Provider Communication Bulletin #39
December 23, 2014

IN THIS BULLETIN:

Partners Rate Increases
Incident Reporting
Utilization Management Updates:

- **Attention: Residential Level III/Day Treatment/Outpatient Providers**
- **Attention Innovations Providers:**
  - **Services in the Home of a Direct Service Employee**
  - **Day Supports**
  - **Reminder to ICF-IID Providers**
- **Additional UM Updates:**
  - **Opioid Maintenance Treatment**
  - **Diagnosis Mapping**
  - **Updated Benefit Grids**

Claims Updates

- **2015 Checkwrite Schedule**
- **Medicaid Top 5 Claim Denials For October 2014**

Provider Reminders

- **January Provider Forum**
- **Provider Change/Add/Delete Request Form**
- **Provider Alerts**
- **Advancing Strong Leadership for IDD Providers**
- **High Fidelity ACT 101 Training**

State News

- **Proposed Policy 8A-1 Assertive Community Team (ACT) Program**
- **Major Medicaid Formulary Changes**
- **DMA Medicaid Bulletin**

NCTracks News

- **Coming AtTrackions**
- **More Opportunities to Learn About ICD-10**
- **ITP Claim Pricing Functionality in NCTracks**

Partners Rate Increases

Partners BHM continues to assess rates for services and follow through with our commitment to reinvest future Medicaid savings into services for those you serve. With this in mind, we are pleased to announce the following rate increases effective January 1, 2015. (Rate changes include respective IPRS rates.)

Service and Specialty	Current Rate	New Rate	Increase	% Increase
90791 - Psychiatric Diagnostic Evaluation (No Medical Services)				
101 MD Specialty	$125.39	**$131.32**	$5.93	4.7%
109 Licensed Psychologist	$125.39	**$131.32**	$5.93	4.7%
111 Certified Nurse Specialist	$106.58	**$111.62**	$5.04	4.7%
112 Certified Nurse Practitioner (MA)	$106.58	**$111.62**	$5.04	4.7%
110 LCSW, LPC, LMFT	$94.04	**$98.49**	$4.45	4.7%
128 LPA	$94.04	**$98.49**	$4.45	4.7%
129 LCAS, Certified Clinical Supervisor	$94.04	**$98.49**	$4.45	4.7%
210 Physician Assistant	$125.39	**$111.62**	($13.77)	-11.0%
99214 - E+M - Moderate -Established Patients				
101 MD Specialty	$84.29	**$103.28**	$18.99	22.5%
112 Certified Nurse Practitioner	$71.65	**$87.79**	$16.14	22.5%
210 Physician Assistant	$84.29	**$87.79**	$3.50	4.1%
99215 - E+M DETAILED - High - Established Patients				
101 MD Specialty	$114.00	**$138.57**	$24.57	21.6%
112 Certified Nurse Practitioner	$96.90	**$117.78**	$20.88	21.6%
210 Physician Assistant	$114.00	**$117.78**	$3.78	3.3%
90853 Group				
(101) MD Specialty	$26.09	**$48.00**	$21.91	84.0%
(111, 112) Certified Nurse Practitioner, Certified Nurse Specialist	$21.74	**$40.80**	$19.06	87.7%
(210) Physician Assistant	$26.09	**$40.80**	$14.71	56.4%
(110, 128, 129) LCSW, LPC, LCAS, LMFT, LPA	$19.18	**$36.00**	$16.82	87.7%
(109) Licensed Psychologist	$25.57	**$40.80**	$15.23	59.6%
H2011 HK Mobile Crisis Management				
This rate is effective only for community response and excludes hospital Emergency Department as place of service.	$33.68	**$56.00**		

Incident Reporting

Partners will not be requesting a waiver for Subsection (e) of Rule 10A NCAC 27G .0604 *Incident Reporting Requirements for Category A and B Providers* for its provider network. If your agency is interested in obtaining the waiver, please contact the Division of Mental Health/Developmental Disabilities/Substance Abuse Services Quality Management Team at 919-733-0696 or email ContactDMHQuality@dhhs.nc.gov for assistance.

Starting on July 1, 2014, Partners Behavioral Health Management developed a new ***Quarterly Provider Incident Report form***. This form **MUST** be used when completing your second quarter reports due on January 12, 2015. The old forms on the state website will no longer be accepted! You can download the new form from our website at http://partnersbhm.org/providers/provider-forms.aspx#. Go to **For Providers -> Information & Documents -> expand the Provider Information Category.** Scroll down until you see **Quarterly Incident Reporting** form. If you have questions, please contact Amy Dotson, Consumer Relations, at 704-884-2576.

Utilization Management Updates

Attention: Residential Level III/Day Treatment/Outpatient Providers: This communication is intended to clarify clinical expectations for the Residential Level III service, as outlined in Clinical Coverage Policies, Communication Bulletins, and accepted standards of Best Practice. This includes utilization of Day Treatment and/or Outpatient therapy during the same authorization period as Residential Level III.

The following areas are addressed:

- CLINICAL REQUIREMENTS RELATED TO THERAPY
- REQUESTS FOR CARE PAST 180 DAYS
- DISCHARGE PLANNING
- DAY TREATMENT IN CONJUNCTION WITH LEVEL III RESIDENTIAL SERVICES

CLINICAL REQUIREMENTS RELATED TO THERAPY: Partners BHM notes the following as stated in Clinical Coverage Policy 8D-2 Residential Services, August 1, 2014 revision: *"Consultative and treatment services at a qualified professional level shall be provided four hours per child per week. This staff time may be contributed by a variety of individuals. For example, a social worker may conduct group treatment or activity; a psychologist may consult on behavioral management; or, a psychiatrist may provide evaluation and treatment services. These services must be provided at the facility site. Group therapy or activity time may be included as total time per consumer (i.e., if there are six members in a group for 90 minutes, this may be counted as 90 minutes per consumer).*
***Note: Periodic Services may not be used to augment residential services*"**

Partners Recommended Therapy Standards for Individual, Group and Family Therapy included in Residential Level III Services:

1. **Individual Therapy**: Minimum of two times a month as specified in the Person Centered Plan based on medical necessity and consistent with the consumer's treatment goals.
2. **Family Therapy:** Minimum of once a month as specified in the PCP based on medical necessity and consistent with the consumer's treatment goals. Facilities' documentation should include efforts to include family members in sessions as clinically appropriate. If family members are not able to attend sessions in person, efforts to apprise family members of progress and facilitate communication between provider, family member, and consumer

should also be documented. It is expected that the frequency of family sessions will increase as consumer prepares to transition out of this level of care.

3. **Group Therapy:** Group therapy should be provided regularly according to consumer needs and best practice indicators. Group therapy should not be the sole method of therapeutic intervention.
4. **Evidence-Based Practice:** As in any service, it is expected that providers use evidence based practices in the residential setting that are based on consumer's clinical presentation and that these practices are delivered to fidelity to the extent possible in this setting. In consideration of the service definition, it is Partners' expectation that therapy services be provided on-site at the residential facility by an appropriately qualified/licensed professional. **Therapy services outside of those provided by the residential provider may be necessary only when there is a clinical issue that requires specialized assessment or counseling services.** It is anticipated that this circumstance will be rare. Examples of specialized services may include but are not limited to specialized therapeutic services for sex offender treatment or treatment for eating disorders.

It is of particular importance for individual practitioners who are providing services for consumers receiving Residential Level III care to understand all Clinical Coverage Policies.

REQUEST FOR CARE PAST 180 DAYS: Partners would like to remind providers that the following applies for any consumers for whom there is a request for Residential Level III treatment for longer than 180 days:

Required documents:

- An independent psychological or psychiatric assessment if the provider is not a CABHA. (A CABHA provider may have the assessment completed by a licensed professional associated with the CABHA).
- Documentation of a "Child and Family Team Review of Goals and Treatment Progress" is also required. This review will be demonstrated through submission of a PCP update noting any changes being made to strategies and interventions, and details of progress towards goals.

Providers are directed to consult Clinical Coverage Policy Implementation Update #90.

DISCHARGE PLANNING: Discharge planning is a required element of **ALL** services. A realistic measurable discharge plan and clear active planning/coordination with discharge service providers should begin from admission and be documented in all authorization requests.

Partners encourages that the independent assessment referenced above be discussed, and coordination of care to obtain this assessment should begin to occur once a consumer has been in this level of care for 120 days, to ensure that this is completed and submitted to the Utilization Management department in a timely fashion.

DAY TREATMENT IN CONJUNCTION WITH LEVEL III RESIDENTIAL SERVICES: Because the Residential Level III service is intended to be "*responsive to the need for intensive, active therapeutic intervention*" per Clinical Coverage Policy (CCP) 8D2, it is expected that this service will thoroughly meet the needs of consumers who qualify for this level of care. Please note that Clinical Coverage Policy also states that "*This setting has a higher level of consultative and direct service from psychologists, psychiatrists, medical professionals, etc.*" than lower levels of residential and of outpatient services. Although there may be some cases in which both Day Treatment and Residential Level III should be authorized at the same time for the same consumer, this is expected to be an exceptional circumstance.*****

Day Treatment services are designed to address the behavioral health needs of the consumer in an intensive manner for a limited period of time. Collaboration with school systems is expected to assist with accessing educational assessments and services to address consumers' educational needs. Residential Level III should not be designed to rely on concurrent Day Treatment service to supplement care. When these services do occur during the same authorization period, it is expected that there should be a high degree of collaboration and consultation between the providers of these services.

Please remember that a Level III facility shall be responsible for ensuring supervision of children or adolescents when they are away from the facility in accordance with the child or adolescent's individual strengths and needs as specified in the treatment plan.

Additional Information related to Residential Level III and Day Treatment:

- Consistent with Administrative Code (NCAC 27G .1704(e))* and Clinical Coverage Policy 8D-2, Partners views Residential Level III as a *comprehensive service*.
- Interventions to address behaviors occurring in the school setting that are related to the consumer's diagnosis should be addressed in the PCP.
- Partners is committed to serve consumers in the least restrictive Level of Care, as indicated by accepted best practice standards.
- Day Treatment is intended to serve populations for whom school interventions have been attempted and deemed insufficient in addressing the consumer's needs. Consumer barriers to education are a primary responsibility of the school system. As with any request for the Day Treatment service, documented evidence identifying that interventions by the school system have not been effective in addressing consumer's behavioral needs is required for evaluation of medical necessity.
- Per Clinical Coverage Policy 8A, Day Treatment is intended to be time-limited and titrated.

***Note**: Early Periodic Screening Diagnosis and Treatment ("EPSDT") guidelines can allow for an override of service exclusions and requests can be approved when EPSDT criteria apply. When requesting services that are considered exclusionary, the provider should indicate this needs review under EPSDT.

Attention Innovations Providers

Services in the Home of a Direct Service Employee: Per Clinical Coverage Policy 8P, Services in the Home of a Direct Service Employee: *If a beneficiary needs to receive Personal Care or Respite services in the home of a direct service employee, the Provider Agency, Employer of Record or Agency With Choice is required to complete the Health and Safety Checklist/Justification for Services form prior to the delivery of service in that home. The beneficiary or legally responsible person will be asked to sign this checklist. Beneficiaries should consider the provision of services in the direct service employee's home very carefully. While the checklist covers basic health and safety concerns, it does not provide for an independent review or cover the same areas that formal licensure of service locations covers.*

When IDD UM receives requests for services to be provided in the employees' homes, as written into the ISP, a Health and Safety Checklist should be on file in AlphaMCS. Therefore, please upload your Health and Safety Checklists as they are completed in order to avoid delay of processing related authorization requests.

Day Supports*:* Per Clinical Coverage Policy 8P, *Day Supports is primarily a group service that provides assistance to the beneficiary with acquisition, retention, or improvement in self-help, socialization and adaptive skills.*

Partners recognizes the need for some individuals to receive Individual support during a portion or all of the time in which the individual is being served with this service. In an effort to clarify this need and to ensure standardization with other LME/MCO's Partners is implementing the Day Supports-Individual Needs Determination Guide to be submitted upon request for Day Supports Individual services. This tool is completed by the Care Coordinator with input from the Treatment Team. This guide is available on the Partners website (For Providers -> Information & Documents -> Utilization Management).

Reminder to ICF-IID Providers: Intermediate Care Facilities for Individuals with Intellectual Disabilities (0100) service authorization requests require the current Innovations Initial Level of Care (LOC) Eligibility Determination form and Medical Assessment (if applicable) signed by an MD. However, Partners UM is requesting that upon completion, the Person Centered Plan and any subsequent assessments are uploaded into the Patient Portal. Updated information is reviewed with submission for continued authorization.

Additional UM Updates:

Opioid Maintenance Treatment: Providers have inquired about the 60-day limit on concurrent requests. When a consumer has reached a "maintenance" phase of treatment, the provider can request up to 90 days for concurrent requests. The criteria for OTS Maintenance phase is**: six months of consecutively negative UDS for all substances, excluding prescribed amphetamines.** All requests must contain appropriate clinical justification for the service

Diagnosis Mapping: Currently, the benefit plan in AlphaMCS has some diagnosis that map to both Mental Health and IDD populations. Back in August 2014, the state put out a diagnosis array and identified the correct mapping of diagnosis to population. This workbook is available on the Partners website (For Providers -> Information & Documents -> Utilization Management).

As of January 1, 2014, AlphaMCS will have uploaded the approved diagnosis array and mapping to the correct population. Providers should review the Diagnosis Array. In the past some, diagnosis may have been used for both populations.

Since August 1, 2014, providers have been working to update diagnosis and target pops as SARs were submitted. It is important to ensure you have the correct diagnosis associated with your consumers. After the update is completed in AlphaMCS, claims submitted with an incorrect diagnosis could deny for payment.

Updated Benefit Grids: Partners' Benefit Grids are posted on our website at the links below:

- IPRS Benefit Plan (Effective Dec. 1, 2014)
- Medicaid Benefit Plan with B3 Services (Effective Dec. 1, 2014)

Claims Updates

2015 Checkwrite Schedule: The 2015 statewide Standardized LME-MCO checkwrite schedule is posted on the Partners Website at For Providers -> Information and Documents -> Finance and Claims.

Medicaid Top 5 Claim Denials For October 2014:

MEDICAID TOP 5 CLAIM DENIALS NOVEMBER 2014	PROVIDER RECOMMENDED ACTION STEPS
Max Basic Units Exhausted	A SAR will need to be entered for the service they're trying to get approved.
Client has other insurance(COB)	Ensure that the primary insurance for the patient has been billed and is indicated on the claim being submitted to the MCO.
Claim received after billing period	Write off charges as non-billable. Do not rebill.
Duplicate Claim	Claim has previously been submitted and adjudicated. Do not refile.
Service is not authorized	Verify Service Authorization for consumer. Contact Utilization Management.

Provider Reminders

January Provider Forum: Partners will host an All-Provider Forum on January 13, 2014 beginning at 1 p.m. Providers are asked to register for the site where you will attend:
Partners BHM - Elkin, 200 Elkin Business Park Dr., Elkin, NC
Partners BHM-Gastonia, 901 S. New Hope Rd., Gastonia, NC
Partners BHM-Hickory, 1985 Tate Blvd. SE (First Plaza), Hickory, NC

Handouts from all Provider Forums are available on the Partners website (For Providers > Information & Documents > Provider Forum Information).

The Provider Change/Add/Delete Request Form has been updated on the Partners website. Please make sure to submit this version for any changes that need to be made to your contract, site changes, etc. It can be located at For Providers->Enrollment and Credentialing.

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.

Advancing Strong Leadership for IDD Providers: Advancing Strong Leadership is a leadership development initiative for early career professionals in the intellectual/developmental disability field in North Carolina. The program is funded by the North Carolina Council on Developmental Disabilities and operated by the National Leadership Consortium on Developmental Disabilities at the University of Delaware. To learn more and how to apply, click here. The deadline for applications is January 30, 2015.

High Fidelity ACT 101 Training will be held January 20-22 in Raleigh. The training is capped at 50 individuals. To register, go to https://docs.google.com/forms/d/1Kp5lCmm3QysdyorpeohaALhnHyoOpJ8XPn-rcpFBUis/viewform?usp=send_form

State News

Proposed Policy 8A-1 Assertive Community Team (ACT) Program is scheduled to be posted for another 15 day public comment on Wednesday, December 17, 2014. It can be viewed at http://www.ncdhhs.gov/dma/mpproposed/index.htm.

Major Medicaid Formulary Changes: Effective January 1, 2015, The NC Medicaid Outpatient Pharmacy Program will implement changes to the NC Medicaid Preferred Drug List (PDL). Behavioral Health medications, including ANTIDEPRESSANTS, ANTIPSYCHOTICS and ADHD medications, will have non-preferred agents listed on the PDL for the first time.

Community Health Partners (a Community Care of NC network) has made several educational documents available on their website www.communityhlthpartners.org (Go to Providers -> Pharmacy ->

Medicaid Preferred Drug List). These documents will be emailed to office managers this week. CHP will also host a webinar on January 7th, 2015, 12-1:00 p.m., presented by Dr. Karen Melendez, to review these changes and provide general navigation instructions for NC Tracks online prior authorization submission.

To join the meeting, go to:
https://bluejeans.com/447144679?ll=en
Connecting directly from a room system?

1) Dial: 199.48.152.152 or bjn.vc
2) Enter Meeting ID: 447144679 -or- use the pairing code

Just want to dial in? (http://bluejeans.com/numbers)

1) +1 408 740 7256
    a. +1 888 240 2560 (US Toll Free)
    b. +1 408 317 9253 (Alternate Number)
2) Enter Meeting ID: 447144679

DMA Medicaid Bulletin: Providers are encouraged to review the monthly NC Division of Medical Assistance Medicaid Bulletin. Bulletins are posted at http://www.ncdhhs.gov/dma/provider/.

NCTracks News

Coming At*Track*ions: NCTracks has announced the publication of a newsletter, Coming At*Track*ions that will feature additional information and updates. Partners does not post all NCTracks info in PCB. To get all updates from NCTracks, visit https://www.nctracks.nc.gov/content/public/providers/provider-communications.html to register for email communications.

More Opportunities to Learn About ICD-10: In this video on Coding for ICD-10-CM: More of the Basics, Sue Bowman from the American Health Information Management Association (AHIMA) and Nelly Leon-Chisen from the American Hospital Association (AHA) provide a basic introduction to ICD-10-CM coding. The objective of this video is to enhance viewers' understanding of the characteristics and unique features of ICD-10-CM, as well as similarities and differences between ICD-9-CM and ICD-10-CM. The video covers:

- How to assign a diagnosis code using ICD-10-CM
- ICD-10-CM code structure
- Coding process and examples: Combination codes, 7th character, placeholder "x," excludes notes, unspecified codes, external cause codes
- Resources for coders

To help you prepare for ICD-10, CMS recently released two new Medscape videos and an expert column. Available on the CMS ICD-10 website, these resources provide guidance about the transition to ICD-10 with a focus on small practices. Continuing medical education (CME) and nursing continuing education

(CE) credits are available to health care professionals who complete the learning modules. Anyone who completes the modules can receive a certificate of completion.

The Road to 10 Tool, also available through the CMS ICD-10 website, gives an overview of ICD-10 and answers frequently asked questions. The tool is designed to help small practices jumpstart their transitions. Providers can build an ICD-10 action plan and review tailored clinical scenarios to learn more about how ICD-10 affects their practice.

From now until ICD-10 goes live in October next year, you can send your ICD-10 questions and comments to NCTracks-Questioner@dhhs.nc.gov. You will get an answer personally, and we will get an idea of the kinds of information you need. The best will be shared with everyone. We're all in this together.

ITP Claim Pricing Functionality in NCTracks: Coming January 4, 2015, claim pricing functionality for ITP claims will be implemented in NCTracks. This will allow the ITP claims to be processed automatically by the system, instead of the current manual review process. This change will also provide quicker disposition of ITP claims submitted.

As a result of the manual review process, some providers may have had ITP claims denied, pended, or paid incorrectly since go-live on July 1, 2013:

- Claims that are currently pending will be recycled, so they will be processed automatically. No action is required by providers.
- Claims that were denied can be resubmitted by the provider as a new claim.
- Claims that were paid incorrectly can be addressed by the provider submitting a replacement claim.

Training on the submission of professional (1500) claims is available in SkillPort, the NCTracks Learning Management System. Providers can register for these courses by logging on to the secure NCTracks Provider Portal with your NCID and clicking the Provider Training button to access SkillPort. Open the folder labeled **Provider Computer-Based Training (CBT) and Instructor Led Training (ILT)**. The courses can be found in the sub-folders labeled **CBTs** and **ILT Guides**, depending on the format of the training material. Refer to the Provider Training page of the public Provider Portal for specific instructions on how to use SkillPort. The Provider Training page also includes a quick reference regarding Java, which is required for the use of SkillPort. If you have any questions or need assistance, please contact the CSC Help Desk at 1-800-688-6696.