on June 20, 2014. This bulletin states the form changes to NCTOPPS that began July 1, 2014.

One change worth noting relates to the **Common Name Data Services (CNDS) number**. For Medicaid recipients, the CNDS number is same as their Medicaid ID. For individuals NOT enrolled in Medicaid, LME/MCOs have been charged with providing this CNDS number when an individual is admitted to an NC-TOPPS required service. Partners directs providers to use the consumer's assigned Alpha ID number for **non-Medicaid enrollees** on NCTOPPS forms. If you have any questions, please contact Sheila Wall, swall@partnersbhm.org, or the NCTOPPS team at NCTOPPS@partnersbhm.org.

Change in Submission of Innovations Waiver Failure to Provide Back-Up Staffing Incident Reports

Effective Tuesday, July 1, 2014 providers of Innovations Waiver services may submit the **Failure to Provide Back-Up Staffing Report** to Partners BHM using the Back-up Reporting module in the AlphaMCS Provider Portal. Partners will continue to accept submission by other methods (i.e. fax) until July 31.

Beginning August 1, 2014, only reports submitted though the AlphaMCS Provider Portal will be accepted. Any reports submitted by fax, email or other method will be returned to the provider with a request for re-admission via the AlphaMCS Provider Portal.

***Please note that this communication is in reference to Innovations Waiver Failure to Provide Back-Up Staffing Reports ONLY**. Level II and III incident reports will continue to be submitted through the IRIS system and the DHHS Quarterly Provider Incident Reports are to be submitted to the Partners BHM Consumer Relations Department.*

If you have any questions regarding this change or when submission of a back-up report is required please contact Marsha Johnson, Quality Management Analyst at 336-527-3230 or email mjohnson@partnersbhm.org

State-Funded Enhanced MH/SA Service Definitions

A revised *State-Funded Enhanced MH/SA Services* document is now available on the Division of Mental Health, Developmental Disabilities and Substance Abuse Services website at http://www.ncdhhs.gov/mhddsas/providers/servicedefs/index.htm. The document contains technical revisions based on DSM-5, ASAM, NC TRACKS and Benefit Plan language changes and is effective August 1, 2014.

Reminder--NC-SNAP Web Information

NC-SNAP information and forms may be accessed via the MH/DD/SAS web site at http://www.ncdhhs.gov/mhddsas/providers/NCSNAP/index.htm. Once you have accessed the web page go to the bottom under NC-SNAP Publications; click on NC-SNAP Manuals 7/2014 to access the current examiners guide; click on forms to access the NC-SNAP assessment and the supplemental information sheet. Click on Assessment Profile (7/3/14) for a printable NC-SNAP assessment form and click on

Summary Report and Supplement Information Coversheet (7/3/14) to access the up to date supplement information sheet.

AlphaMCS Information

Site Adjudication Changes for Claims and Authorizations: Previously the Alpha MCS system updated claims to include the site from the authorization on the claim, even when an alternate site was originally billed on the claim. This is altering of claim information and this is not appropriate for Partners to change. With the implementation of the new site adjudication changes, claims will be adjudicated based upon the site that is billed on the claim. If that site is different from the site authorized, the claim will deny.

Tips and helpful reminders to prevent denials for site adjudication changes:

- Make sure that the site billed for on any current claim matches the site on the current authorization in the Partners system. Any claims billed with a site that is different from the site on the current authorization will deny.
- All new authorization requests should be requested for the site from which the service will be delivered. (Note--this is not the same as Place of Service). Claims should be billed with the same site requested and approved on the authorization.

If you have further questions, please contact Claims at claims_department@partnersbhm.org or call 1-877-864-1454, select option 4, option 3.

Place of Service to Procedure Code Map: Alpha will be implementing new place of service to procedure code mapping on August 1, 2014. An Excel file has been developed to assist providers with mapping. The file is available on the Partners website in For Providers > AlphaMCS Info.

DSM-5 and State Benefit Plan Questions and Answers

Q: Will we be able to bill 799.9 (deferred diagnosis) from August 1, 2014 until October 2015?

A: 799.9 cannot be used after August 1, 2014 as it is not in the DSM-5.

Q: Can we still bill 799.9 and use an AMI target pop (especially when the crisis target pops are removed on August 1, 2014)?

A: You cannot use 799.9 for any State Benefit Plan (target pop). In the DSM-5, there is a dx 300.9 (Other Specified or unspecified mental disorder). It is on page 708 of the DSM-5 manual. Providers should use this code with the GAP pop. It is for assessments. The GAP cannot be used with any other Benefit Plan (Target Pop) and is short term (60 days). If the consumer needs additional service(s) after an assessment a diagnosis would be needed and the State Benefit Plan (target pop) would be changed

Q: Once ICD-9 moves to ICD-10, will we be allowed to bill R69 with an AMI target pop?

*A: Until more ICD 10 information is available it is not clear if R69 can be used. If a consumer fits the criteria for AMI the criteria states the following, "The **presence of a diagnosable mental, behavioral, or emotional disturbance** that meets diagnostic criteria specified in the Benefit Plan Diagnosis Array," which indicates you should have a diagnosis to use AMI as the selected Benefit Plan (target pop.)*

Q: Can a provider be paid for a State Benefit Plan Target Pop that has changed, after August 1, 2014?

A: The following is found in Communication Bulletin # 141 dated April 16, 2014:
"Inclusion in DMHDDSAS Benefit Plans after July 31, 2014 shall be based on the covered DSM-5 diagnoses and eligibility criteria listed in the attached documents. ICD-9 diagnosis codes

covered in FY14 will continue to be allowed for claims adjudication in NCTRACKS through the end of FY15, for the Benefit Plans that are not expiring. Please see communication bulletin #142 for information on Benefit Plans, Diagnostic Array and Service Array"

Q: When the nomenclature related to a diagnosis changes while the code and criteria remain generally unchanged? (Example: 317 –Mild Retardation in DSM 5 is 317 Intellectual Disability: Mild). Will providers need to end date the DSM IV diagnosis and start date the new DSM 5 diagnosis in the MCO billing system to prevent denials?

A: No, the current diagnosis does not need to be end dated. Claims are submitted with an ICD-9 code. The provider needs to use the ICD-9 code that will track to a DSM-5 diagnosis.

Q: Will a PCP update with new signatures from the guardian be required when the only change is the language of the diagnosis?

A: A PCP with new signatures will not be need if the only change is the wording of the description. If a diagnosis is eliminated and a new one is required, an updated PCP with signatures is required.

Q. When the code changes and nomenclature change but the general criteria do not change, (Example: 299.80 (Asperger's Disorder in DSM IV TR and Autism Spectrum Disorder in DSM-5), the claim that would be sent in after August 1 would be under diagnosis code Autism Spectrum Disorder (ICD-9 code 299.00). Will this claim be denied or cause an issue upon audit from the MCO?

A: This should not cause a denial in claims.

Q. With the example of a change in 299.80 Asperger's Disorder in DSM IV TR and Autism Spectrum Disorder in DSM-5, will a new assessment be required for submitting a service authorization request?

A. With the first submission of a SAR on or after August 1, 2014, the DSM-5 diagnosis must be used. The clinical criteria to support the Autism Spectrum diagnosis must be present in the documentation used for clinical justification. This can be included in an update to a clinical assessment, or a new comprehensive clinical assessment or psychological evaluation.

	MEDICAID TOP 5 DENIALS from June 2014	PROVIDER RECOMMENDED ACTION STEPS
1	Invalid PC / DX Combo	Verify that Procedure code corresponds with DX and that all information is submitted correctly. Refile only if incorrect.
2	Missing/incomplete/invalid diagnosis or condition	Rebill the claim with a valid corresponding Diagnosis code.
3	Claim received after billing period	Write off charges as non-billable. Do not rebill.
4	Duplicate Claim	Claim has previously been submitted and adjudicated. Do not refile.
5	Service is not authorized	Verify Service Authorization for consumer. Contact Utilization Management.

Provider Reminders

Provider Alerts are emailed to all providers subscribed through Constant Contact for "Information for Providers" and "All Partners BHM Communications", and are posted at the bottom of the "For Providers" page at www.partnersbhm.org.

Register for the August Provider Forum: The August Provider Forum will focus on issues pertaining to all providers. The forum will be held via videoconference on Tuesday, August 12, 2014, in Partners' Elkin, Hickory and Gastonia offices. The forum begins at 1 p.m. If you plan to attend the meeting, please RSVP online.

Handouts from the July 8th Provider Forum are available on the Partners website (For Providers > Information & Documents > Provider Forum Information)

Partners Training Academy

All Partners Training Academy-sponsored opportunities are posted on the Calendar at http://www.partnersbhm.org/calendar/ and in the monthly PTAU, posted on the For Providers > Resource and Training page.

Please note that:

- Participants are asked to please arrive at least 10 minutes prior to the start of the training to allow for check in.
- Partners also has a 15-minute rule—once the training has started, individuals will be admitted only within the first 15 minutes of the training. After 15 minutes, any late arrivals will not be able to participate.