Provider Communication Bulletin #49
November 4, 2015

IN THIS BULLETIN:

Partners Develops New Collaborative Groups for Providers

Partners has introduced two new provider collaboratives to address, identify and explore treatment solutions:

The Residential Services Collaborative will hold its first meeting on Wed., Nov. 18 at 1:30 p.m. This collaborative offers Level I, II, III, IV, and PRTF Residential Treatment providers and Partners' staff the opportunity to work together to move children through the treatment continuum.

The meeting will be via teleconference to Partners' Elkin, Hickory and Gastonia regional offices. Providers can attend at any one of the regional offices to participate in the meeting. If you are interested in participating in the Residential Services Collaborative, please RSVP to Liza Go-Harris at LGo-Harris@partnersbhm.org.

The Substance Use Disorder Collaborative had its first meeting on Wed., Oct. 21. The **SUD Collaborative** is an opportunity for SUD treatment providers and Partners' staff to collaborate periodically across levels of care, as we work together to meet the complex needs of this population.

The SUD Collaborative will meet monthly via webinar and face-to-face on a quarterly basis. The next meeting (via webinar) will be held on Nov. 20, 2015 beginning at 2 p.m. To participate, please RSVP Lynne Grey at LGrey@partnersbhm.org.

Home and Community Based Services Assessments – Additional Information Requests

Partners is in the process of reviewing the assessments providers have submitted for the Home and Community-Based Services (HCBS) Project. In some instances, we have accepted the assessment, but had questions that the provider needed to answer. When the Accept button was selected, the question(s) were not sent to the provider. As such, you may be contacted by a Partners staff member requesting additional information. **Please make sure that you promptly reply if we reach out to you with questions regarding the assessment.**

As we review the assessments, you, the provider, may receive the following message along with questions:

"*This assessment was inadvertently accepted during the initial review. It should have been placed in a pending status to afford the opportunity for response, by you, as provider. We are requesting that the questions, noted below, be addressed, and submitted to the LME-MCO so the process can be appropriately completed. We apologize for any inconvenience, but recognize, as noted, on Slide 99 of the Statewide Training, that we are all engaging in a new process where all the answers are not known, and that as circumstances arise we will work through them together. We appreciate your assistance.*"

If you have any questions regarding your agency's HCBS assessment, please contact your Provider Specialist.

Relative as Direct Support Employee Forms Updated

The NC Division of Medical Assistance has updated the "Relative as Direct Support Employee" application. **Partners cannot process any RADSE requests sent in on the old forms**, as there additional questions relating to HCBS on the new application that must be addressed.

Providers should use the version located on the Partners website - For Providers -> Intellectual and Developmental Disabilities -> Relative as Direct Support Employee.

Innovations Waiver Webinars

The NC Division of Medical Assistance will present the first of a number of webinars related to the Innovations Waiver on Friday, Nov. 6, 2015 from 11 a.m.-4 p.m. This webinar is focused on Care Coordination.

To participate in the webinar, please use the following to log on:

Event address:
https://dsohf.webex.com/dsohf/onstage/g.php?MTID=e1ded9ac8dee31758b2a32ed79ee98b0c
Event Number: 667 223 518
Event Password: CC321

If you would like to see the full schedule of webinars, or access previous webinars, please visist: http://www2.ncdhhs.gov/dma/lme/Innovations.html (webinar information is listed under NC Innovations Waiver – Proposed Changes – Webinar Series.)

Inpatient Hospital Notice for Medicaid and IPRS Funding

A Provider Alert was released on October 23, 2015, clarifying information posted in Provider Bulletin #48 regarding the elimination of the Unmanaged Admission pass through days for all Medicaid and IPRS inpatient services initiated October 1, 2015.The explanation is below:

Inpatient Hospital Notice for Medicaid and IPRS Funding Clarification of notice in Provider Bulletin #48, Partners Behavioral Health Management, regarding Partners BHM elimination of the Unmanaged Admission pass through days for all Medicaid and IPRS inpatient services initiated October 1, 2015. The updates in this bulletin are effective November 1, 2015.

Initial requests: On October 1, 2015, Partners BHM stopped allowing a 72 hour pass through for inpatient admissions. Clinical Coverage Policy 8B, allows a hospital up to 48 hours from time/date of admission to notify MCO of the admission. If SARs are submitted within 48 hours of admission, Partners Utilization Management (UM) will review back to the first day of treatment. If Medical Necessity is met, the request will be approved beginning with the first day of admission. When Medical Necessity is questionable, the request will be reviewed by Partners medical staff. If the Partners medical staff determine medical necessity is not met, the request will be denied from the date of admission forward. There will be no payment for any of those days. Hospitals accept financial responsibility for all denied days.

If SARs are submitted after the first 48 hours, UM will review for the 48 hours prior to the submission of the SAR but will not process days outside of the 48 hour timeframe. Example: If patient admits on Friday at 2100 the SAR should be submitted by Sunday @ 2100. If the SAR is not submitted until Monday by 2100, UM will review for Saturday, Sunday, and Monday only. Requests for Friday would not be processed as that is considered a retroactive request.

In a situation like the example given above, the hospital staff should only request authorization, on the SAR, for Saturday, Sunday, and Monday. If the SAR that is submitted includes Friday, UM will Unable to process the SAR and the facility will need to resubmit a SAR with correct dates.

The above process is only for the initial requests. Initial requests are to be submitted through AlphaMCS.

Submitting SARS on the day of admission can help hospitals avoid potential financial loss.

UM will respond to all Initial requests within 12 hours of submission.

Concurrent requests: Any concurrent request for additional days must have a SAR submitted through Alpha MCS and should be submitted prior to or on the last date of the current authorized time-frame. Continued stay SARs will not be reviewed retroactively.

UM will respond to all continued stay requests within 24 hours of SAR submission.

The process outlined above for initial requests does NOT apply to three-way contracts. Three-way admissions will still have a four day pass through for substance abuse consumers, a three day pass through for enhanced mental health requests and a seven-day pass through for standard mental health requests as is stated in the contract.

Provider Taxonomy Verification Assistance Training

Partners will host taxonomy assistance trainings at our Hickory location on November 16, 2015. Staff from Partners will be offering assistance verifying taxonomies in Alpha and NCTracks during the sessions. It is advised that the person attending the training is the NCTracks administrator for your agency. Attendees are also reminded to bring their AlphaMCS and NCTracks logins to the training.

Registration is required as seating is limited. Please select the time you wish to attend to complete registration.

8:30 a.m. 9:30 a.m. 10:30 a.m. 1:30 p.m. 2:30 p.m.

If you have questions, please email Rhonda Colvard at rcolvard@partnersbhm.org.

To learn more about taxonomy verification, check out page 17 of the August 2015 Provider Forum handout. Handouts from all provider forums are located in the "For Providers" section of the Partners website.

Utilization Management Updates

Assertive Community Treatment Team (ACTT)

In Communication Bulletin #32, published on June 27, 2014, Partners informed providers that they could begin asking for two months (eight units) on initial request and concurrent requests would remain at six months.

The ACTT Clinical Coverage Policy was *updated on August 1, 2015* and posted to the DMA webpage. In this latest update, there is a statement about utilization management and time frame for authorizations. The CCP states: "Medicaid and NC Health Choice (NCHC) covers 180 days for initial authorization period based on medical necessity. This does not require the MCO to give 180 days on an initial request."

Partners will continue to authorize up to 60 days on initial requests and 180 days on concurrent requests. Please submit your service authorization requests (SARs) accordingly to avoid having the SAR sent back as "Unable to Process".

Clinical Coverage Policy (CCP) Changes

The following CCPs were updated as of October 1, 2015, to add ICD-10 codes information and requirements:

- 8A Enhanced Behavioral Health Services
- 8B Inpatient

- 8C Outpatient
- 8D1 PRTF
- 8D2 Child Residential Services
- 8P Innovations

8C Outpatient Services **- Additional Changes and Clarifications**

Psychotherapy for Crisis

- **Section 3.2.1.5** states this service is only covered when the consumer is experiencing an immediate, potential life threatening, complex crisis situation and must be experiencing one of the following symptoms:
    a. Ideation, intent and plan for harm to oneself or others or;
    b. Active psychosis possibly requiring immediate stabilizations to ensure safety of self or others
- **Section 4.2.1.3** states this service is not covered under the following circumstances
    a. if the focus of treatment does not address the symptoms of the DSM 5 diagnosis or related symptoms
    b. for routine psychotherapy not meeting medical necessity outlined in subsection 3.2.1;
    c. in emergency departments, inpatient settings or facility based crisis settings
    d. if the consumer presents with a medical, cognitive, intellectual or developmental issue that would not benefit from outpatient treatment services; and
    e. When the requirements and limitations in Section 5.0 are not followed.
- **Section 5.0** states prior authorizations not required for the psychotherapy crisis services.
- **Section 5.3** states:
    a. if Psychotherapy for Crisis is billed no other outpatient services may be billed on the same day;
    b. Only two add-on Crisis codes can be added to Psychotherapy for crisis event
    c. A provider shall not provide more than two Psychotherapy for Crisis services per consumer, per state fiscal year

Psychological Testing

- **Section 4.2.1.2:**
  Psychological testing shall NOT cover for the following:
    a. For purpose of educational testing
    b. If requested by the school or legal system, unless medical necessity exists for psychological testing.
    c. If proposed testing measures have no standardized norms or documented validity
    d. If service is not provided face to face (can use telemedicine or tele-psychiatry is guidelines are met)
    e. When requirements and limitation in section 5.0 are not followed

- **Section 5.3:**
    a. Psychological testing is not allowed on the same day as a diagnostic assessment by the same provider
- **Section 7.5:**
    a. Prior approval is required for all hourly Psychological Testing code requests of over eight hours even if the consumer has available unmanaged visits
    b. Event based psychological testing CPT codes do not require prior authorization if unmanaged visits are available
    c. The appropriate CPT codes shall be utilized. Hours billing the CPT code may include time spent performing the clinical interview, performing the testing , scoring the testing, interpreting the result so testing, reasonable review of patient records, and preparing a written report.
    d. Billing for psychological testing must only occur on a date(s) the consumer is seen face to face and can involve activities in item c above. Each CPT code equals one unit even though the testing CPT code may involve multiple hours of testing. Thus, five hours of psychological tearing using a single code would count as one unit toward the consumers' unmanaged visits.

Service orders

- **Section 5.2.2.1 and 5.2.2.2**
    a. A written service order is required by a MD, PhD, NP or PA for **Associate Level Professionals** (LPA, LCSW,LPC, LMAFT, LCAS, etc.) prior to on the first day of treatment
    b. Services provided by a **fully licensed professional** (LCSW, LPA, LPC, LMFT, LCAS) do not require a separate service order

Electronic Person Centered Plans

UM is aware that many providers are choosing to use electronic Person Centered Plan software to create and update their PCPs. It is important that these electronic versions retain the original formatting and content of the state-approved PCP form. All required PCP and Comprehensive Crisis Plan elements must be present and complete in order for the PCP to be valid.

Electronic Signatures

Per Chapter 9-5 of the *NC Records Management and Documentation Manual:*

If an electronic signature is used, the following standards shall be followed:

1. When an electronic signature is used, the provider shall be given an opportunity to review the entry for completeness and accuracy prior to electronically signing the entry.
2. Once an entry has been signed electronically, the computer system shall prevent the entry from being deleted or altered.

3. If errors are later found in the entry, or if information must be added, this shall be done by means of an addendum to the original entry. The addendum shall also be dated and signed electronically.
4. Passwords or other personal identifiers shall be controlled to ensure that only the authorized individual can apply a specific electronic signature. Passwords should be changed at specified intervals.
5. Any staff authorized to use electronic signatures shall be required to sign a statement that acknowledges their responsibility and accountability for the use of their electronic signature. The statement should explicitly state that the provider is the only one who has access to and use of this specific signature code/password.
6. An electronic signature shall be under the sole control of the person using it. A provider shall not delegate their electronic signature authorization to another person.
7. Policies and procedures shall be developed to:
    a. Safeguard against unauthorized use of electronic signatures. The policy shall also address sanctions for improper or unauthorized use of electronic signatures.
    b. Address procedures that staff should follow if the application is unavailable.
    c. Close deficiencies created when a staff member is not available to electronically sign documents.
8. A list of staff who are authorized to use electronic signatures shall be maintained.
9. The governing body shall authorize the use of the electronic signature.

Authenticated/Dated Signatures

Per Chapter 9-6 of the *NC Records Management and Documentation Manual:*

> There are some instances where a person's signature is critical to the authenticity of a document, whether it is the signature of the service provider, the individual, the legally responsible person, or other individual. In situations when a dated signature is required, as in the case of service orders and Person Centered Plans, etc., the signature is authenticated when the responsible person enters the date next to his or her signature.
>
> A handwritten signature requires a handwritten date, and an electronic signature may have a typed date. In either case, entering the date at the time that the signature is written confirms that the signature was made on that date. The date entered should be the date that the responsible person signs the document. The practice of pre- or post-dating signatures in any form or circumstance is prohibited.

Attention IDD Providers

Partners has made the determination that if a Revision is requested for services other than Respite, the current authorization will end and a new authorization will begin. UM will no longer update current authorizations.

- **Innovations Providers:** If you have concerns that ending an authorization will not reflect all units utilized during that period, please communicate your concerns with the Care Coordinator and Treatment Team. Authorizations will be ended and units pro-rated based on the request that is submitted to UM.
- **Prior Authorization:** *All requests require Prior Authorization.* UM does not review requests that are requested to begin prior to the submission date (i.e., Retro Authorizations). These will be returned as "Unable to Process".
- **Innovations Day Supports Providers:** According to Clinical Coverage Policy 8P: "Transportation to and from the home of the beneficiary is built into the rate for Day Supports. Time once the beneficiary reaches the licensed day program can be billed to Day Supports. Transportation to and from the licensed day program is the responsibility of the Day Supports provider. If the beneficiary leaves the facility to participate in community programming, the Day Supports authorization includes the time the beneficiary is transported to and from community activities."

Top Five Claim Denials for September 2015

The following table highlights the top five reasons for claim denials in September 2015.

MEDICAID TOP 5 CLAIM DENIALS September 2015	PROVIDER RECOMMENDED ACTION STEPS
Claim received after billing period	Write off charges as non-billable. Do not rebill.
Another concurrent service has been approved or waiting to be processed	Confirm the service previously sent is correct. If not, send a reversal or replacement claim.
No coverage available for Patient/Service/Provider combo	Go to Patient Search. Check the Insurance tile to ensure the patient has effective insurance covering the DOS submitted on the claim. If this appears to be correct then contact Partners for further assistance.
No contract exists or rate is not set up yet	Refer to your contract and call your Provider Network Specialist if you have any questions.
Patient not enrolled on the date of service	Verify that all patient information is correct on claim. Check the existence of a patient insurance.

Provider Reminders

November Provider Forum: The next Provider Forum is scheduled for November 10, 2015. This forum is for all providers. Please RSVP for the location in which you will attend:

- Partners-Elkin, 200 Elkin Business Park Dr., Elkin, NC
- Partners-Gastonia, 901 S. New Hope Rd., Gastonia, NC
- Partners-Hickory, 1985 Tate Blvd. SE (First Plaza), Hickory, NC

Handouts from previous forums are located at www.partnersbhm.org on the Provider Forums page.

Provider Orientation Toolkit and Provider Manual Revisions: Providers new to the Partners' Network need to make sure and review the Provider Orientation Toolkit located on the Provider Enrollment and Credentialing webpage. In addition, the Provider Operations Manual is available on the "For Providers" page.

Find a Provider Website Search Tool: Partners frequently updates the information in its "Find a Provider" website search tool. Providers are asked to review the information for your organization and submit any corrections or changes to your Provider Specialist. Provider Specialists Assignment lists are located on the For Providers/Provider Network Management Page at www.partnersbhm.org.

Provider Alerts: Provider Alerts are emailed to all providers subscribed through Constant Contact for "Information for Providers" and "All Partners Communications," and are posted on the main "For Providers" page at www.partnersbhm.org.
Provider Alerts issued since the last Bulletin:

- Oct. 23,2015--Clarification of Inpatient Hospital Notice
- Oct. 12, 2015--Home and Community Based Supports, Taxonomy Training, NCDMHDDSAS Grant
- Oct. 2, 2015--Taxonomy Training Available

Looking for a Provider Alert? Check out the Provider Alert Archive.

State News

NC Division of Medical Assistance Launches New Website

The NC **Division of Medical Assistance (DMA) launched a new website on Tuesday, Oct. 27.** The website is organized and designed for easier access to the information to make it easier to serve Medicaid beneficiaries. Some of the new features are:

- **Document Library.** The new document library will be a convenient place to go for documents such as clinical coverage policies, fee schedules and manuals. By using "search" and selecting a type of document from a drop-down menu, you'll see a list of documents that apply to you.
- **Get Started**. Beneficiaries will start off with five straightforward steps to help them determine if Medicaid is right for them – without having to read through complex webpages. For example,

Step 3 lists possible personal situations, such as having a disability, that list a quick description of available programs. There is even a "Fast Start: Apply Now" button on each page that takes an applicant directly to ePass.

- **Get Involved.** This is a one-stop place to view public notices, comment on proposed policy changes or report fraud. It also includes contact information for committees and work groups. As we continue to engage the public, especially with Medicaid reform, future additions could include a public event calendar.
- **Find a Doctor.** The dental, PCP and specialist provider lists now include an interactive map as an option. These lists will be updated on a regular basis.
- **ADA Compliant.** The site design is more supportive of accessibility and the Americans with Disabilities Act, and also reflects the new North Carolina state government branding.
- **RSS feeds.** You can elect to be automatically notified when a file is posted to the document library.
- **Accessible.** The website is more easily viewed on mobile devices and tablets.

Please note that the new website does not replace NCTracks, which will continue to be your source to file claims.

The DMA website is part of the N.C. Digital Commons Project, a multi-year effort to redesign all state department websites to be easier for our customers to navigate and provide a consistent look.

One of the best features of a website is its ability to be constantly improved. Your input is invaluable to help DHHS in its ongoing efforts to improve customer service. Please share comments and suggestions using the link at the bottom of each webpage.

LME-MCO Joint Communication Bulletins

All LME-MCO Joint Communication Bulletins can be found at https://www.ncdhhs.gov/divisions/mhddsas/communication-bulletins. (Partners does not post the LME-MCO Joint Bulletins on its website.)

Bulletins issued since the last Provider Bulletin:

- October 2, 2015 - #J163 - SFY 2016 LME-MCO Community Behavioral Health Service Needs, Providers and Gaps Analysis Requirements
- October 9, 2015 - #J164 - Implementation Date for New Due Process Letters
- October 13, 2015 - #J165 - Out of Network Provider Contract Requirements
- October 26, 2015 - #J166 -Taxonomies
- October 29, 2015 - #J167-Tenancy Support Service Definition and TCL Benefit Plan
- October 30, 2015 - #J168 - Individual Placement and Support-Supported Employment (IPS-SE) Funding Streams and Targeted Populations

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

There are several enhancements to NCTracks that were implemented on November 1, 2015. All of the updates are posted to the NCTracks Provider Portal. Providers are encouraged to read this information to understand the changes and how they affect provider enrollment, prior approval, and claim processing in NCTracks.

New Information Required on Provider Record for Agents, Managing Employees, and Owners

IntelliCorp Records, Inc. serves as the state approved vendor for the criminal background searches performed during NCTracks provider enrollment, verification and credentialing activities. IntelliCorp has informed CSC of changes required to perform any future background checks on individuals named in the NCTracks provider records.

Beginning November 1, 2015, modifications will be made to the NCTracks provider application process to ensure the physical address, email address, and phone number is included for each Agent, Managing Employee, and Owner. Note: NCTracks currently captures the physical address of Owners that are listed on the application; this modification will require the email address and phone numbers of Owners as well.

How will this information be added? Providers can add this information by completing a full Manage Change Request (MCR) at anytime.

Note: If you submit a Manage Change Request for any reason you will be required to complete this information if it is missing from your provider record.

Those providers that are required to complete Re-credentialing will be prompted to complete a Manage Change Request (MCR) prior to completing the Re-credentialing application if the information is missing from your provider record.

Note: For more information on Re-credentialing, refer to the October 28 announcement and the new Provider Re-credentialing/Re-verification webpage on the NCTracks Provider Portal.

All new provider enrollments or re-enrollments that list an Owner, Agent, or Managing Employee will be required to provide this information.

NCTracks provider enrollment, verification and credentialing activities cannot be completed without a background check on Owners, Agents, and Managing Employees.

New NCHC Claim Edit for Non-Covered Diagnosis Codes

Beginning November 1, 2015, claims for N.C. Health Choice (NCHC), also known as SCHIP, billed with non-covered diagnosis codes (ICD-9 or ICD-10), will deny as result of a new edit. Edit/EOB 01814 - CLAIM DENIED FOR NON COVERED DIAGNOSIS FOR NCHC RECIPIENT will affect NCHC original and adjustment claims when any non-covered diagnosis code is billed. When a claim is billed with a combination of covered and non-covered diagnosis codes, it will deny regardless of the diagnosis pointers at the detail line.

Changes to Ongoing Payment of QMB Crossover and Secondary Claims on Nov. 1

As noted in the July 15, 2015, announcement, the N.C. Division of Medical Assistance (DMA) conducted a comprehensive review of changes made to its processing of Medicare crossover and secondary claims for services rendered to Qualified Medicare Beneficiaries (QMBs). It was determined that the changes implemented on March 1, 2015, were not aligned with the federal Centers for Medicare and Medicaid Services' (CMS) evolving guidance to state Medicaid plans.

This change is applicable to beneficiaries with the following Category of Eligibility codes: MQBQN, MAAQN, MAAQY, MABQN, MABQY, MADQN, MADQY, SAAQN, SAAQY, SADQN, and SADQY.

To align the processing of Medicare crossover and secondary claims for services rendered to QMB recipients with CMS guidance, DMA has been taking a series of steps. The next step in this process is to implement the ongoing payment methodology for QMB crossover and secondary claims.

"Lesser of" Logic

Beginning November 1, 2015, the "lesser of" logic will be applied to services covered by both Medicare and Medicaid that are rendered to QMB recipients. Specifically, payment for Medicare-covered services that are also covered in the Medicaid state plan will be paid at the lesser of the Medicare cost-share (which is the sum of co-insurance, deductible and co-pay) or the difference between the amount paid by Medicare and the Medicaid state plan rate (if any). Refer to the Medicare Crossover Update dated October 7, 2013, for additional information.

For services not covered under the North Carolina Medicaid plan, DMA will pay the Medicare cost share amount.

This applies to crossovers as well as secondary filed claims (Part C) for Q class recipients. This methodology results in the provider receiving the Medicare or Medicaid allowable and the QMB recipient not being responsible for any additional monies for services covered by Medicaid and/or Medicare.

The final step to be taken in this process is to address the previously paid QMB crossover and secondary claims for services not covered under the North Carolina Medicaid plan, where the provider should have received the Medicare cost share amount. The date for reprocessing of these claims has not yet been determined. More information will be posted as soon as it is available.

Crossover Claims To Deny If Medicare Denies

Beginning November 1, 2015, if Medicare has denied a line on a crossover claim, NCTracks will also deny the line with Edit/EOB 01760 - MISSING MEDICARE LINE OTHER PAYER INFORMATION.

If the claim was denied by Medicare due to billing issues, the provider should submit a corrected claim to Medicare. Otherwise, refer to the User Guide "How to Indicate Other Payer Details on a Claim in NCTracks and Batch Submissions" on the Provider User Guides and Training page of the Provider Portal for information on the process for billing secondary claims to NCTracks.