Serving individuals with Mental Health, Intellectual/Developmental Disabilities and Substance Use Disorders in Burke, Catawba, Cleveland, Gaston, Iredell, Lincoln, Rutherford, Surry and Yadkin County.

Revised July 2020 • Effective July 1, 2020
WELCOME TO PARTNERS BEHAVIORAL HEALTH MANAGEMENT!

This *Partners Behavioral Health Management Provider Operations Manual* is available on the Partners’ Provider Knowledge Base website at [http://providers.partnersbhm.org](http://providers.partnersbhm.org). Providers may request a printed copy by contacting their assigned Provider Account Specialist.

It is the responsibility of contracted providers to be familiar with and adhere to the policies and procedures outlined in this manual. Additionally, Partners shares new information and procedural changes to providers on an ongoing basis so that providers are up-to-date and understand revised expectations as they happen. This information is distributed through the *Provider Communication Bulletins* monthly and *Provider Alerts* as-needed. Changes are incorporated and published in revised editions of this *Provider Operations Manual* periodically. It is important to refer to Provider *Communications Bulletins* and periodic updates on the Provider Knowledge Base for the most current information. The *Provider Orientation Toolkit* is also available and provides links to forms, manuals, and documents that will assist Providers in becoming acquainted and conducting business with Partners.

PLEASE NOTE:

The (toll-free) Access to Care line, 1-888-235-HOPE (4673), is intended for members and issues involving member care.
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This manual is a binding part of the agreement or contract between Partners Behavioral Health Management (Partners), the Local Management Entity-Managed Care Organization (LME-MCO), and providers of Medicaid, state-funded, and county-funded services. The intent of this manual is to reference detailed information and where possible, require the same statewide procedures as part of the agreement between the LME/MCO and the provider.

**WHO WE ARE**

Partners was formed on July 1, 2012 as a merger between Crossroads Behavioral Healthcare, Mental Health Partners, and Pathways LME. Partners manages publicly funded behavioral health services for nine counties in the central and western sections of North Carolina.

Partners administers local, state, and federal (Medicaid) services and funds for mental health, intellectual/developmental disabilities and substance use services in Burke, Catawba, Cleveland, Gaston, Iredell, Lincoln, Rutherford, Surry and Yadkin counties. Likewise, Partners began to manage the Medicaid funded services for the same populations and communities effective February 1, 2013. The corporate office of the organization is located at 901 South New Hope Road in Gastonia, North Carolina. Regional offices are located in Elkin and Hickory.

Business hours are 8:00 a.m. to 5:00 p.m., Monday through Friday. Partners recognizes the following holidays and all locations are closed accordingly:

- New Year’s Day
- Good Friday
- Independence Day
- Veteran’s Day
- The day after Thanksgiving
- Christmas Day
- Martin Luther King Jr. Day
- Memorial Day
- Labor Day
- Thanksgiving
- The day before Christmas
- The day after Christmas

*Partners Behavioral Health Management’s mission is to manage a behavioral health care system funded by federal, state and local taxpayer dollars. We ensure all individuals who are eligible for our programs have access to quality providers and effective services.*

*We improve lives and strengthen our communities by focusing on positive outcomes and the proper use of funds entrusted to us.*
**GOALS AND EXPECTATIONS FOR OUR PROVIDER NETWORK**

Partners’ goal for its Provider Network is to have a comprehensive array of providers who are:

- Accessible to the local citizens who need their assistance.
- Focused in providing high quality, results-oriented care to those in need.
- Dedicated to achieving measurable and desired outcomes for members.

Partners expects its Provider Network participants to be categorically accountable to:

- Comply with all regulatory rules and standards.
- Fully comply with terms and conditions of the contract with Partners and all related information contained in this manual.
  Serve members in a way that is member-led and results in the achievement of the treatment goals desired by those being served.

**CONFIDENTIAL SCREENING AND SELF-HELP TOOLS FOR MEMBERS**

Partners wants members to have the best overall health they can have. To assist our providers in delivering this care, we have confidential screening and self-help tools on our website. These tools can help a member identify how they are feeling and serve as a starting point for a conversation with their provider. Screening tools are intended to be for informational purposes and do not take the place of a diagnosis by a professional. The screening tools can be accessed on the [Partners’ website](https://partnersbhm.org/confidential-screenings) by clicking *Confidential Screenings* under the Member tab on the home page. Providers may contact the Member Engagement Department for any technical assistance at 704-884-2666.

Other self-help tools for Members [https://www.partnersbhm.org/member-education/](https://www.partnersbhm.org/member-education/) include:

- **Member Handbook**
- **Available Services Guide**
- **Provider Search Tool**
- **Member Portal** [https://www.partnersbhm.org/#login/](https://www.partnersbhm.org/#login/) Encourage members to register for Partners’ Member Portal, a secure website that helps them stay connected to your agency and with Partners.

  - Members can access it from any computer or mobile phone to:
    - Find resources
    - Upload documents
    - View their plan
    - Take a health screening
- Private message their health team
- Learn about events in your community
- Stay connected to information and updates

Pyx Health App: Please encourage members to register for the Pyx Health phone app to monitor their health and mental health between services. They can download the app to their mobile device from Google Play or the Apple Store. Through interacting with Pyxir, the chatbot, they can access resources and helpful tips to live a healthier life. The Pyx Health app focuses on daily mood and wellness check ins, screenings, messages and assistance as needed either through the app or by calling the Care Call Center. A “geofencing” component alerts Partners when the user is close to a crisis facility. For assistance with the app, members can call 1-855-499-4777.

**WHAT IS THE NC MENTAL HEALTH, INTELLECTUAL/DEVELOPMENTAL DISABILITIES, SUBSTANCE ABUSE SERVICES HEALTH PLAN?**

The NC Mental Health, Intellectual/Developmental Disabilities, Substance Abuse Services Health Plan is a pre-paid inpatient health plan (PIHP) funded by Medicaid. All Medicaid mental health, intellectual and developmental disabilities, and substance use disorder (MH/IDD/SUD) services are authorized by and provided through the Partners’ Provider Network in accordance with the risk-based contract between the NC Division of Health Benefits and Partners. As a prepaid inpatient health plan, Partners is at financial risk for a specific set of MH/DD/SUD services, including both NC Medicaid State Plan services and services included in the NC Innovations Waiver.

The NC MH/DD/SAS Health Plan is a combination of two types of waivers authorized by the federal Social Security Act, the federal legislation creating and governing the Medicaid program. They are identified by the specific sections of Social Security Act - 1915(b) and 1915(c).

The 1915(b) Waiver, commonly referred to as a “Freedom of Choice Waiver,” allows states to waive the provisions of the Medicaid program that require “any willing and qualified Provider,” statewide requirements (meaning Medicaid must operate the same way in every part of the state), and certain fiscal requirements regarding rate-setting and payment methodologies.

The 1915(c) Waiver, generally known as a “Home and Community Based Waiver,” allows the state to offer home and community-based services not normally covered by the state’s Medicaid program if they can be proven to be no more expensive than an institutional level of care covered by Medicaid.
Both waivers are approved under different federal Medicaid regulations and require different reporting and oversight. This type of waiver system is not intended to limit care but to create an opportunity to work closely with members and Providers on better coordination and management of services, resulting in better outcomes for members and more efficient use of resources.

**Opportunities Afforded by the 1915(b)/(c) Medicaid Waiver System**

- **Coordination** ≈ The waiver allows Partners to better coordinate a system of care for members, families and providers.
- **Efficient management of limited public resources** ≈ Partners can manage all system resources so money can be directed to services most appropriate for identified member needs.
- **Flexibility in services offered** ≈ Partners can develop a more complete range of services and supports in the community, including new services, to reduce and redirect reliance on high cost institutional and hospital care.

**ABOUT THE NC MH/DD/SAS HEALTH PLAN**

The waivers apply to individuals whose Medicaid originates from one of the counties in Partners’ service area. All Medicaid enrollees in specified eligibility groups are eligible and automatically enrolled into this plan for their mental health, intellectual/developmental disability and substance use service needs.

Available services include all current NC Medicaid Plan services for mental health, intellectual/developmental disabilities and substance use services, including inpatient hospitalization, outpatient therapy, Enhanced Services, residential services, crisis services, Psychiatric Residential Treatment Facilities (PRTF) and Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF-IID) and Division of State Operated Healthcare Facilities (DSOHF.)

Members can choose from any provider in the Partners’ Network that is contracted with Partners to deliver the service he or she needs. If a member needs emergency services, he or she has the right to any hospital or other setting for emergency care, with no prior authorization required.
ABOUT THE NC INNOVATIONS WAIVER

The NC Innovations Waiver is a 1915(c) Home and Community Based Waiver. Under this waiver, individuals who would otherwise meet the criteria for services in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID) setting may receive services in his or her home and community, if the aggregate cost of those services does not exceed the cost of ICF-IID care.

This waiver incorporates the essential elements of self-direction, Person-Centered Planning, individual budgets, member protections and quality assurance. The waiver supports the development of a stronger continuum of services enabling members to move to more integrated settings. The members served, and their families, have the information and opportunity to make informed decisions about their health care and services, and exercise more control over the decisions they make regarding services and supports.

The NC Innovations Waiver has a Provider-Directed and Individual/Family-Directed track. In the Provider-Directed track, the services are delivered in a traditional manner with staff in the employment of an agency. Members and their families may participate in the Individual/Family-Directed services Agency with Choice model.

(b)(3) SERVICES

Section 1915(b)(3) of the Medicaid Waiver enables states to provide health-related services in addition to those in the approved NC Medicaid Plan to beneficiaries participating in the 1915(b) waiver.

The cost for these services come from savings measured against the cost of State Plan services before the inception of the waiver.

(b)(3) services are approved by the Centers for Medicare and Medicaid Services (CMS) and meet all applicable CMS requirements. (b)(3) Services:

- are cost-effective, supplemental services and supports;
- are aimed at decreasing hospitalization and helping members remain in their homes and communities (when preferred and appropriate);
- cannot be used for people who do not have Medicaid; and
- include mental health, intellectual and developmental disability, and substance use services.

Providers may contact their assigned Provider Account Specialist to address questions. A listing of Account Specialists is available on Partners’ website.
Partners is a Public Authority established by Mutual Agreement between Crossroads Behavioral Healthcare, Mental Health Partners, and Pathways LME under North Carolina General Statute 122-35.20. Originally formed as a merger, Partners was formed on July 1, 2012. The agency is governed by a 21-person board. The Partners’ Board of Directors is a policy-making body, which focuses on establishing and monitoring goals as well as the development of public policy. The Chief Executive Officer (CEO) reports to the Board and all other Partners’ staff report to the CEO.
**MEMBER RIGHTS & EMPOWERMENT**

**MEMBER ENGAGEMENT**

Partners’ Member Engagement team supports member empowerment through advocacy, education, and navigation of North Carolina’s public behavioral health and I/DD health care system.

The Member Engagement staff are dedicated to building strong partnerships with our internal departments, providers, the North Carolina Department of Health and Human Services (NC DHHS), external stakeholder groups and disability-specific advocacy groups to better serve our members with resource needs and continuity of care.

We would like to partner with you to help our members make the most of available services, supports, and resources. Encourage each member to register for our Partners’ Member Portal accessed on the front page of [www.partnersbhm.org](http://www.partnersbhm.org) and to also visit our Member Education page for support and training information for members and families at [https://www.partnersbhm.org/member-education/](https://www.partnersbhm.org/member-education/).

You may contact the department at memberquestions@partnersbhm.org or by calling **704-884-2666**.

**Northern Region** (Surry, Yadkin, Iredell) 336-527-3225  
**Central Region** (Rutherford, Catawba, Burke) 828-323-8047  
**Southern Region** (Gaston, Lincoln, Cleveland) 704-772-4271

**RIGHTS OF MEMBERS**

**Member/Enrollee Handbook**

The protection and promotion of individual rights is a crucial component of the service delivery system. All members are assured rights by law. We expect providers to respect these rights always and provide members continual education regarding their rights, as well as support them in exercising their rights to the fullest extent.

Members receive a Welcome Letter from Partners after their first appointment is scheduled. The letter
provides members with a phone number to call to request a Member/Enrollee Handbook. Additional copies are available by calling (toll-free) 1-888-325-HOPE (4673) or by using the TTY system at (toll-free) 1-800-749-6099. In addition, copies may be viewed, printed or saved from Partners’ website. Upon admission and annually thereafter, Partners notifies each member of the availability of the Partners’ Member Handbook containing information to help them access services for mental health, intellectual/developmental disabilities and substance use.

The handbook includes information and instructions for members regarding:

- Where to call when they need assistance.
- A list of rights and responsibilities.
- How to obtain services.
- How to make a complaint or grievance.
- How to contact Partners.

### Member Rights and Responsibilities

The following is the message Partners publishes to members about their rights and responsibilities:

North Carolina General Statutes and Administrative Code outlines rules and regulations about Consumer (or Member) Rights and Responsibilities. People receiving services are free to exercise their rights. Partners expects all providers to let you know of your rights and help you understand them. The Rights and Responsibilities below outline exactly what you can expect from your health care experience and how you can improve that experience, too.

#### RIGHTS

You, as a member of Partners’ Health Plan, have the right to:
- Get information about Partners’ structure and operations, services, providers and practitioners.
- Have member rights and responsibilities presented in a way you can understand.
- Have information presented in a culturally and linguistically appropriate way, including the right to receive oral interpreter services at no cost.
- Be treated with respect and recognition of dignity and right to privacy by Partners staff, network providers, and others who are part of your health team.
- Express freedom of speech and freedom of religious expression.
- Connect to providers in our network to get the services you need.
• Get treatment in the most natural, age-appropriate, and independent setting as possible.
• Get information about changes in benefits, services or providers. Partners will notify members in writing of any important changes to programs or services.
• Get information on available treatment options in a way you can understand.
• Make suggestions about Partners’ member rights and responsibilities policy.
• Make suggestions to us about our policies and services by calling the 24-hour, toll-free Access to Care Line at 1-888-235-HOPE (4673) (for deaf or hard of hearing, TTY: 1-800-749-6099) and asking to speak to a Member Engagement Specialist. If you would prefer to email your suggestions, they can be sent to the Member Engagement department at memberquestions@partnersbhm.org or by completing our feedback form online at https://www.partnersbhm.org/feedback/. If you prefer to contact someone other than Partners, you may contact the NC Department of Health and Human Services (NC DHHS) Customer Service Center at 1-800-662-7030.
• Participate with providers and practitioners in making decisions about healthcare, including the right to refuse treatment.
• Prepare Advance Directives. These are instructions for your care if, in the future, you are unable to make decisions about your care.
• Ask questions when you do not understand your care or what you are expected to do.
• Have an open discussion with service providers or practitioners on appropriate or medically necessary treatment options for your conditions, regardless of cost or what your benefits cover. You may need to decide among related treatment options, risks, benefits and consequences, including your right to refuse treatment and to express your preferences about future treatment decisions regardless of limits of what your benefits cover.
• Voice concerns or complaints about us or the care you receive. You may voice your concerns in a confidential and secure way by filing a grievance by:
  o Telephone—1-888-235-HOPE (4673)
  o Mail – Partners Behavioral Health Management, c/o Grievances, 901 South New Hope Road, Gastonia, NC 28054
  o Email – Grievances@partnersbhm.org
  o Online – Use our feedback form https://www.partnersbhm.org/feedback/
  o Or in person – Every employee at Partners can take your grievance
• Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.
• Receive a second opinion from a qualified behavioral health professional within the Partners network, or one that is out of network at no cost to the member.
• Request and receive a copy of your medical records and request a change to it.
• Disagree with what is written in your medical records. If you disagree, you have the right to write a statement to be placed in your file. However, the original notes will also stay in the record until the time for retention ends according to the MH/DD/SAS retention schedule. (11 years for adults; 12 years after a minor reaches the age of 18; 15 years for DUI records)
• You have the right to appeal if you disagree with our decision to deny, reduce, suspend, or terminate a service. An appeal is a request for review. Your provider and care coordinator can help you file a request using the Reconsideration Request Form https://www.partnersbhm.org/wp-content/uploads/2017/10/ReconsiderationRequestFormAppeals.pdf.
• Have a state-level Fair Hearing.
• Take part in creating a written, person-centered treatment plan that builds on your needs, strengths and choices. A treatment plan must be put into action within 30 days after services start.
• Participate in the creation of an Individual Support Plan (ISP) to request services specific to people with I/DD or a Person-Centered Plan for other services.
• Help create and update your treatment plan or ISP and consent to treatment goals in that plan.
• If you live in an Adult Care Home, you have the right to report any suspected violation of your rights to the North Carolina Division of Health Service Regulation, who oversees licensed facilities in our state. You may contact them by phone at 1-800-624-3004 or 1-919-855-4500.

Rights of Minors

Under NC state law, minors have the right to treatment for the following conditions without the consent of a parent or guardian:
• Venereal diseases.
• Pregnancy.
• Use of controlled substances or alcohol.
• Emotional disturbances.

Do I have additional rights if I have an intellectual or developmental disability?

Information about rights for individuals living with an intellectual or developmental disability is found in the Mental Health, Developmental Disabilities, and Substance Abuse Act of 1985. (1985, c. 589, s.2; 1989, c. 625, ss. 1, 2.), available on the internet at http://www.ncga.state.nc.us/EnactedLegislation/Statutes/HTML/ByChapter/Chapter_122C.htm.

What are my rights if I am in a 24-hour facility?

If you live in a 24-hour facility, you have the right to
• Receive necessary medical care if you are sick. If your insurance does not cover the cost, then you will be responsible for payment.
• Send and receive unopened mail and have access to writing material, postage, and staff assistance, if requested.
• Contact and consult with the Grievance/Member Rights Coordinator at 1-888-235-HOPE (4673).
• Contact and see a lawyer, your own doctor, and other private professionals. This will be at your own expense, not at the expense of the facility.

• Contact and consult with your parent or legal guardian at any time, if you are under 18 years of age.

• Make and receive confidential telephone calls. All long-distance calls will be at your expense, not at the expense of the facility.

• Have visitors between 8:00 a.m. and 9:00 p.m. Visiting hours must be available at least six hours each day. Two of those hours must be after 6 p.m. If you are under the age of 18, visitors cannot interfere with school or treatment.

• Communicate and meet with other individuals. These meetings and communications may be supervised if your treatment team feels it is necessary.

• Make visits outside the facility, unless your Person-Centered Plan states otherwise.

• Be outside daily and have access to facilities or equipment for physical exercise several times per week.

• Have individual storage space for your private belongings.

• Keep personal possessions and clothing, except items prohibited by law.

• Keep and spend a responsible sum of your own money.

• Participate in religious worship, if you choose.

• Retain a driver’s license, unless you are prohibited to do so by a court of law.

You also have the right and responsibility to give Partners input on policies and services. The best way to give this input is to:

• Complete Partners Needs Assessment Survey every year

• Attend Consumer and Family Advisory Committee or Human Rights Committee meetings Committee and meeting information can be found at www.PartnersBHM.org/consumer-family-advisory-committee/ or www.PartnersBHM.org/human-rights-committee/

• Attend a Partners Board Meeting. Meeting information can be found at www.PartnersBHM.org/partners-board-directors/

• Submit a formal grievance or compliment. Visit www.PartnersBHM.org/feedback and choose the submission method you prefer.

Partners looks forward to your suggestions for how we can treat you, your family, and your community better. If you have questions or would like more information, call 1-888-235-HOPE (4673).
Can my rights be restricted?

Your rights can only be restricted by your treatment team for reasons related to your care or treatment. You must be part of your own treatment team and must be involved in making the decision. You have the right to have an advocate or someone you trust involved. A Human Rights Committee must approve the plan to restrict your rights. Any restriction will be documented and kept in your medical record.

What if my rights have been violated?

If you feel that your rights have been violated, Partners wants to hear from you! Please call 1-888-235-HOPE (4673) or follow the instructions on page 21 (What if I am not happy with my services?) to file a grievance.

Exercising Your Rights: You are free to exercise all these rights. Exercising these rights will not negatively impact your access to services or the way that Partners or our network providers treat you.

RESPONSIBILITIES

In addition to your rights as a member, you can reach the best results for yourself by taking on the following responsibilities:

- Understanding your benefits and plan before receiving care.
- Always carrying your Medicaid or other insurance card with you.
- Understanding the roles of the providers and professionals who deliver your services or treatment.
- Contacting your provider when you have a concern or need help.
- Sharing the information needed for your care.
- Following the plans and instructions for care that you have agreed to with your providers.
- Using emergency room services only for injuries and illnesses that require immediate treatment.
- Understanding your health problems and taking part, as much as you can, in creating treatment goals.
- Telling the doctor or nurse about any changes in your health.
- Asking questions when you do not understand your care or what you are expected to do.
- Inviting people who will be helpful and supportive to you to be included in creating your treatment plan.
- Respecting the rights and property of other members and of provider staff.
- Respecting other members’ needs for privacy.
- Working on the goals of your person-centered plan.
- Keeping all the scheduled appointments that you can.
- Canceling an appointment at least 24 hours in advance, if you cannot keep it.
- Paying for services, if payment is included in your established agreement.
- Informing staff of any medical condition that is contagious.
- Taking medications as they are prescribed for you.
- Telling your doctor if you are having unpleasant side effects from your medications, or if your medications are not helping you feel better.
- Telling your provider if you do not agree with their suggestions.
- Telling your provider when or if you want to end treatment.
- Cooperating with those trying to care for you.
- Being considerate of other members and family members.
- Seeking additional support services in your community.
- Reading, or having read to you, written notices from Partners about changes in benefits, services, or providers.
- Requesting a discharge plan when you leave a provider; being sure you understand it and being committed to following it.
- Contacting our Access to Care Call Center 24/7 if you feel that your rights have been violated at 1-888-235-HOPE (4673). You may also email Member Engagement Department at memberquestions@partnersbhm.org. If you prefer to contact someone other than Partners, you may contact the NC DHHS Customer Service Center at 1-800-662-7030.
HUMAN RIGHTS COMMITTEE

From North Carolina General Statute 122C-64 and North Carolina Administrative Code 10A 27G.0504, all providers who provide “enhanced services” should have a Human Rights Committee that undertakes all the following:

1. Compliance with Article 3 of NC GS 122C;
2. Establish a process to discuss, review, and monitor concerns, complaints, and alleged violations of the rights of members or groups;
3. Review the use of restrictive procedures/plans prior to implementation;
4. Review failure to provide needed services that are available in the Partners service area;
5. Participate in all quality improvement measures; and
6. Produce and submit Provider’s Human Rights Committee/Client Rights Committee meeting minutes for at least two quarters and an annual report of the Provider’s Human Rights Committee/Client Rights Committee meeting minutes for review by the Partners Human Rights Committee each year. The report should be sent to the Partners’ Human Rights Officer by email at humanrightscommittee@partnersbhm.org.

As a sub-committee of the Partners’ Board of Directors, members of the Human Rights Committee are appointed by the Board of Directors.

CONSUMER AND FAMILY ADVISORY COMMITTEE (CFAC)

It is the policy of Partners Behavioral Health Management (Partners) to establish and maintain a local self-governing and self-directed Consumer and Family Advisory Committee (CFAC) to ensure effective, successful, and meaningful collaboration in the development and management of the mental health, developmental disabilities and substance use service system as outlined in NCGS 122C-170.

The Consumer and Family Advisory Committee (CFAC) is a volunteer group of individuals who have received or currently receive services, and family members of these individuals. CFAC represents our members, families, and communities by advocating on their behalf in every aspect of planning and delivering mental health, intellectual/developmental disabilities, and substance use disorder services, and advising Partners on improving its effectiveness.

Providers are encouraged to refer members or family members of members to become involved with this group. All three disability areas are represented from each of our nine counties. It is not a conflict of interest to be active in services and serve on CFAC.

For more information please call 704-884-2646 or email memberquestions@partnersbhm.org.
**INNOVATIONS STAKEHOLDERS COMMITTEE**

The purpose of the Partners Behavioral Health Management (Partners) Innovations Stakeholders Committee, is to ensure meaningful participation by members, families, providers and other community stakeholders to assist and have a voice in managing the delivery of services for intellectual/developmental disabilities and co-occurring mental health and/or substance use disorders for the populations of Burke, Catawba, Cleveland, Gaston, Iredell, Lincoln, Rutherford, Surry, and Yadkin counties. Our purpose is defined in the contract between the North Carolina Department of Health and Human Services, the Division of Health Benefits and Partners Behavioral Health Management.

Partners’ Innovations Stakeholders Committee shall on an ongoing basis, offer education and training about relevant behavioral health topics identified by Partners’ members, family members, providers, and other interested community stakeholders. Such education and training shall be available at convenient times, in accessible locations, and at no cost to attendees.

As per the contract of the North Carolina Department of Health and Human Services, Division of Health Benefits and Partners Behavioral Health Management, this committee is open to members, families, advocates, providers and stakeholders of Burke, Catawba, Cleveland, Gaston, Iredell, Lincoln, Rutherford, Surry and Yadkin counties.

Partners welcomes new members and family members to this committee. Please contact Member Engagement at 704-884-2666 or at MemberQuestions@PartnersBHM.org

**ADVANCE DIRECTIVES**

Members have the right to develop a plan for mental health treatment they prefer to receive if they experience a crisis and are unable to communicate for themselves or make voluntary decisions of their own free will. The plan may be referred to as an Advance Directive for Mental Health Treatment or a Psychiatric Advance Directive, which are interchangeable terms.

A statutory form for Advance Instruction for Mental Health Treatment is provided by NCGS §122C- 77 of the North Carolina General Statutes. The member must sign the form in the presence of two qualified witnesses and it must be acknowledged before a notary public. The witnesses may not be the attending physician, the mental health treatment provider, an employee of the physician or mental health treatment provider, the owner or employee of a health care facility in which the member is a

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For more information, go to NC Secretary of State web page.
resident, or a person related to the member or the member’s spouse. The document becomes effective upon its proper execution and remains valid unless revoked.

When presented with an Advance Directive, the physician or other provider must make the document a part of the person’s medical record. The attending physician or other mental health treatment provider must act in accordance with the statements expressed in the Advance Directive when the person is deemed to be incapable, unless compliance is not consistent with NC GS §122C-74(g), i.e., generally accepted practice standards of treatment to benefit the member, availability of the treatments or hospital requested, treatment in case of an emergency endangering life or health, or when the member is involuntarily committed to a 24-hour facility and undergoing treatment as provided by law. If the doctor is unwilling to comply with part or all the Advance Directive, he or she must notify the member and record the reason for noncompliance in the member’s medical record.

Partners offers trainings on Psychiatric Advance Directives to providers, members and community stakeholders. Please contact the Member Engagement Department at 704-884-2666 or by emailing MemberQuestions@PartnersBHM.org

CONFIDENTIALITY

Providers are charged with ensuring all persons providing services maintain the confidentiality of all members and other information received during providing services. Providers may not discuss, transmit, or narrate in any form, member information of a personal nature, medical or otherwise, except as authorized in writing by the member or his/her legally responsible person, or except as otherwise permitted by applicable federal and state confidentiality laws and regulations. This includes NC GS §122C, Article 3, which addresses confidentiality of all information acquired in attending or treating a member, and 42 CFR, Subchapter A, Part 2, which addresses confidentiality of records of drug and alcohol use service recipients.

A disclosure to next of kin can be made when a member is admitted or discharged from a facility, but only if the person has not objected.

A minor (under 18 years of age) has the right to agree to some treatments without the consent of his/her parent or guardian for:

- Use of controlled substances or alcohol
- Emotional disturbance; has behavior that presents threat to life or physical well-being.
If the member disagrees with what a physician, treating provider, clinician, or case manager has written in his/her record, the member can write a statement from his/her point of view to go in the record, but the original notes will also stay in the record in accordance with state requirements.

**Grievance & Complaint Process**

Grievances (also called complaints) are defined as “an expression of dissatisfaction about matters involving the MCO or MCO Provider Network”. Grievances are expressions of dissatisfaction about any matters other than an “action” (summarized as UM decisions to deny, reduce, suspend or terminate any requested services). Grievances or complaints can be received by anyone at Partners. Complaints may be received via telephone, mail, email, Access to Care web address, or in person. All grievances and complaints are entered into the AlphaMCS System by the staff receiving the grievance or complaint. Access to Care staff is responsible for entering complaints received from the Partners’ Access to Care toll-free number.

The Legal Department of Partners is responsible for assignment of complaints to appropriate staff/departments for resolution, tracking, monitoring, and ensuring completeness of all complaints received. All grievances are acknowledged upon receipt with an initial written or oral response made to the complainant from partners within five working days as confirmation that the process has started.

Partners works to resolve concerns as fully and quickly as possible. Grievances and complaints are resolved, along with written notification of the resolution, no later than 90 days from when Partners received it, unless additional time, up to 14 additional calendar days, is needed for special circumstances. Special circumstances include if the concern was made by or on behalf of a member and the complainant requests this additional time or if Partners demonstrates that additional information is needed, and the delay is in the best interest of the member. In most cases, Partners can resolve concerns within a much shorter time frame; however, the highest priority is to assure a thorough process with the best possible outcome and is in compliance with the various binding rules, regulations, and laws.

If the complainant is a member or acting by or on behalf of a member and would like to request an extension to the resolution of the grievance or complaint, this request* should be submitted either in person, by calling 1-877-864-1454 (option 3), or in writing to the following address:

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Partners Behavioral Health Management Provider Operations Manual
*Include the grievance/complaint reference number located at the top of the Grievance Acknowledgement letter in the request.

Any person or organization has the right and ability to bring a complaint or grievance. Partners may receive grievances from members, their family members, providers, stakeholders or concerned citizens. Based on the nature of the grievance, Partners may investigate a grievance to determine its validity, refer a grievance to external agencies for investigation, or contact the person who submitted it to resolve the grievance. Partners has a standardized appeal process for grievances. The process for requesting an appeal, and the steps of appeal review are made available to any grievant, including notification that the final grievance resolution cannot be appealed to the Office of Administrative Hearings (OAH) for a State Fair Hearing.

Additionally, all contracted network providers must have a grievance/complaint process to address any concerns of members and the member’s family related to the services provided. The provider must keep documentation on all grievances received, including dates received, the issues included in the grievances, and resolution information. Any unresolved concerns or grievances should be referred to Partners.

Upon enrollment and upon request, the grievance/complaint process must be shared with all members and families of members accordingly. Additionally, providers must inform members and families that they may contact Partners directly about any concerns or grievances.

Providers must publish and make available the toll-free Partners’ Access to Care number for members and family members, along with the telephone number for the Disability Rights of North Carolina.

### Incident Monitoring

An incident is defined as any happening which is not consistent with the routine operation of a facility or service, or the routine care of a member that is likely to lead to adverse effects to the member. Incidents are classified into three categories (Level I, Level II, and Level III) according to the severity of the incident. Providers are required as outlined in their contract with Partners to develop and maintain a system to collect documentation on any incident that occurs in relation to a member. This includes all state reporting regulations in relation to the documentation and
reporting of critical incidents. Providers must enter all Level II and Level III Incident Reports into the Incident Response and Reporting System (IRIS) and provide the verbal notification for all deaths and Level III Incidents to Quality Management staff at 1-877-864-1454 option 4 within the appropriate timeframes. Partners no longer requires the submission of Level I incident reports on a quarterly basis. However, the provider should continue to collect and report that data to their Human Rights Committee.

Additional information and instruction for the process of Incident Reporting may be found in the *Incident Response and Reporting Manual*, the *IRIS Technical Manual*, this Provider Operations Manual, the *North Carolina Innovations Technical Guide* and on the *Partners Knowledge Base*.

As part of its quality management process, it is important for the provider to implement procedures that ensure the review, investigation and follow up for each incident that occurs through its own internal Quality Management process. This includes:

- Conducting reviews of all incidents on an ongoing basis to monitor for trends and patterns;
- Implementing strategies aimed at the reduction/elimination of trends/patterns;
- Documentation of the efforts at Improvement as well as an evaluation of ongoing progress;
- Ensuring that mandatory reporting requirements are followed;
- Minutes of Peer Reviews for all deaths and Level III incidents to be uploaded on IRIS along with death certificates and any media stories related to the incident; and
- Entering Level II and Level III Incidents into IRIS.

The Consumer Rights Officer reviews all incidents when received for completeness, appropriateness of interventions, achievement of short and long term follow up both for the individual member, as well as the provider’s service system. If questions/concerns are noted when reviewing the Incident Report, the Consumer Rights Officer works with the provider to resolve them. If concerns are raised related to member’s care or services or the provider’s response to an incident, the Consumer Rights Officer or the Partners Quality of Care Committee may request that the Provider Network staff conduct a review. A Plan of Correction may be required for failure to report incidents as required by Administrative Rule and the provider contract.
**NC-TOPPS**

The NC-TOPPS interviews provide information to improve each member’s service needs and outcomes, support monitoring of services, and provide data for meeting federal performance and outcome measurement requirements. NC-TOPPS interviews are required for all Medicaid and State Benefit Plan, (formerly IPRS) adults and children ages six years and above who are receiving any qualifying service for any mental health and/or substance use issues or Supported Employment. Providers must complete an initial NC-TOPPS interview with the member in an in-person interview at the beginning of an episode of care. The initial interview should be completed during the first or second treatment visit as part of the development of the member’s treatment plan.

When a member leaves a provider, the responsibilities of the provider depends on whether the member is continuing services at a new provider, or no longer continuing in services that require NC-TOPPS submissions.

Partners’ Quality Management Department monitors NC-TOPPS completion monthly. For providers who fail to complete NC-TOPPS, training and technical assistance is provided. If non-compliance persists, the provider is referred to the Provider Network Management Committee for review and appropriate corrective action. “Intro to NC-TOPPS Super User Training” is periodically offered by Partners. All notices of changes from NC-TOPPS are forwarded via email to Provider Agency Super Users.

**HOUSING**

Housing Coordinators work to ensure members have options for safe, decent and affordable housing. Housing staff serve on, facilitate, and support community groups, boards, councils and organizations that share Partners’ goal of welcoming people with disabilities into the community.

For a link to NC-TOPPS go to: http://www.ncdhhs.gov/mhddas/providers/NCTOPPS/index.htm

If the member is continuing services at a new Provider, the Qualified Professional at the new Provider must contact the member’s LME-MCO and fax the "Authorization for Use, Disclosure and Exchange of Protected Health Information" for NC-TOPPS to 704-884-2724.

Contacts for Housing Coordinators:
- Burke, Catawba, Iredell, Yadkin, and Surry — call 828-323-8084
- Lincoln, Cleveland, Gaston, and Rutherford — call 704-884-2514
In addition, housing staff procure grants to expand community capacity for stable residential options that provide the opportunity for growth, skill building, and increased independent living. They maintain an inventory of housing resources and information on the unmet housing needs of members and families served.

Providers may seek assistance from housing staff for members who are seeking safe and affordable housing. Staff can also provide or arrange for education to providers on a variety of housing topics such as *NC Fair Housing Law* and *How to Be a Good Landlord/Tenant*.

Housing Coordinators do not:

- Provide case management
- Directly assist members with housing
- Manage rental property
- Make residential/group home placements
COMMUNITY ENGAGEMENT

Partners Behavioral Health Management has a strong commitment to community engagement. We believe in active participation, collaboration and innovative approaches to achieve individualized goals within each of our communities. Our Community Engagement department works with key community partners through a variety of outreach methods to promote awareness of the special populations we serve and address their unique needs. We believe by working together, we can collectively create the most focused, positive impact in our communities.

REGIONAL DIRECTORS

Our Regional Directors serve as the principal representative of our organization in the communities we serve. These individuals work with elected officials, county leaders and key community stakeholders to ensure we are engaged with and responsible to our communities. They serve as the primary contact for county dollar allocations. They also lead Partners efforts with local and state-wide community disaster behavioral health plans.

SYSTEM OF CARE

The System of Care team operates within the guiding principles of the system of care framework. It is a strengths-based approach for organizing and coordinating services and resources. It is not a program but an approach where members and families dealing with mental health, intellectual/developmental disabilities, and/or substance use challenges work together with public and private agencies to better meet their needs to reach their full potential. The System of Care team includes Community Engagement Specialists that are responsible for collaborating with select stakeholders in the community. They focus on educating community members about our network of treatment services, community services and natural resources to assist individuals/families with knowledge of availability and how to access services. Our specialists participate in community awareness events, collective impact projects and play an integral role in the local community collaboratives.
SYSTEM OF CARE/COMMUNITY TRAINING COORDINATORS

The System of Care/Community Training Coordinators develop, coordinate and implement staff and community-based trainings in concert with the guiding principles of the system of care philosophy and practice principles. They offer a variety of curricula and modalities to meet the needs of the treatment providers, schools, law enforcement, stakeholders and community members.

To learn more about community trainings, please check our website at http://partnersbhm.org/event-calendar/

GERIATRIC AND ADULT MENTAL HEALTH SPECIALTY TEAM

Partners’ Geriatric and Adult Mental Health Specialty Team (GAST) provides free information, education and training to people working with older adults in long-term care facilities and the community. The skills provided by the GAST help to increase caregiver understanding of mental health issues and how they relate to older adults.

The GAST trainings are accredited by the NC Division of Health Service Regulations for continuing education credits.

COMMUNITY COLLABORATIVES

Partners Behavioral Health Management has nine active Community Collaboratives within our service area. Each collaborative represents both adult and child service systems and operate within the System of Care philosophy, striving to ensure services are available, accessible, and strengths based. The Community Collaborative provides a forum for discussion related to the enhancement or development of treatment services, support services or other related need for individuals living with a behavioral health challenge. The collaboratives utilize local data to assess community needs, drive priorities and monitor progress. Each collaborative includes representatives from a multitude of local agencies, community partners, treatment providers, members, family members, and advocates. All meetings are open to the public and attendance and participation are welcome.

For Collaborative meeting dates/times, visit our website at http://www.partnersbhm.org/event-calendar/
Social Determinants of Health

“90 percent of health care spending in the United States is on medical care. While access to high-quality medical services is crucial to health, research shows that up to 80 percent of a person’s overall health is driven by other social and environmental factors and the behavior influenced by them—known as “social determinants of health” or SDOH.” (1)

Partners welcomes network providers to join us to take the next, important step recognizing that health is determined not merely by behavioral, biological and genetic factors and that many environmental and social issues significantly contribute to better health and well-being.

Nearly a quarter of North Carolina children have experienced adverse childhood experiences (ACEs), including physical, sexual or emotional abuse or household dysfunction, like living with someone struggling with a substance use disorder. Conditions such as food insecurity, housing instability, unmet transportation needs and interpersonal violence not only have a deep impact on a person’s health, safety and well-being, but also on healthcare utilization and costs.

Strategic interventions and investments in these initial core domains of food, housing, transportation and interpersonal safety, in partnership with local community groups and healthcare providers, will help to improve health, safety and well-being for all North Carolinians. It will also provide short and long-term cost savings and make our healthcare system more efficient. (2)

To discuss adding the SDOH tool to your practice, email SDOH@partnersbhm.org. Partners is prepared to provide technical assistance as need.

1. https://www.ncdhhs.gov/about/department-initiatives/healthy-opportunities/about-healthy-opportunities

The Partners information system must support both members and providers while ensuring confidentiality and privacy. This is done by maintaining secure software systems and e-mail.

**ZIXMAIL: SECURING PROTECTED HEALTH INFORMATION (PHI)**

Zixmail is a web appliance used by Partners to ensure the safety of our provider and member information. Zixmail allows Partners to send and receive encrypted data via email. This application safeguards information from would-be hackers and data thieves by scrambling the data in transmission from sender to receiver, rendering any hacked or stolen information indecipherable to anyone outside our Network.

Zixmail is important not just because it safeguards information, but it also helps to make Partners HIPAA compliant. Protected health information (PHI) must be protected and handled with the utmost care.

The IT Department works to inform and educate staff and providers about the potential risks involved in transmitting PHI and strive to treat everyone’s PHI like it is their own.

**Note:** It is important to save email received via Zixmail as an attachment as the email and information is not retrievable after 30 days. Refer to the link in this section for more information and instructions.

- To receive full instructions on setting up Zixmail web portal, visit [http://providers.partnersbhm.org/alphamcs-zixmail-sign/](http://providers.partnersbhm.org/alphamcs-zixmail-sign/)

- Staff terminations, resignations, or changes must be reported to servicedesk@partnersbhm.org so AlphaMCS login access may be inactivated. Include staff name, agency name, and effective date of request.

- Provider portal trainings may be requested on an individual basis by emailing servicedesk@partnersbhm.org.

- Information & updates related to AlphaMCS are posted routinely at [http://providers.partnersbhm.org/alphamcs-zixmail-sign/](http://providers.partnersbhm.org/alphamcs-zixmail-sign/)
**NC Tracks**

### Individual Medicaid Eligibility Verification

Providers are responsible for monitoring and verifying Medicaid eligibility for their members. This can be completed through NC Tracks. Providers’ employees who are responsible for this function need an NC Tracks unique login and password.

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### Provider Profile Information

Providers are responsible for ensuring profile information in *NCTracks* is accurate and current. Providers of Medicaid services may correct and update information in their provider profiles by completing a Manage Change Request through their website.

**Partners** is required to ensure that all provider information loaded in *AlphaMCS* matches the information loaded in *NCTracks* for the purpose of claims processing. This includes individual clinicians as well as provider agencies and hospitals. If the information in NCTracks has lapsed, expired, been terminated; or if the site/address information for an agency, a hospital, or for an individual clinician is not included in NCTracks, then we are unable to load it in AlphaMCS.

Please note that the site/address where a clinician will be providing services must be listed in the “Name/Address” section of NCTracks and not simply in the “Affiliation” section. If a clinician works at multiple sites for the same provider or at multiple locations with multiple providers, all of those site addresses must be loaded in the “Name/Address” section of NCTracks.

In situations where the information in NCTracks does not match the request Partners receives from you, then you will receive an Enrollment Status letter from Partners’ Enrollment staff. We understand that, many times, providers may have already submitted a Managed Change Request (MCR) through NCTracks to update the information with them. Unfortunately, we are unable to update the information based on the MCR until we can verify the change inside NCTracks. Once your MCR has been processed with NCTracks, you should receive a notification from them.

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For more information about getting started with NC Tracks, go to: [https://www.nctracks.nc.gov/content/public/providers/getting-started.html](https://www.nctracks.nc.gov/content/public/providers/getting-started.html).

Follow the link for more information on how to maintain provider information: [https://www.nctracks.nc.gov/content/public/providers/faq-main-page/qa-for-manage-change-requests.html](https://www.nctracks.nc.gov/content/public/providers/faq-main-page/qa-for-manage-change-requests.html).
Partners does NOT receive that notification from NCTracks, so providers should contact the enrollment group at enrollment@partnersbhm.org as soon as you are notified that the update has been completed with NCTracks. At that point, Partners will verify the information and update AlphaMCS.

Please note that some license types expire/renew on June 30 each year as a matter of routine. Those license types include LCMHC and LCSW. We will not be able to update the license for those clinicians inside of AlphaMCS until those licenses are updated inside of NCTracks. Please notify us at enrollment@partnersbhm.org as soon as the license update is complete and can be verified inside of NCTracks.

**ALPHA MCS PROVIDER SETUP**

The following details how to establish a provider within the AlphaMCS software used by Partners.

Entities that transmit or receive HIPAA compliant X12 Electronic Transactions must mail an original, completed and signed Trading Partner Agreement (TPA) to:

Partners Behavioral Health Management  
901 South New Hope Road  
Gastonia, NC  28054  
Attn: IT Department

Allow 72 hours for processing.

**Complete Electronic Data Interchange (EDI) Format Testing.**

Providers need to submit a test 837 file by uploading it to Partners secure file transfer protocol (FTP) site. Once the format testing is complete, providers are given their login credentials for a permanent FTP site inside of AlphaMCS. Instructions for completing this testing are included within the TPA document.

**Request Individual/Unique Partners AlphaMCS Logins for Staff.**

Each staff member will need his or her unique AlphaMCS Provider Portal Login and must complete online training prior to receiving the login. To obtain an AlphaMCS Login or to schedule AlphaMCS Provider Portal online training, call the Partners’ Information Technology Service Desk at 704-842-6431.

**Adding Users for Third Party Billers**

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1) Call the IT Service Desk at 704-842-6431, Monday-Friday, 8 a.m.-5 p.m. to request an AlphaMCS login.

2) A letter from the requesting contract provider agency must be mailed to the Partners HIPAA Security Officer granting permission for this user to access their individual information through Partners AlphaMCS to submit claims. A third-party login will not be issued until letter has been received and reviewed. Send letters to:

   HIPAA Security Officer  
   Partners Behavioral Health Management  
   901 South New Hope Road  
   Gastonia, NC 28054

**PARTNERS’ PROVIDER KNOWLEDGE BASE 📈**

**HTTPS://PROVIDERS.PARTNERSBHM.ORG**

Partners maintains three websites:

**Our public website**, [partnersbhm.org](https://partnersbhm.org), focuses on information for members, families, and the public. This site is where you can find information about behavioral health, available services, how to get services, and many other helpful topics and resources.

**Providers, and the public**, can find clinical guidelines, operational forms, and information concerning credentialing, utilization management, and claims at [https://providers.partnersbhm.org/](https://providers.partnersbhm.org/). This site also hosts publications such as Provider Communication Bulletins and Provider Alerts. (Please note – hyperlinks in publications and documents prior to August 2016 will no longer be active.)

**Our third website is dedicated to the great training and events coordinated by Partners Training Academy** to educate and inform those in our communities, our network of providers, and internal staff. The training website, [http://partnerstraining.com/](http://partnerstraining.com/), maintains our philosophy that the key to creating healthy communities is education and resources.

**WANT TO BE IN THE KNOW? REGISTER FOR EMAILS FROM PARTNERS!**

Providers can sign up to receive email alerts and notifications of interest to providers by [ClickingHere](https://partnersbhm.org/).

Providers signing up for email communications need to contact their company’s Information Technology department to ensure that they can receive messages via Constant Contact.
The websites are essential elements in how Partners and the provider network communicate and conduct business with each other. The Provider Knowledge Base contains a multitude of forms and documents needed to conduct business, along with operational guidance and information.

### Opportunities to Stay Up To Date with Partners

- **Provider Webinar Documents**: Partners hosts Provider Webinars quarterly. All handouts/documents from the webinars are posted to the Provider Knowledge Base site under [Provider News](#).

- **Provider Communication Bulletins**: Partners issues [Provider Communication Bulletins](#) at least monthly. The *Provider Communication Bulletin* contains operational information, notices and updates. Providers should review this document for information pertaining to conducting business with Partners. [Provider Communication Bulletins](#) are available in the Provider Knowledge Base.

- **Provider Alerts**: There are times that Partners needs to communicate time-sensitive information. Provider Alerts are used to communicate this information. They are emailed to all email subscribers that have selected to be informed of Provider Communications through our subscription system.

- **Subscribe to Partners Provider Emails**: Want to be in the know? Be sure to subscribe to Partners’ email communications. To subscribe, [click here](#).

### Check Partners out on Facebook!

The page is designed to provide general Partners and behavioral health information, guide readers to relevant events, and have a little fun to encourage redirection and reflection. Share posts with friends and family. Comments and discussions are encouraged. Please refer to the General Information section in the [Page Info](#) for the full Comment Policy/User Agreement. Visit Partners’ [Facebook page](#) often.

### How to Contact Us:

- **Call 1-877-864-1454, and select Option 4 to reach the following departments:**
  - **Provider Network** = includes Provider Account Specialists and Enrollment/Credentialing
  - **Finance, Claims and Contracts**
  - **Utilization Management** = includes Medicaid, State Benefit Plan and Hospital Inpatient Authorizations
  - **Information Technology Service Desk for AlphaMCS Technical Assistance**
PARTNERS’ RESPONSIBILITIES TO PROVIDERS

- AlphaMCS is hosted at Alpha, not at Partners. However, Partners still supports the software, as well as provider issues, and escalates those issues to AlphaMCS when appropriate.  
- Provide Service Desk technical assistance to support provider interface Monday through Friday, 8:00 a.m. to 5:00 p.m. Providers can contact the Service Desk by calling 704-842-6431.

PROVIDERS’ RESPONSIBILITIES

- Ensure and maintain high-speed internet connectivity. 
- Provide complete and accurate data in all submissions to Partners. 
- Follow technical support procedures as identified by Partners. 
- Comply with HIPAA Security Regulations. 
- Use and maintain a corporate e-mail address. 
- Notify Partners when clinical staff terminate employment – so AlphaMCS logins can be withdrawn.

PLEASE NOTE: The (toll-free) Access to Care line, 1-888-235-HOPE (4673), is intended for members and issues involving member care.
Partners is charged with effectively and expertly managing publicly funded services for those with behavioral health, intellectual and developmental disabilities, and substance use needs. It is understood our communities are best served when we enhance access to services, create a more effective array of convenient quality services, and ensure those with disabilities receive services that are integrated and coordinated with physical health services. As such, Partners conducts an annual Community Needs and Services Gap Analysis that serves as primary documentation to NC Department of Health and Human Services (DHHS) that Partners’ Provider Network is sufficient to meet the needs of the Medicaid-eligible enrollees from the nine-county catchment area.

Partners has been approved by the Center for Medicare and Medicaid Services (CMS) and the State of North Carolina to operate as a Prepaid Inpatient Health Plan (PIHP) for Medicaid beneficiaries (both adults and children/adolescents) with mental health (MH), intellectual and developmental disabilities (I/DD), or substance use disorder (SUD) diagnoses. Partners has also been contracted by the State of North Carolina to operate as a Local Management Entity/Managed Care Organization (LME/MCO) to serve similar populations covered by state revenues. Essentially, Partners must manage the specialty behavioral health services (funded by federal and state revenues) for its designated service region.

Prepaid Inpatient Health Plans (PIHPs) are required by contract (either with federal and/or state government or commercial purchasers) to serve their enrolled beneficiaries by making available multiple resources able to address a range of health care needs whenever and however they emerge. These resources are delivered through multiple providers deployed over large regions. But to do this, the PIHP must actively develop, organize and oversee a network of diverse providers.

Provider Network Department is responsible for:

1. Evaluating the probable demand for particular services - and the types of services and Providers needed;
2. Contracting with and ensuring a sufficient and appropriate number and the types of Providers;
3. Establishing with Providers the expected service performance expectations regarding safety, efficiency, effectiveness, beneficiary satisfaction, and cost;
4. Monitoring and supporting the improvement of Provider performance; and
5. Continually strengthening the ability of the Provider Network to better achieve the goals established in the PIHP contract.
**TYPES OF PROVIDERS IN THE PARTNERS NETWORK**

1. Critical Access Behavioral Healthcare Agency (CABHAs)

A Critical Access Behavioral Health Agency (CABHA) is a state designation of providers that deliver a comprehensive array of mental health and substance use services. The CABHA’s role is to ensure that critical services are delivered by a clinically competent organization with appropriate medical oversight and the ability to deliver a robust array of services. It must ensure that member care is based upon a comprehensive clinical assessment and appropriate array of services for the population served.

CABHAs maintain national accreditation and deliver three core services (i.e., comprehensive clinical assessment, medication management and outpatient therapy) and at least two additional services listed below:

- a. Intensive In-Home (IIH)*
- b. Community Support Team (CST)*
- c. Substance Abuse Intensive Outpatient Program (SAIOP)
- d. Substance Abuse Comprehensive Outpatient Treatment (SACOT)
- e. Child Residential Level II, III and IV
- f. Day Treatment*
- g. Psychosocial Rehabilitation (PSR)
- h. Assertive Community Treatment Team (ACTT)
- i. Multi-Systemic Therapy (MST)
- j. Partial Hospitalization (PH)
- k. Substance Abuse Medically Monitored Community Residential Treatment
- l. Substance Abuse Non-Medical Community Residential Treatment
- m. Outpatient Opioid Treatment

*In accordance with the North Carolina State Plan for Medical Assistance, may only be provided by a CABHA.*

2. Agencies

Agencies are providers of outpatient, enhanced benefit, specialty or other MH/IDD/SUD services that are organized as a corporation, LLC, partnership or other entity required to be enrolled and registered with the NC Secretary of State’s office.
3. Hospitals

This is a facility licensed by the North Carolina Division of Health Services Regulation as a Hospital and accredited by the Joint Commission on Accreditation of Health Care Organizations (JCAHO). Hospitals in the Partners Provider Network may provide outpatient, inpatient, and/or emergency department-based behavioral health services.

4. Specialty Providers

Specialty Providers concentrate on a specific service (such as vocational or residential) or serve a specific disability area, or both. Specialty providers fulfill an important component of the provider network as they can focus their efforts on best practices strategies for Supported Employment, Mobile Crisis and Innovations Waiver Services.

5. Licensed Independent Practitioners (LIP) and Professional Practice Groups

Among LIP and Professional Practice Groups are Medical Doctors (MD), Practicing Psychologists (PhD), Licensed Psychologist Associates (Master’s Level Psychologist [LPA]), Licensed Clinical Social Workers (LCSW), Licensed Marriage and Family Therapists (LMFT), Licensed Clinical Mental Health Counselors (LCMHC), Licensed Clinical Addiction Specialists (LCAS), Advanced Practice Psychiatric Clinical Nurse Specialists, Psychiatric Nurse Practitioners, and Licensed Physician Assistants who are participants of the Partners Provider Network and bill under their own licenses.

6. Provisionally Licensed Practitioners

These practitioners are provisionally licensed in NC and are employed by an Integrated Healthcare Hub, CABHA, agency, hospital, or group practice that is fully contracted with Partners to provide outpatient therapy.

7. Facilities

Facilities are 24-hour residential facilities that are required to be licensed under Chapter 122C of the North Carolina General Statutes, such as Psychiatric Residential Treatment Facilities (PRTFs), Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF-IIDs), Supervised Living Facilities, Residential Treatment/Rehabilitation Facilities for Individuals with Substance Use Disorders, Outpatient Opioid Treatment Facilities, .5600 Group Homes or other licensed MH/IDD/SUD facilities. A Certificate of Need or Letter of Support may be required, and facilities
must meet all applicable state licensure laws and rules, including but not limited to NCG.S. §122C-3 and Title 10A, Subchapters 27C, 27D, 27E, 27F, 27G, 26B and 26C.

PRTFs deliver non-acute inpatient care for children and adolescents who have a mental illness and/or substance use disorder and need 24-hour supervision and specialized interventions.

ICF-IIDs deliver services in a protected residential setting for persons with intellectual and/or developmental disabilities and/or a related condition.

Services may include ongoing evaluation, planning, 24-hour supervision, coordination, and integration of health or rehabilitative services to help each member function at his or her greatest ability.

8. Out of Network Providers (OON)

Some members with Medicaid that originates in one of Partners’ nine counties live in other parts of the state. Partners is committed to ensuring that providers are available to meet the needs of these members and, to that end, frequently makes arrangements for individual-specific contracts. Specific procedures are followed to determine the need for an individual-specific contract with Providers outside of Partners’ catchment area.
**LOCATION OF PROVIDERS**

Community-based services typically fall into one of two categories, urban and rural. While most services are available within these standards, some specialty Providers may be located outside the person’s county of residence. There may be only one provider of facility-based services, such as psychosocial rehabilitation (PSR) in a county due to insufficient demand to support two providers and economy of scale factors. Partners annually evaluates the location of providers and types of services in its capacity study and determines the need for additional providers. A provider mapping program is maintained which allows Partners to associate location of providers in relation to where individuals live within the catchment area.

**QUALITY OF CARE**

Partners is responsible for the quality of services provided by the Provider Network. The NC Division of MH/DD/SAS and the Division of Health Benefits charges Partners with the management of both state and Medicaid services and funds. In addition to state requirements, Medicaid waiver quality requirements are extensive and include:

- Health and safety of members
- Rights protection
- Provider qualifications
- Member satisfaction
- Management of complaints
- Incident investigation and monitoring
- Assessment of outcomes to determine efficacy of care
- Management of care for Special Healthcare Needs populations
- Preventive health initiatives
- Clinical best practices

Other committees that are external to Partners, but impact the organization’s Quality Management functions, include the Provider Council and the Global Continuous Quality Improvement Committee (GCQI) formed through the Provider Council.
GCQI is independently composed and led by providers, CFAC members, and stakeholders with Partners staff serving in a facilitative role only. The purpose of this committee is to promote improvements and processes within provider agencies which lead to greater member satisfaction with services and choice among providers who use Best Practice models of treatment throughout the catchment area. Aggregate trends of network performance will be reviewed and addressed in this committee.

**STRENGTHENING THE PROVIDER NETWORK**

**Value Based System**

Partners Value Based Contract Strategy and Plan supports a comprehensive value based payment program with providers, while ensuring the program aligns with the Department’s quality strategies. This program aligns financial incentives and accountability around total cost of care and overall health outcomes while ensuring providers are recognized and rewarded for quality gains.

- Value based programs and contracting is fundamentally a population health management tool
- Value based payment pays for value instead of volume
- Value based payment focuses on better care, better outcomes and reduced costs

The mechanics of Value Based Payment:

- Benchmarking: what is the baseline spend against which the future spend will be measured?
- Risk Adjustment: a change to the benchmark to reflect consumer characteristics (i.e., age, gender, health status)
- Attribution: how and to whom is the care and wellbeing of the consumer assigned?
- Predictive Modeling: Analyzing data to create a statistical model of expected future performance or results
- Stop Loss: an upper limit on the amount a provider can lose in a shared risk arrangement

**Population Health Management Goals**

Value based contracting is a population health management tool that provides leverage to achieve identified population health goals. Partners can leverage initial Value Based Contracts to address
gaps in the system of care to improve provider readiness for improved outcomes with the Tailored Plan.

- **Opportunity:** There are three distinct categories identified for opportunities: data infrastructure and reporting, program development or enhancements, care management

- **Specific Pilots:** The categories that Partners is focusing for pilot purposes is Care Management, reporting infrastructure and programming

- **Key Participants and Management Team:** Key participants in this process involve operational and clinical departments. The Operations Team is charged with driving the strategic plan and the provider network departments works to engage providers in the process. The Quality Management and Finance departments work to ensure that we can collect the data and pay the provider in this type of arrangement.

- **Clinical/Regulatory:** Partners is using the guidance through the Health Care Payment and Learning Action Network (HCP-LAN) as a guide to move the goals through the framework towards category 2-4 payments. ([https://hcp-lan.org](https://hcp-lan.org))

- **Return on Investment:** Partners will drive and leverage value-based payments and build on current alternative payment mechanisms, create targeted goals based on specific programs with metrics that align with the tailored plan. Target a highest value populations and conditions and design quality into the payment system.
Use of evidenced based practices provides a structured method of higher quality service provision. EBPs have outcomes data that demonstrate the effectiveness of the program, if there is adherence to the fidelity of the program. Most EBPs include training programs, ongoing consultation and fidelity measures to ensure effectiveness. Partners encourages the use of EBPs that meet four criteria.

Partners’ Criteria for Selected Evidenced Based Practices:

1. Must be registered with the National Registry of Evidenced Based Programs and Practices (NREPP), California Evidenced-Based Clearinghouse (CEBC) or Washington State Institute for Public Policy (WISPP) (can be emerging or promising practices).
2. Must include the training of non-licensed direct care staff.
3. Must include continuous quality control practices.
4. Must include outcomes measures.

In addition to models meeting the above listed criteria; Partners accepts the EBPs listed on page 114 of this manual and on the website at https://providers.partnersbhm.org/evidence-based-practices/.
**Performance Measures and Outcomes Tools**

Partners is committed to developing performance measures to include in contracts. Measures and tools used will vary based on the type of provider and service. Outcomes tools include ACORN, NC TOPPS, CQL-POM and the CDC Healthy Days Measure and the Patient Health Questionnaire (PHQ9).

Values based systems are driven by data. Data reveals strengths and weaknesses in services, providing a foundation on which a provider can improve the effectiveness and efficiency of services. Contracts will begin to include specific performance measures, evidenced based practices and outcomes tools to be used to provide quality information to Partners. This information will be used to strengthen and increase the effectiveness and efficiency of the provider network. It can also be used to provide information from which members can augment their decision making for provider choice. For example, NC-TOPPS data is collected monthly. Partners has been sending NC-TOPPS providers their individual score cards on a quarterly basis. This promotes awareness of Partners’ target goals for specific indicators. One indicator is methods (in person, telephonic) used in episode of completion.

Higher quality performance through use of evidenced based, data driven services will improve the lives and strengthen communities of our members.

**NON-DISCRIMINATION AND NO REJECT REQUIREMENTS**

In accordance with 42 CFR § 438.214, Partners does not discriminate against providers that serve high-risk populations or specialize in conditions that require costly treatment. Discrimination is prohibited by any Partners’ employee, staff member or independent contractor to the effect that no person shall, on the grounds of sex, age, race, religious affiliation, handicap, or national origin, be subjected to discrimination in the provision of any services or in employment practices. Partners’ staff may not impose their own personal beliefs on members, providers, employees and other stakeholders.

Equally, discrimination by any contracted provider (including staff, employees or independent contractors of such provider) against a member, employee or other stakeholder due to race, age, religion/spiritual beliefs, sex, national origin, political affiliation, culture, and/or language, ability, handicapping condition, sexual orientation, socioeconomic status, or other personal beliefs is strictly prohibited. Providers may not impose their own personal beliefs on members, employees and other stakeholders.

When screening members, Partners staff and contracted providers must also consider the visual, auditory, linguistic and motor limitations of the member. When members with special needs are
identified in the referral screening process, services will be tailored to meet those needs to the extent that resources are available.

Additionally, providers are required to attest that upon application to Partners’ Network that a “no-reject policy” for referrals within the capacity and the parameters of their competencies is in place. Providers also agree to accept all referrals meeting criteria for services they provide when there is available capacity.

**Cultural Competency of the Network**

The past two decades have seen unprecedented demographic shifts nationally and in North Carolina. Increased cultural and linguistic diversity have produced significant challenges for health care delivery systems. It is our responsibility to plan for, implement and deliver MH/IDD/SUD services that are culturally competent, member-focused and person-centered to an increasingly diverse community.

The fundamental precepts of cultural competence include developing respect for differences; cultivating successful approaches to diversity; increasing awareness of one’s self and of unstated institutional cultural norms and practices; and having a working knowledge of the history, culture, beliefs, values and needs of diverse people and communities. A culturally competent approach to services requires the system examine and potentially transform each component of mental health, intellectual and developmental disability and substance use services.

Partners’ Cultural Competency Plan is reviewed for ongoing development with input from the Partners Provider Council.

Partners is committed to:

- Outlining a Cultural Competence Initiative for Partners and Network Providers
- Employing strategies for recruiting, hiring and maintaining a culturally diverse workforce at all levels of staffing
- Providing technical assistance and training for Network Providers

Providers are required to develop a Cultural Competence Plan. The provider’s Cultural Competence Plan should be consistent with Partners’ most current Cultural Competence Provider Plan posted on the Partners website. The provider shall develop procedures for the implementation of systems to evaluate and/or measure adherence to their Cultural Competence Plan, ensure that all staff are trained, and have training available for review by Partners’ Quality Management Monitoring Teams.
Providers must offer language interpretation services by telephone and/or in person as needed. TDD (telecommunication devices for the deaf) must also be made available by providers for persons who have impaired hearing or a communication disorder.

**PROCUREMENT CONTRACTS & GENERAL CONDITIONS**

Network Providers are required to have a fully executed Partners contract, which lists services and approved sites prior to the authorization for and delivery of services to a Partners’ member.

The Partners contract is divided into two sections: a procurement contract and a set of general conditions. Each contract outlines the details for the provider type, including approved services Providers may deliver and bill to the members in Partners’ catchment area. Partners’ contracts may be executed on a multi-year or an annual basis.

The procurement contracts are customized to the type of provider and services provided. The general conditions describe requirements according to federal and state regulations, as well as our Medicaid (b)/(c) Waiver participation.

This Provider Operations Manual and the *North Carolina Innovations Technical Guide* are incorporated into the contract by reference.

Partners uses the standardized contract template generated by DHHS and DHB and approved by the Secretary of the Department of Health and Human Services as required by *NC GS §122C 142(a).* Division of Medical Assistance (DMA) and Division of Health Benefits (DHB) combined into one division called the NCDHHS Division of Health Benefits. For use in this manual we will reflect DHB and DMA. These contracts include the following requirements:

1. Practitioners and providers will comply with the organization’s QI activities.
2. Practitioners may freely communicate with patients about their treatment, regardless of benefit coverage limitations.

**INSURANCE REQUIREMENTS**

Providers must purchase and maintain insurance from a company, which is licensed and authorized to do business in the State of North Carolina by the North Carolina Department of Insurance. Insurance policies require that the coverage cannot be suspended, voided, canceled or reduced in coverage or limits without 30 days prior notice to the LME/MCO. Providers must list
Partners as a certificate holder for all required policies and also list Partners as additionally insured for general liability.

Providers must purchase and maintain professional liability insurance protecting itself and any employee performing work under the contract with Partners for an amount of not less than $1,000,000 per occurrence and proof of coverage at or exceeding $3,000,000 in the annual aggregate.

Comprehensive General Liability is required. Specifically, Bodily Injury and Property Damage Liability Insurance that protect the provider and any employee performing work under the contract with Partners from claims of Bodily Injury or Property Damage, which may arise from operations under the contract. The amounts of such insurance may not be less than $1,000,000 per Occurrence/$3,000,000 per Aggregate/$1,000,000 Personal and Advertising Injury/$50,000 Fire Damage.

Automobile Bodily Injury and Property Damage Liability Insurance covering all owned, non-owned, and hired automobiles for limits of not less than $1,000,000 each person and $1,000,000 each occurrence of Bodily Injury Liability and $1,000,000 each occurrence of Property Damage Liability is required.

Additionally, Workers’ Compensation and Occupational Disease Insurance is required for providers with three or more employees. The insurance coverage must meet the statutory requirements of the State of North Carolina; and Employer’s Liability Insurance for an amount of not less than: Bodily Injury by Accident $100,000 each Accident, Bodily Injury by Disease $100,000 each Employee, and Bodily Injury by Disease $500,000 Policy Limit.

**PROVIDER COMMUNICATION**

Partners is committed to keeping providers well-informed of state or federal changes, new information, trainings, requests for proposals, and opportunities for collaboration. We offer links to provider webpages through the [Provider Search](#) web tool and disseminate critical and/or time-sensitive information through the Partners’ [Communication Bulletins](#), and email alerts to providers. The NC Division of Mental Health, Developmental Disabilities and Substance Abuse also posts [NC MH/DD/SAS Communication Bulletins](#) with up to date information to their website.

![Providers can sign up to receive email alerts and notifications by clicking here.](#)
Partners has also incorporated provider representation into numerous aspects of our operations. Participation in the following committees affords providers invaluable opportunities to share their perspectives and voices as decisions and processes are determined:

- Human Rights Committee
- Credentialing Committee
- Clinical Advisory Committee
- Quality Improvement Committee
- Request for Interest/Request for Proposals Committees
- Ad Hoc Work Groups
- Regular Provider Webinars and Provider Meetings
- Online AlphaMCS technical assistance regarding enrollment, authorization requests and service billing/claims
- Training Activities

**Provider Credentialing**

Partners is required to credential and re-credential all applicants for participation in our provider network including, but not limited to Licensed Practitioners (LP) providing services through a contracted provider agency, Licensed Independent Practitioners (LIP) providing services under their own individual contract, agencies (including Integrated Care, CABHAs, group practices and licensed facilities such as Psychiatric Residential Treatment Facilities) **every three years**. It is the individual provider’s responsibility to make application for recredentialing prior to their three-year credentialing expiration date. All provider types listed above must be recredentialled every three years in order to continue to receive referrals and bill for services to Partners enrollees. Partners has obtained URAC Health Care Network Accreditation, which includes but is not limited to standards governing network management, provider credentialing, quality management and improvement, and member protection. URAC requires that all providers listed in our Provider Directory undergo credentialing. It is the policy of Partners to implement a standard credentialing process for applicants to become participants in our provider network and be listed in the Provider Directory. The process includes review of licensure, sanctions, exclusions, criminal background checks, and other relevant documents and information to determine if the applicant meets credentialing criteria based on quality of care and quality of services standards and on the needs of Partners network as determined by the annual Access and Accessibility Analysis (formerly Needs and Gap Assessment). A provider may be removed from the Provider Directory if it is determined through processes of continuous credentialing monitoring or recredentialing that the provider no longer complies with credentialing criteria, and/or recredentialing has not occurred within the time frame required.
Partners does not discriminate against any provider seeking qualification as a participating provider. Partners does not approve or deny a provider’s credentialing application on the basis of gender, sexual orientation, gender identity, age, race, religion, ethnic origin, national origin, patient type, or other such prejudicial policies. (DMA Att. B 7.7) Partners promotes anti-discriminatory practices in their credentialing process by informing committee members through its policies of the expectation to uphold anti-discriminatory decisions. Partners Quality Management (QM) department monitors for discrimination in the Credentialing and Re-credentialing process through their quarterly reviews. If any instances of discriminatory practices are discovered these are escalated to the Chief Performance and Compliance Officer for further investigation and remediation.

Partners maintains a network that provides culturally competent services. The network is composed of providers that demonstrate competencies in best practices and member outcomes, ensure health and safety for members, and demonstrate ethical and responsible practices. Partners is committed to the achievement of positive outcomes for members, as well as member satisfaction, and depends on its network to offer quality services and demonstrate accountability for the well-being of our members.

All credentialing related materials are stored and maintained in a manner designed to ensure the security, privacy and confidentiality of all materials in accordance with all applicable governing authorities and is only accessible and released to authorized personnel.

### Application Process

**A. Process for Initial Agency Credentialing or Addition of Sites/Service**

This section applies to applicants seeking to enroll as a new agency or existing network providers seeking to add a new or additional site or service to their existing contract. Potential applicants must submit a *Request for Consideration* for initial applications or *Provider Change Form* for additions to current provider credentialing. Provider Enrollment and Credentialing Forms can be found on Partners’ Provider Knowledge Base website at [https://providers.partnersbhm.org/](https://providers.partnersbhm.org/).

Partners reviews the request for network participation and a decision is made based on internal policies, procedures and criteria. A denial results in a telephone call to the requesting provider followed by a letter of notification being sent to the applicant. New applicants who are denied participation in the network may reinitiate the process by resubmitting the Request for Consideration form one year after the original Request for Consideration was submitted.

An approval of the Request for Consideration for network participation results in the initial applicant being supplied with electronic access to the appropriate credentialing application,
instructions and contact information for questions. The Provider Change Form serves as both the request and the application for in-network providers requesting to add sites/services. Once approved, no additional application is required. Applications/Provider Change Forms must be submitted with all required information/documentation and must be signed by the applicant no more than 180 days prior to the initial review of the application by the Credentialing Committee.

Within 60 days of receipt of electronic access to the application, the applicant must submit a complete credentialing application packet using the approved template(s). The components of a complete credentialing application packet are outlined in the application. If the completed application is not received within 60 days, the application is withdrawn and an email sent to the applicant. The applicant may re-initiate the process by resubmitting the Request for Consideration form one year after the original Request for Consideration was submitted.

If additional or corrected information or documentation is required after the application has been submitted, the applicant is electronically notified of the specific information that is needed to meet the definition of a complete application. The effective date of credentialing is the date the application is complete. Therefore, it is critical that providers respond with additional information required in a timely manner. If the applicant does not return all necessary information within five business days of the notification, a second electronic notification is sent. If the applicant does not return all necessary information within five business days of the second notification, the application will not be processed. No further notification will go out to the provider. In such event, the applicant may reinitiate the process by contacting the credentialing team at credentialingteam@partnersbhm.org. For initial credentialing applications and existing providers seeking to add a new/additional site to an existing contract, a site visit or verification of facility licensure is required prior to completion of credentialing. Stability of past operations is important. An assessment of the applicant’s record of services, compliance with applicable laws, standards and regulations, the qualifications and competency of its staff, the satisfaction of members and family members served, systems of oversight, adequacy of staffing infrastructure, use of best practices, and quality management systems are evaluated by Partners prior to enrollment to the extent possible and at regular intervals thereafter through Focused and Routine Monitoring.

Applicants may be asked to demonstrate how members and families are involved in treatment and services. Applicants need to have a good system of communication with members. In the event the applicant does not meet site visit criteria, the applicant has 30 calendar days in which to correct any deficiencies and undergo a final site visit. Failure to meet site visit criteria on the final visit will result in the application not being presented to Credentialing Committee and a denial letter will be sent to the applicant.

Once the application is determined to be complete Partners conducts primary source verification and background checks of all applicants. During the verification process, if Partners obtains
information that is substantially different from the information provided, the applicant is electronically notified of the specific information that is inconsistent. The applicant is given five business days to supply additional information/explanation of the inconsistencies in advance of the Credentialing Committee review. All applications along with details of any adverse findings are presented to the Credentialing Committee for a decision. Correspondence is maintained with providers to clarify and/or accept additional information, prior to review to correct incomplete, inaccurate or conflicting credentialing information. Through the instructions provided on the credentialing application and/or supplemental forms, applicants are notified of their right to review and correct information to support their credentialing application and to request the status of their credentialing application at any time. The approval of credentials is only one requirement for network membership. A credentialed provider (site/agency/facility) must be enrolled in NCTracks and must have an executed contract to be a participant in Partners’ Provider Network. **Credentialing and Enrollment are two distinct processes.** Providers must be credentialed and fully/appropriately enrolled in NCTracks in order to be enrolled with Partners or receive a contract with Partners. The **effective date of enrollment in AlphaMCS** is the date when the provider (LP, LIP or Agency) is both credentialed with Partners and fully/appropriately enrolled in NCTracks. Claims and authorization processing are directly impacted by the credentialing, enrollment and contract effective dates.

### B. Process for Initial Credentialing of Licensed Practitioners (LP) and Licensed Independent Practitioners (LIP)

All the following fully licensed or Associate Practitioners seeking to provide clinical services (including but not limited to psychiatric care, assessment and outpatient therapy) must undergo credentialing:

- a. Licensed Clinical Social Worker (LCSW)
- b. Licensed Professional Counselor (LPC) effective January 1, 2020 Licensed Clinical Mental Health Counselors (LCMHC)
- c. Licensed Marriage and Family Therapist (LMFT)
- d. Licensed Clinical Addiction Specialist (LCAS)
- e. Licensed Psychologists – (Health Service Provider-Psychologist (HSP-P))
- f. Licensed Psychological Associate (LPA) – (Health Service Provider-Psychological Associate (HSP-PA))
- g. Licensed Psychiatrist (MD, DO)
- h. Licensed Psychiatric Nurse (RN)
- i. Advanced Practice Psychiatric Clinical Nurse Specialist
- j. Psychiatric Mental Health Nurse Practitioner (PMHNP)
k. Licensed Physician Assistant (PA) providing MH/SU services under the supervision of a Licensed Psychiatrist

l. Physician with substance use specialty or psychiatric training/experience (general physicians with no substance use or psychiatric training are not eligible to apply)
   i. Nurse Practitioners (non-PMHNP) must meet requirements of Joint Communication Bulletin J253 or be granted a waiver in order to be credentialed and are not eligible to contract as Independent Licensed Professionals. Effective 10/16/2020-Partners’ Credentialing Committee will require 10 hours of the total 20 hours of continuing education be completed face to face/live. Prior to the effective date, Partners will continue to review all CEUs in the categories of psychiatric physiology, diagnosis, and psychopharmacology, regardless of how they were completed. The provider is required to attach CEU documentation ONLY in psychiatric physiology, diagnosis, and psychopharmacology. CEUs will need to be documented on how the provider participated (exp.: online, face to face, webinar). Partners recommends no more than 24 hours of training in a 24-hour period without submitting justification.

m. Physical Therapist (providing Specialized Consultative Services)

n. Occupational Therapist (providing Specialized Consultative Services)

o. Speech Therapist (providing Specialized Consultative Services)

Note: Associate/Provisionally Licensed Practitioners are eligible to enroll as practitioners associated with an organization but are not eligible to contract with the LME/MCO as a Licensed Independent Practitioner (LIP) (see DMA Clinical Coverage Policy 8C for more information).

Psychiatrists must complete an approved/accredited residency. Sub-specialty fellowship training must be documented (if taken). Board Certification is not required; however, practitioners who identify themselves as board certified must do so in accordance with the definition of board certification for that recognized specialty board (i.e., for psychiatrists – The American Board of Psychiatry and Neurology).

The applicant must meet state licensure or certification requirements and hold a valid North Carolina license or certificate as listed above, unless the applicant is seeking to provide services out of state, in which case the applicant must meet all licensure or certification requirements of the state in which he or she is seeking to provide services.

The approval of credentials is only one requirement for network participation. A credentialed practitioner must have an executed independent contract or be associated with an in-network provider agency and must be enrolled in NCTracks to be a participant in Partners’ Provider
Network. **Credentialing and enrollment are two distinct processes.** The effective date of enrollment in AlphaMCS is the date when the provider (LP, LIP or Agency) is both credentialed with Partners and fully/appropriately enrolled in NC Tracks. Claims and authorization processing are directly impacted by the enrollment and contract effective date.

Network Providers seeking to affiliate LP applicants to existing network provider contracts must complete and submit the Provider Change Form found at [https://providers.partnersbhm.org/provider-enrollment-credentialing](https://providers.partnersbhm.org/provider-enrollment-credentialing). Potential Licensed Independent Practitioner (LIP) applicants, seeking a contract, must contact Partners and submit a Request for Consideration form. Partners makes a decision about the LIP’s request in accordance with its internal policies, procedures and criteria. A denial results in a telephone call to the requesting provider followed by a letter of notification being sent to the applicant. Applicants who are denied may reinitiate the process by resubmitting the Request for Consideration form one year after the original Request for Consideration was submitted.

If the Request is approved, the LIP applicant will be sent the *Credentialing Initiation Form* (CIF) with instructions for electronic submission. The applicant has a maximum of 60 calendar days to submit a completed CIF form. This is due to the possibility of changes for standards of services, changes in service needs, or changes to the requirements of services by the state. If the complete CIF form is not received within 60 calendar days, the request for participation will be withdrawn and an email sent to the applicant. The LIP applicant may reinitiate the process by resubmitting the Request for Consideration Form one year after the original submission date of the Request for Nomination.

Once the CIF or **Provider Change Form** is available, Partners begins the process to complete a site visit as described in Section A. above for LIPs and verifies documentation of a site visit already on file for LPs. If information in the CIF or **Provider Change Form** is incomplete, inaccurate or conflicting, the applicant is electronically notified of the specific information that is missing or incorrect. If the applicant does not return all necessary information within five business days of the notification, a second electronic notification will be provided. If the applicant does not return all necessary information within five business days of the second notification, the request will not be processed. No further notifications will be sent to the provider. In such event, the LIP applicant or network provider attempting to affiliate an LP Applicant to an existing Network Provider contract may reinitiate the process by contacting the credentialing team at credentialingteam@partnersbhm.org. Correspondence is maintained with providers to clarify and/or accept additional information, prior to review to correct incomplete, inaccurate or conflicting credentialing information. Through the instructions provided on the credentialing application and/or supplemental forms, applicants are notified of their right to review and correct information to support their credentialing application and to request the status of their
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credentialing application at any time. The **effective date of credentialing** is the date the application is **complete** so it is critical that providers respond with additional information required in a timely manner.

The CIF form for LIPs and the Provider Change Form for LPs is used to initiate the process of engaging the practitioner in the Council of Affordable Quality Healthcare (CAQH) online application process. If the completed CIF form is not received within 60 calendar days, the application will be denied, and a letter sent to the applicant. The LIP Applicant may re-initiate the process by resubmitting the Request for Consideration Form. The LP Applicant employed by a network provider may re-initiate the process by resubmitting the Provider Change Form.

Partners must be able to view the completed on-line application before the credentialing process can proceed.

a. CAQH notifies practitioners already registered with CAQH of Partners’ interest in viewing their online application. If the practitioner already has a completed on-line application with CAQH, but has not granted Partners viewing privileges, CAQH notifies the practitioner of Partners’ request.

b. For those not already registered, CAQH sends an initial registration packet with CAQH log-in information. The practitioner completes the online CAQH application and adds Partners as an authorized entity.

If the CAQH application is not available within 30 calendar days from the date that the applicant was added to the CAQH roster, the application will be withdrawn from processing. Partners then will notify the applicant that the application will not be processed. The applicant will need to reinitiate the process. The **effective date of credentialing** is the date the application is determined to be **complete**. Therefore, it is critical that providers allow Partners access to the CAQH application in a timely manner.

Upon receipt of the CAQH application, if additional or corrected information or documentation is required, the applicant is electronically notified of the specific information that is needed to meet the definition of a complete application. If the applicant does not return all necessary information within five business days of the notification, a second electronic notification is sent. If the applicant does not return all necessary information within five business days of the second notification, the application will not be processed. In such event, the applicant will be required to

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Providers have the right to review and correct information to support their credentialing application. Applicants can request such a review or request the status of their credentialing application at any time during the process by contacting Partners at credentialingteam@partnersbhm.org.
reinitiate the process. The effective date of credentialing is the date the application is determined to be complete. Therefore, it is critical that providers respond with additional information required in a timely manner.

Once the application is determined to be complete Partners conducts primary source verification and background checks of all applicants. During the verification process, if Partners obtains information that is substantially different from the information provided, the applicant is electronically notified of the specific information that is inconsistent. The applicant is notified of the date of the next Credentialing Committee meeting and given the opportunity to supply additional information/explanation of the inconsistencies in advance of the meeting. All applications along with details of any adverse findings are presented to the Credentialing Committee for a decision. Providers are notified of the Credentialing Committee decision within 10 business days of that decision.

The approval of credentials is only one of many requirements for network membership. A credentialed provider (Site/Agency/Facility) must be enrolled in NCTracks and must have an executed contract to be a participant in Partners’ Provider Network. Credentialing and Enrollment are two distinct processes. Providers must be credentialed and fully/appropriately enrolled in NCTracks in order to be enrolled with Partners or receive a contract with Partners. The effective date of enrollment in AlphaMCS is the date when the provider (LP, LIP or Agency) is both credentialed with Partners and fully/appropriately enrolled in NCTracks. Claims and authorization processing are directly impacted by the enrollment and contract effective date.

C. Credentialing and Re-Credentialing of Hospitals and/or Health Systems

Partners accepts hospitals/health systems enrollment in NC Tracks including all facilities and sites enrolled with DHB and affiliated with the hospital/health system and all practitioners billing through the hospital/health system’s NPI(s), in lieu of credentialing. Hospitals and/or health systems may seek to enroll in the Partners Provider Network at any time by submitting the Hospital Data Form to Partners Provider Network Manager, Natalie Mooneyham, at nmooneyham@partnersbhm.org.

**Re-Credentialing**

All network providers including LPs, LIPs and Agencies must be recredentialed every three years in order to maintain credentials to participate in Partners’ Provider Network. Network providers bear the responsibility for keeping track of their own individual and/or agency credentialing expiration date(s). In order to track the credentialing expiration dates of associated clinicians, Partners recommends that network providers use an internal auditing process. Partners does not
notify the affiliated agency of the LPs credentialing expiration date. However, Partners does post recredentialing dates for all network providers (LP, LIP and Agency) on our website at the following link https://providers.partnersbhm.org/provider-enrollment-credentialing. This information is updated monthly and is archived and available for provider access at all times.

Providers who do not submit a complete re-credentialing application before their credentialing expiration date are no longer eligible to bill for State-funded or Medicaid-funded services. Continuing to bill for services after the credentialing expiration date may result in claim denials, loss of revenue, recoupment and/or contract suspension/termination.

At least 180 days prior to the applicable re-credentialing expiration date, the credentialed provider (LIP, LP or Agency) is notified via email of the requirement to make application for recredentialing. The electronic notice includes instructions, deadline for submission and contact information for questions. In addition, LIP and Agency providers who have contracts with Partners are also notified via certified mail of the recredentialing due date. If an application is not received at least 90 days prior to the credentialing expiration date, Partners notifies the provider again of the upcoming expiration date. In addition, 90 days prior to expiration of credentialing all LIP and Agency providers who have contracts with Partners, receive notification via certified letter of contract termination to be effective in 90 days (the date of credentialing expiration.)

Applications for recredentialing must be submitted with all required information/documentation. The required information and documentation are outlined in the applications. Applications must be signed by the applicant no more than 180 days prior to the review of the application by the Credentialing Committee. After the application is submitted, it is reviewed and processed following the same guidelines and timeframes as outlined for initial credentialing. In addition, Partners collects quality of care information for all applicants for recredentialing. Quality of care information includes but is not limited to complaints, grievances, satisfaction surveys, monitoring reviews, performance reports and sanctions. All applications along with any adverse findings from the verification process and quality of care review are presented to the Credentialing Committee for a decision. Notification of the Credentialing Committee decision is sent to the provider within 10 business days of the decision.
**VERIFICATIONS & GOOD STANDING**

All applicants must demonstrate “Good Standing” status at the time of application and shall continuously meet Good Standing criteria while a member of the Network. Good Standing means that the applicant has no current Medicare or Medicaid sanction(s), no relevant findings on criminal background checks on agency ownership, board and leadership, no legal actions pending as of the date of application, no open Plans of Correction, and has not received sanctions or administrative actions more than two times from the LME/MCO in the previous 12 month period. Further, the provider must not be currently suspended from a Medicaid program or listed with a negative action in any of the following databases as applicable:

1. Excluded Parties List
2. Health Care Registry (Owners)
3. Office of Inspector General (OIG)
4. National Plan & Provider Enumeration System (NPI) Number
5. NC Secretary of State website (Corporations)
6. DHB Program Integrity Database (pending)
7. Criminal database
8. National Accrediting Boards (e.g. URAC, CARF, COA, others)
9. National Practitioner Data Bank (NPBD/HPDB)

Good Standing further means that the applicant (or any entity which shares the same Employee Identification Number (EIN) as the applicant) has submitted all required documents, payments and fees to Partners and to the U.S. Internal Revenue Service, the NC Department of Revenue, NC Secretary of State (if organized as a corporation, partnership or limited liability company), the NC Department of Labor, and the NC Department of Health and Human Services, and has not had any sanction issued by those entities or by the LME/MCO, including but not limited to the following:

1. LME/MCO: Credentialing Revocation or Withdrawal, Contract Termination or Suspension, Referral Freeze or Suspension, Unresolved Plan of Correction, Outstanding Overpayment, Prepayment Review, Payment Suspension; Credentialing Program Description Page 22 of 33.
2. DHB: Contract Termination or Suspension, Payment Suspension, Prepayment review, Outstanding Final Overpayment.
3. DMH/DD/SUS: Revocation, Unresolved Plan of Correction.
4. DHSR: Unresolved Type A or B penalty under Article 3, Active Suspension of Admissions, Active Summary Suspension, Active Notice of Revocation or Revocation in Effect.
5. U.S. Internal Revenue Service/ N.C. Department of Revenue: Unresolved tax or payroll liabilities.
6. N.C. Department of Labor: Unresolved payroll liabilities.
7. N.C. Secretary of State: Administrative Dissolution, Revocation of Authority, Notice of Grounds for other reason, Revenue Suspension.
8. Sanctions issued by any board of licensure or certification for the applicable scope of practice.
9. Sanctions by the provider’s selected accrediting body.

For purposes of this policy and procedure, Partners considers an action of NC DHHS to be final upon notification to the provider, unless the provider has requested a reconsideration review with NC DHHS, in which case Partners considers the action final upon issuance of a decision by the NC DHHS Hearing Office.

To be considered in Good Standing, the applicant’s owner(s) and managing employee(s) may not previously have been the owners or managing employees of a Provider which had its participation in any state’s Medicaid program or the Medicare program involuntarily terminated for any reason or owes an outstanding overpayment to the LME/MCO or an outstanding final overpayment to NC DHHS. Good Standing will be based on self-disclosure and verification on the Provider Penalty Tracking Database (DHSR) and any other publicly available databases. Partners’ applicants with an identified deficiency related to Good Standing will be flagged and reviewed by the Credentialing Committee.

**Continuous Monitoring of Credentials**

Partners will monitor the U.S. Office of Inspector General (OIG) List of Excluded Individuals and Entities (LEIE) and the System for Award Management (SAM) on a monthly basis against all LPs, LIPs, owners and managing employees credentialed by Partners. Periodically, but no less than quarterly, Partners will monitor reports of disciplinary actions published by state licensing boards, the NC Department of Health and Human Services and its Divisions, and the National Practitioner Data Bank (NPDB), and National Technical Information Service for DEA certificates. Partners reserves the right to routinely monitor any additional verification databases. Partners will be responsible for continuous monitoring of the insurance coverage of each Network Provider, licensed independent practitioner, agency/facility in the LME/MCO Network. Partners monitors LP affiliation with in-network provider organizations. LPs not affiliated with in-network provider organizations at the time of recredentialing are not eligible to apply for recredentialing. Partners
verifies insurance coverage at credentialing and at recredentialing and requires that providers include Partners as a certificate holder for direct notification of any changes in coverage.

Upon receipt of the compliance issues, the Credentialing Supervisor will work with appropriate Provider Network, Compliance and Quality Management Departments and other Partners staff to research and bring these issues and requisite findings to the appropriate LME/MCO Committee (e.g., Credentialing Committee, Network Management Committee and/or Corporate Compliance Committee). A formal notification and Plan of Correction or sanction may be sent to the provider(s) determined to be non-compliant with network standards. In the event of a Plan of Correction, a Quality Management Monitoring Specialist will be assigned to the provider(s) to monitor actions taken by the provider and bring the Plan of Correction back to the appropriate committee for final determinations. [N-CR 14(b)] In the event the Credentialing Committee, Network Management Committee and/or Corporate Compliance Committee are not convening within needed response timeframes, Partners’ Chief Medical Officer or designee may make a determination, which will then be shared with the appropriate committee at its next meeting. In situations where the clinician’s license is found to have expired, Partners will first offer the option to withdraw from the network and wait 45 calendar days before presenting the expired license to the committee in order to give the provider time to respond prior to action by the committee.

**MEMBER SAFETY CREDENTIALING INVESTIGATION**

During the Credentialing Process (including initial credentialing, recredentialing and on-going monitoring of credentials), if information is revealed that is indicative of factors that may impact the quality of care or service provided to enrollees, Partners shall conduct additional reviews and/or investigations of that provider. Further review and information may be triggered by a number of findings or circumstances including, but not limited to, the following: malpractice litigation, sanctions, license revocation, grievances, quality of care concerns, missing information and/or inconsistent information. An additional review of information can be requested by the Credentialing Specialist or Credentialing staff with the Provider Network Director, Partners’ Chief Medical Officer or another senior clinician within the LME/MCO. The Chief Medical Officer reserves the right to suspend providers during the investigation of quality of care concerns as necessary in order to protect the health and safety of enrollees. Notification of suspension will be sent to the impacted provider immediately. In the case of suspended practitioners, both the practitioner and the provider organization associated with that practitioner will be notified immediately. All findings shall be discussed in greater detail with the Credentialing Committee, who will determine further action (e.g., on-site monitoring, referral to Corporate Compliance for further investigation, etc.). All follow-up activities regarding credentialing investigation must be
documented in a clear and detailed manner. Documentation must include what was done, who did it, when the activity was conducted, and any further recommendations/referrals. This documentation shall be reviewed by the appropriate Provider Network staff on a regular basis, with a quality review to be conducted by the Provider Network Operations or his/her designee on an annual basis.

**CREDENTIALING COMMITTEE**

In accordance with URAC standards, Partners has a senior clinical staff person overseeing the clinical aspects of its Credentialing Program. Partners’ Credentialing Program, including all its clinical aspects, is overseen by its Chief Medical Officer. The Chief Medical Officer chairs the Credentialing Committee, reviews and approves providers’ credentialing files that meet criteria for participation, provides input to policy changes and/or revision of policies and procedures and follows up with providers as needed. While day-to-day aspects of the Credentialing Process are overseen by the Provider Network Director or other designee, the LME/MCO’s Credentialing Committee retains responsibility over the Credentialing Program.

The Credentialing Committee meets at least quarterly or more frequently at the discretion of the Credentialing Committee Chair. The Credentialing Committee keeps detailed minutes of all meetings and committee actions, decisions made regarding each applicant, and prepares the annual report to the LME/MCO Board, CEO and Operations Team on the number of applicants reviewed, accepted, timeliness of processing, volume of applications received and substantiated complaints.

The Credentialing Committee has final authority to approve or disapprove applications by providers for organization participation status and is tasked with assuring that Licensed Independent Practitioners meet standards of care for entrance into the Partners Provider Network. The committee reviews licensure, education, sanctions, criminal background checks and other documents to decide if the applicant meets LME/MCO standards. If those standards are met, the committee “credentials” the provider. The provider can enter Partners Provider Network once a contract is signed by the provider and the LME/MCO. The Credentialing Committee ensures it accesses appropriate clinical peer input when discussing standards of care for a provider. Partners does not discriminate against any provider seeking qualification as a participating provider.

The Credentialing Committee may change a provider’s credentialing status (i.e., suspension or revocation) based on an action or non-action that is found to violate LME/MCO’s standards of practice. The Credentialing Committee may make reports to the licensing boards for Licensed Independent Practitioners based on continuous monitoring findings.
In the event that the Credentialing Committee is not able to make a decision regarding an application for participation, the Credentialing Committee Chairperson reserves the right to conduct a personal review, schedule an interview with the provider on a case-by-case basis and render a recommendation to the Credentialing Committee.

Reasons to request a review include but are not limited to the following:

1. Perceived medical disciplinary cause or reason, meaning an aspect of the practitioner’s competence or professional conduct which is reasonably likely to be detrimental to patient safety or to the delivery of member care, or;

2. Perceived conduct or professional competence which could adversely affect the health or welfare of a member.

In accordance with URAC standards regarding credentialing time frames, Partners’ Credentialing Specialists may not apply to the Credentialing Committee and/or Chief Medical Officer for consideration that:

- is signed and dated more than 180 calendar days prior to the credentialing committee review, or;
- has verification information collected more than six months before review.

The application and information it contains shall be re-sent to the provider with additional information requested and added to the application where needed to complete the application, update verifications, and/or provide the Chief Medical Officer and Credentialing Committee with the most recent and relevant information to make an approval or denial decision. Applications may need to be reviewed more than once, the timeframe standards mentioned above apply only to the first time the application comes before the Credentialing Committee.

Once a credentialing determination has been made regarding an application submitted by a provider, Partners sends notification to the provider in writing within ten business days of that determination. Once credentialing is approved and NCTracks enrollment is verified, Partners initiates the process to execute a contract (when applicable). All providers approved for credentialing and appropriately enrolled in NCTracks are entered into the AlphaMCS system. **AlphaMCS enrollment effective and the contract effective date (when applicable) is the earliest date at which the Provider is both credentialed by Partners and appropriately enrolled in NC Tracks.**
**Changes to Credentialing Information**

Network Providers are required to notify Partners of any changes to the information presented in their most recent credentialing or re-credentialing application within three business days of such change using the applicable Provider Change Form including but not limited to changes to NPI, ownership, management, accreditation, address, contact or other information.

Requests to add a new or additional site or service must go through the process described in Section A in the application process above.

All changes in ownership or additions of managing employee(s) require the provider to submit the applicable components of the credentialing application and a completed Criminal Background Release form.

Agencies and group practices are required to notify Partners of any changes in their practitioner roster. Practitioners are permitted to withdraw from the Partners Network by notifying Partners via email to credentialingteam@partnersbhm.org.

**Out of Network Client Specific Agreement Process (OON)**

In the event that a Partners member has a medically necessary need for behavioral health or intellectual/developmental disability services that are not available through in-network providers, an out of network (OON) agreement may be required. All of the following requirements must be met in order for an out of network agreement to be issued:

1. Member enrollment with Partners must be verified.
2. Services must be authorized as medically necessary per benefit plan limits.
3. Provider must submit a complete and accurate out of network enrollment request/packet. Out of network providers should contact Partners Access to Care or work with the Partners member’s Care Coordinator (when applicable) in order to request an OON agreement.

In-network providers do not qualify for and should not request OON agreements. Instead, in-network providers should submit a Provider Change Form in order to request to add sites/services to their existing contract with Partners in order to offer additional services needed by Partners members.

For questions on initiating the credentialing process or the status of submitted applications, email enrollment@partnersbhm.org. For questions on credentialing process or the status of submitted applications, email credentialingteam@partnersbhm.org.
**Access to Care Process for Initiating an OON**
Out of Network requests for members not assigned to Care Coordination should go through the Access to Care line at 1-888-235-HOPE (4673).

**Partners Care Coordination Process for Initiating an OON**
All Out of Network requests for members assigned to a Care Coordinator should be made through the assigned Care Coordinator.

**Hospitals and Health Systems Process for Initiating an OON**
Partners members may be admitted for inpatient behavioral health services at a hospital that is not contracted in Partners Provider Network. The inpatient behavioral health treatment may be an admission to a psychiatric unit, medical detox that is coded as the primary treatment that occurs on a medical floor, or an admission to a medical floor for a behavioral health diagnosis when there is psychiatric consultation involved with the treatment. Forms and instructions related to hospital out of network requests can be found at the following link: [http://providers.partnersbhm.org/hospitals-working-partners/](http://providers.partnersbhm.org/hospitals-working-partners/)

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**MONITORING**

It is Partners’ responsibility is to assure the quality of services provided by the Provider Network. Likewise, Partners is accountable to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services (MH/IDD/SAD) and the Division of Health Benefits (DHB) in the management of both state and Medicaid services. In addition to state requirements, Medicaid Waiver quality requirements are extensive and include:

- Health and safety of members.
- Rights protection.
- Provider qualifications.
- Member satisfaction.
- Management of complaints.
- Incident investigation and monitoring.
- Assessment of outcomes to determine efficacy of care.
- Management of care for special needs populations.
- Preventive health initiatives.
- Clinical best practice.
Providers and practitioners receive a Monitoring review at least once every two years. The Quality Management Department maintains a schedule of Monitoring reviews. Reviews are scheduled and coordinated by Quality Management staff. Monitoring reviews use standardized state tools that are available in the Division of Mental Health/Developmental Disabilities/Substance Abuse Services website, Provider Monitoring page. Monitoring visits include an exit conference with the provider to discuss the outcome of the review. The provider may present any additional information not located during the review process before the conclusion of the scheduled review. The reviewer(s) shares a summary of the review for each area examined, noting strengths as well as areas that may require attention.

Copies of profile review results are sent electronically and/or mailed to the provider within 15 business days of the completion of the review. Documentation outlines areas reviewed; scores achieved and required follow up. After the review visit is concluded, no additional information will be accepted or used to change any established scores.

**Health & Safety Site Review**

If a Health and Safety Site visit is required, the assigned Quality Management Specialist schedules a site visit within 60 days of complete written application. Any site requested to be added to the contract will be reviewed on all applicable areas. During the site visit, Partners staff evaluate the provider’s readiness to provide services according to the requirements outlined in state regulations and the state monitoring tool.

**VERIFICATION OF EDUCATION**

**Provider Responsibilities for Verifying Education of Paraprofessionals**

We all want to ensure that anyone caring for vulnerable members of our communities meet the minimum education requirements. Failure to do so raises risk to the member, provider and our system overall.

Providers are responsible for ensuring that their paraprofessionals have a valid high school diploma or state recognized equivalent of a high school diploma (for example, a GED).

North Carolina Administrative Code Chapter 10A Subchapter 27G.0104, requires the following:

"Paraprofessional" within the MH/DD/SAS system of care means an individual who, with the exception of staff providing respite services or personal care services, has a GED or
high school diploma; or no GED or high school diploma, employed prior to November 1, 2001 to provide a MH/DD/SAS service.”

Providers must also demonstrate that they verified that its staff meets the educational requirements. Verifying means making sure the high school diplomas and state recognized equivalent of high school diplomas (GEDs) presented by staff are valid, issued by legitimate institutions and documenting the steps taken to verify the educational requirements.

**Paraprofessional Education Requirements**

In North Carolina, unless the paraprofessional started employment prior to November 1, 2001, anyone who provides MH/IDD/SUD services must meet the minimum education requirement of having a valid high school diploma/transcript or a valid state recognized equivalent of a high school diploma (GED) from an organization recognized by the state in which the diploma or equivalent was issued.

A **High School Diploma** is typically issued by a regionally accredited high school to students to recognize completion of all state and local graduation requirements.

Whether or not the school is accredited, the diploma must be recognized by the high school’s home state as a high school diploma. Many states recognize schools through regional accreditation, which is generally true for public high schools, though it may or may not be true for private schools, including online and correspondence high schools. In North Carolina, a **private high school must be listed with the NC Division of Non-Public Education for the school year when the student graduated.**

A **Home School Diploma** is a diploma issued by a non-public school where the student receives academic instruction from his/her parent, legal guardian, or a member of the household in which the student resides. The chief administrator of the home school issues the diploma.

An **Adult High School Diploma (Adult HSD)** is generally issued through the community college system in most states. Colleges issuing adult high school diplomas must have nationally recognized regional accreditation in the United States.

The **GED (General Education Development)** is a copywritten test licensed by a trade association and vendor (the American Council on Education and Pearson). The GED tests measure the academic skills and knowledge expected of high school graduates in the United States. Successfully passing the tests results in award of a GED credential (which may be called a diploma,
certificate, credential, or endorsement). The state in which the test is taken will issue the GED credential. A GED prep-course completion certificate is not the same as a GED and alone is not valid proof of a GED.

**WARNING: Graduation Certificate and Certificate of Achievement:** These are high school exit documents for students who do not meet the requirements for a diploma. These documents are NOT recognized as high school diplomas or equivalents.

### Verification of Education Requirements for Paraprofessionals

As was indicated in LME-MCO Joint Communication Bulletin #J270, dated November 2, 2017, the NC Department of Health and Human Services (NC DHHS) provider monitoring tool review guidelines use the phrase “[v]erify educations (diploma, transcript)” with respect to staff documentation and qualifications.

To show that the verification of education requirements was met, you must maintain documentation to demonstrate that you received sufficient evidence that the staff earned a high school diploma or received a GED credential, recognized by the U.S. Department of Education. Typically, keeping in the personnel file the diploma/transcript or GED credential from the school or other organization that issued it may serve as sufficient evidence.

If there is any question about the legitimacy of the documentation or of the organization the staff member claims to have obtained their high school diploma or GED from, you may need to take additional steps and document those steps in the verification process. Be certain to document what you did to verify the education of your staff, e.g., save screen shots, make notes of phone calls (i.e., include the date of the call, the phone number and person you spoke to), etc.

### Resources for Verifying Paraprofessionals’ Education

Some helpful resources for verifying high school diplomas and state recognized equivalent of a high school diploma (GED) include:

**For High School Diplomas:** Recognized regional accrediting bodies for high school diplomas.

[North Central and Southern Association CASI](http://www.advanc-ed.org/oasis2/u/par/search) (commission on accreditation and school improvement). CASI covers the states of Arkansas, Arizona, Colorado, Iowa, Illinois, Indiana, Kansas, Michigan, Minnesota, Missouri, North Dakota, Nebraska, Ohio, Oklahoma, New Mexico, South Dakota, Wisconsin, West
Virginia, and Wyoming, Alabama, Florida, Georgia, Kentucky, Louisiana, Mississippi, North Carolina, South Carolina, Tennessee, Texas and Virginia.


New England Commission on Public Secondary Schools http://cpss.neasc.org/ and New England Commission on Independent Schools http://cis.neasc.org/ (such as traditional boarding and day preparatory schools, private elementary schools, schools serving students with special needs, and religiously affiliated schools of many faiths) Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island and Vermont.

Western Association of Schools and Colleges http://www.wascweb.org/ (secondary schools are listed under The Accrediting Commission for Schools) Covering the states of California and Hawaii, the territories of Guam, American Samoa, Federated States of Micronesia, Republic of Palau, Commonwealth of the Northern Marianas Islands, the Pacific Basin, and East Asia, and areas of the Pacific and East Asia where American/International schools or colleges may apply to it for service.


Adult High School Diploma: The nationally recognized regional accrediting bodies for colleges (and the geographic regions they serve) can be used to verify the legitimacy of an institution issuing an adult high school diploma:

Middle States Association of Colleges and Schools www.msche.org Delaware, the District of Columbia (D.C), Maryland, New Jersey, New York, Pennsylvania, Puerto Rico and the U.S. Virgin Islands.


Southern Association of Colleges and Schools [www.sacscoc.org](http://www.sacscoc.org) Alabama, Florida, Georgia, Kentucky, Louisiana, Mississippi, North Carolina, South Carolina, Tennessee, Texas and Virginia.

Western Association of Schools and Colleges [https://www.acswasc.org/](https://www.acswasc.org/) (senior colleges and universities) and [www.accjc.org](http://www.accjc.org) (community and junior colleges) California and Hawaii, the territories of Guam, American Samoa, Federated States of Micronesia, Republic of Palau, Commonwealth of the Northern Marianas Islands, the Pacific Basin, and East Asia, and areas of the Pacific and East Asia where American/International schools or colleges may apply to it for service.

**Home Schools**: The NC Division of Non-Public Education is authorized by state law to receive home school notices of intent to begin initial operation and to terminate operation, and to annually inspect the school’s student attendance and nationally standardized achievement test result records. They provide a list of home schools by county at this website: [http://www.ncdnpe.org/hhh301.htm](http://www.ncdnpe.org/hhh301.htm).

It is worth noting that schools listed with the NC Division of Non-Public Education change over time and, therefore, diplomas issued at different times may not have the same weight.

**Tip**: Providers need to verify that the home school certification/diploma is an acceptable certification/diploma by contacting the state’s Department of Education from where the certificate was issued to verify it is valid. Once this is documented in the employee’s record no further verification is required.

**GED**: The only official GED is given by the GED TESTING SERVICE and its approved sites. All approved testing locations are listed, as well as instructions on how to obtain a transcript can be found, at: [www.GEDtest.org](http://www.GEDtest.org).

The official GED is NOT offered online via the internet. Currently the GED is a paper and pencil test only. The GED test is a series of five tests covering different subjects and takes seven hours to complete.

**Plans of Correction**

A Plan of Correction (POC) is a tool used by providers to describe how issues that have been identified as out of compliance will be rectified. It is a method for the provider to detail plans for immediate correction of identified problems. It is also a method for ascertaining the systemic root
cause of the problem and what system changes are needed to prevent the problem from reoccurring in the future.

A POC may result from any review or monitoring that finds systemic or programmatic issues that are in violation of or contrary to Federal, State, or Local law, the provider contract, the Provider Operations Manual, or the agency’s own policies/procedures. A POC may also be the result of an investigation of a complaint or allegation which results in out of compliance findings. In cases where the issue is outside the scope of Partners’ oversight, the appropriate point of referral will be determined for the issue or circumstance observed. Such referrals may be made to the Division of Health Service Regulation, the Division of Social Services, the Division of Medical Assistance, the Department of Labor, the appropriate DMH/DD/SAS team or other appropriate agency.

POCs are requested from the provider via a letter on Partners letterhead sent Certified US Mail with a return receipt. The POC request letter provides direction for submission of the POC.

All POCs are submitted by the provider to the department requesting the POC. The POCs are due to Partners within 15 calendar days of delivery or attempted delivery of the request letter. If the POC is accepted, it is appropriate and contains all of the required criteria. The provider is notified in writing of the POC acceptance within ten calendar days and a follow-up monitoring visit will be scheduled no more than 60 days from the acceptance date.

If the POC is not accepted, the provider is notified in writing of its non-acceptance within ten calendar days. The letter will specify what corrections are needed for the second, and final, POC to be accepted. The provider has ten calendar days to revise the POC and resubmit it in full to Partners. Once received, the final POC is reviewed by the designated Partners department.

If the POC is accepted, the provider is notified in writing of the POC acceptance within ten calendar days and a follow-up monitoring visit will be scheduled no more than 60 days from the acceptance date. If the final POC is not accepted, a termination of contract for service(s) will be pursued. Criteria used to review the POC can be found at NC DMH/DD/SAS Policy and Procedure for the Review, Approval and Follow-Up of Plans of Correction (POC).

If a provider does not submit a POC within the required time frames, a reminder letter is sent, including the consequences of failure to submit a POC. If there is still no response within ten days of attempted delivery of the final request letter, it will be treated as a non-accepted POC. Failure to respond and submit a POC will result in implementing applicable consequences as necessary based on review determination by Network Management Committee.

For more information about Plans of Correction, go to [http://www.ncdhhs.gov/mhddsas/providers/POC/index.htm](http://www.ncdhhs.gov/mhddsas/providers/POC/index.htm).
Follow-up Review

No later than 60 calendar days following the date the POC is approved/accepted a Partners Monitoring Review Team will follow-up to ensure the POC has been implemented and the identified out-of-compliance findings have been corrected. The provider will be notified in writing of the follow-up review at least seven calendar days in advance.

At the first follow-up, if the reviewers determine that the POC is being followed and the issues have been corrected, the team will designate the action closed. If the department determines that the POC is not being followed and/or the issues have not been corrected, a second and final follow-up review will be required.

The provider will be notified in writing of the need for the second follow-up. In approximately 20 calendar days following receipt or attempted delivery of the “additional follow-up required” letter, a Monitoring Review Team will follow-up to ensure the POC has been implemented and the identified out-of-compliance findings have been corrected. If the reviewers determine that the POC is being followed and the issues have been corrected, the team will designate the action closed. If the issues are still not resolved, the provider will be notified in writing of the implementation of applicable sanctions as necessary based on review determination by Network Management Committee.

Plan of Action

In situations where it is not feasible to request a Plan of Correction due to the nature of the deficiency cited, time frames for follow-up or other extenuating circumstance the LME/MCO may issue a Plan of Action (POA).

The POA is a detailed letter to the provider citing any deficiency with directions from the LME/MCO as to what the provider must do to correct the deficiency and come into compliance. The LME/MCO shall provide any specific steps the provider must take to eliminate the deficiency, any specific staff that need to address the deficiency and the time frame by which the provider must correct the deficiency and come into compliance.

The LME/MCO may do a follow-up desk review or on-site review to determine if the provider has corrected the deficiency and come into compliance with all Rules and Regulations and any requirements indicated in the contract between the LME/MCO and the provider.
The provider may not formally dispute a POC request or the issuance of a POA, however the provider may informally dispute the out of compliance findings to the QM Monitoring Manager. This informal dispute must be requested prior to the 15-day period ending regarding the submission of the POC/POA. The provider must still comply with time frames indicated in the POC or POA to come into compliance while the informal dispute is in process.

A failure by the provider to correct any deficiency and come into compliance by the time frame directed by the LME/MCO shall result in the provider being presented to the Network Management Committee for possible sanctions or termination of contract.

**DISPUTE RESOLUTION PROCEDURES**

**Initiation of the Dispute Resolution Process**

A participating provider can submit a request in writing utilizing the Dispute Resolution Form no later than 21 calendar days from the receipt of the LME/MCO’s decision resulting in the request. (Note: If the provider fails to meet the timeframes to request initiation of the Dispute Process, the decision of the LME/MCO becomes final and the provider may not utilize the Dispute Process.)

The provider receives a copy of the Dispute Resolution Form, along with the notification of action or decision taken by the LME/MCO. A provider may also contact Partners by telephone or in person, and the appropriate staff person will assist the provider with obtaining a copy of the Dispute Resolution Form.

The Dispute Resolution Form collects the following information, at a minimum:

- The nature of the problem;
- Previous attempts, if any, to resolve it; and
- Any other pertinent information that the provider feels is important.

In addition, the provider may submit additional information in writing either by electronic mail, surface mail, special delivery, or other source of written communication.

**Nature of the Dispute**

As soon as Partners receives the completed Dispute Resolution Form from the provider, a triage of the issue is performed by the Provider Network Director. Partners’ Chief Medical Officer assists with making this determination, if needed. If the dispute is related to actions by Partners that relate to the provider’s professional competency or conduct, a panel-review process is
conducted. If the matter under dispute is administrative in nature, the Provider Network Manager or other assigned qualified individual at Partners reviews the disputes.

The Provider Network Director reviews the appeal and determines the nature of the dispute. The nature of the dispute is determined in accordance with the following guidelines:

Disputes of a **clinical** nature are those that pertain to a provider's professional conduct or competence in relation to matters such as, but not limited to, the following:

- The appropriateness or quality of professional services including assessment, treatment, consultation and referral;
- The appropriateness of interactions between a provider treatment staff and a member; and,
- Conduct by a professional that may adversely affect treatment outcomes—e.g., failure to exercise professional judgment in disclosing client information.

Disputes of an **administrative or non-clinical** nature are those pertaining to matters such as, but not limited to, the following:

- Claims and billing;
- Adequacy of facility and staffing;
- Compliance with state and LME/MCO policy;
- Tentative Notice of Overpayment (TNO);
- Compliance with contractual requirements; and,
- Compliance with state regulatory requirements (e.g., Core Rules, Client Rights Rules, etc.)

### Panel Review

The panel review process may involve two levels of review:

The first level panel consists of at least three qualified individuals, with at least one of those individuals being a peer of the provider who is the subject of the dispute. At least one clinical peer who is not an employee of Partners or a Partners committee participant is included on the panel.

The Partners’ Provider Network Department ensures all the pertinent information is gathered.

Partners sends an acknowledgement letter to the provider via certified or registered mail as soon as possible based on the urgency of the situation, but no later than ten calendar days of receipt of the Dispute Resolution Form. The notification includes an explanation of the dispute resolution
process and their rights, including the right to request a second-level panel if dissatisfied with the first level panel resolution.

This acknowledgement letter also informs the provider that he/she may submit in writing any additional information to Partners for consideration during both the first and, if applicable, the second panel review and that the provider may participate in the panel review in person if he/she so desires.

The designated Partners employee compiles all available information, including any summaries of his/her own research, if applicable. The panel meets as soon as possible, but no later than 30 calendar days and carefully and thoroughly reviews all the information surrounding the case, with special review and consideration of information that the provider being reviewed has presented to Partners to support his/her case.

Once the decision has been made, a written notification is sent within five calendar days to the provider regarding the outcome of the panel review.

In all cases, minutes of the proceedings are kept and held in the strictest confidence.

### Second-Level Panel Review

If the provider is dissatisfied with the first level panel’s resolution and requests a second review, Partners convenes a new panel with all new representation. As with the first-level panel, the second-level panel has at least three individuals that did not participate on the first-level panel. At least one clinical peer who is not an employee of Partners or a Partners committee participant is included on the panel.

The provider being reviewed may submit additional information that he/she deems important to support his/her case. The information must be submitted in writing to Partners prior to the panel review.

The details of the second level review panel process are the same as outlined above for the first level panel, including the timeframes. (Note: If the provider fails to meet the timeframes to submit a Second Level review, the panel’s First Level decision will be considered final and the provider may not utilize the Dispute Process any further.)

Once the decision has been made, a written notification is sent within five calendar days to the provider regarding the outcome of the second panel review.

Included in the written notification is information about the participating provider’s right to appeal to the State Appeals Panel and the mechanism to request such reconsideration.
Member Safety Mechanism

If the Partners Chief Medical Officer or Chief Clinical Officer believes the provider who is the subject of any dispute poses a significant risk to the health, welfare or safety of members, the provider may be immediately suspended pending the results of an investigation. A suspended participating provider will not receive funding to continue services or receive new referrals from Partners.

Written notification of the intent to suspend the provider pending investigation is sent to the Provider as soon as possible based on the urgency of the situation, but no later than five calendar days of becoming aware of the issues. The notification includes the availability of the Dispute Resolution Process and the mechanism for initiation as well as a Dispute Resolution Form.

In addition, Partners provides written notification to the appropriate entities, such as:

- Division of Health Service Regulation,
- The Department of Social Services, and
- The Division of Mental Health/Developmental Disability/Substance Abuse Services-Program Integrity Unit.

As with any dispute, the provider may contact the Provider Network Department to provide any information that he/she believes may bring about a favorable outcome.

Partners makes every effort to achieve final resolution to these kinds of cases ahead of the designated deadlines, given the provider has been suspended. However, Partners does not compromise outcome to complete the case quickly.

When the information gathering and investigation is complete, a first-level panel convenes.

All other steps to the panel review process are the same as outlined above, including the written notification and the right to a second-level panel review.

Disputes Related to Administrative Matters

Disputes triggered by a Partners decision regarding an administrative matter have a different resolution process and are not subjected to a panel review. Such disputes may involve timely filing of claims, Tentative Notices of Overpayment (TNO), Network accessibility issues, failure to submit requested medical records, and administrative denials. These disputes are resolved through mediation with a qualified Partners representative.
The provider receives a copy of the Dispute Resolution Form, along with the notification of action or decision taken by the LME/MCO. To initiate a dispute involving an administrative matter, such as an adverse administrative UM decision, the provider completes and submits the Dispute Resolution Form according to instructions included in the notification. A provider may also contact Partners by telephone or in person, and the appropriate staff person will assist the provider with obtaining a copy of the Dispute Resolution Form.

Information collected from the Provider includes:

- Provider demographic information,
- Summary of problem/issue, and
- Provider’s view of the issue(s), including how to resolve it.

Administrative disputes are investigated by the Provider Network Regional Manager or a Provider Network Department Staff Member. Partners is careful to ensure that the designated person has no conflict of interest and has not previously been involved in the decision that is the subject of the dispute.

As necessary, the staff person will consult with other executives at Partners, such as the Chief Medical Officer or the CEO.

If necessary, the staff person will investigate, which may involve a visit to the provider’s office location. In addition, the staff person works closely with the provider to mediate, negotiate, and if reasonable to do so, negotiate with the provider. If negotiation is not an option, the staff person makes a recommendation for resolution to the Provider Network Director. The Provider Network Director will make the final recommendation to the Chief Legal Officer and CEO after a thorough review of all the facts. The Director consults with other LME/MCO staff, if indicated.

A final determination is made, and a written notification sent by certified or registered mail within 30 calendar days of the provider’s initiation of a dispute. The Final Decision is made by the CEO or his/her designee.

**Documentation**

Information pertaining to all disputes, administrative or clinical is documented in the designated Provider file. Quarterly reports are created for presentation to the Quality Improvement Committee and other appropriate committees for tracking and trending. When patterns emerge, the Quality Improvement Committee will request an action plan to bring about improvements.
Exclusions

For those violations described in the State Benefit contract (the contract with providers who deliver state-funded services), Article IV, “Term and Termination,” the dispute resolution process is not available.

According to the Article, the following violations will result in termination:

- Repeated non-performance of obligations without corrective action,
- Violations of professional standards, or
- The commission of unlawful acts.

Changes in Provider Status

Partners is diligent in maintaining our provider database with the current practice information submitted by our agencies and practitioners in support of our ongoing commitment to quality care.

It is imperative that providers notify the Provider Network Department in writing within five business days of any changes in their status, including, but not limited to the following:

- Hiring and terminating clinicians.
- Changes in ownership.
- Change in management.
- Proposed changes in facility location and/or addresses.
- Changes in capacity.
- Inability to accept new referrals.
- Any proposed acquisitions.
- Any proposed mergers.
- Any pending investigations for Medicaid fraud.
- Licensure status.
- Changes in privileged status with other accrediting organizations.
- Pending citations.
- Pending malpractice claims.

For notification of changes, complete the Provider Change Form and email to credentialingteam@partnersbhm.org
**NETWORK DEVELOPMENT PLAN**

The Network Development Plan is developed using the Partners’ Community Behavioral Health Provider and Service Gap Analysis. The plan is used to delineate priorities for service and program development as identified in our Local Business Plan and the Annual Capacity Study. Partners’ departments and/or committees are incorporated into the plan, as well as accountability at the executive management level. Progress is monitored through regular reports at the Executive and Board levels of the LME/MCO.

**RELATIVE/LEGAL GUARDIANS AS DIRECT SUPPORT EMPLOYEE**

Providers employing a relative/legal guardian, living in the home of an adult (18 years) Innovations recipient and who is the direct support staff for that recipient, must comply with the Relative/Legal Guardian as Direct Support Employee (RADSE) process.

The RADSE process applies only to relatives/legal guardians who live in the home of the adult (age 18 or older) receiving NC Innovations services.

Innovations services that can be provided by the relative/legal guardian include Community Living and Supports.

Provider agencies must submit requests, using the appropriate Verification of Relative/Legal Guardian as Direct Support Application State Forms, to Partners’ Quality Management Department for approval.

Separate requests must be submitted for each relative/legal guardian who will deliver services.

Provider agencies must also submit requests for approval of relatives/legal guardians identified as backup staff who reside in the home of the adult Innovations member and who will deliver services to that recipient.

Relatives/legal guardians should not complete the Verification of Relative/Legal Guardian as Direct Support Application State Forms. It is the provider’s responsibility, as the employer, to complete the form and submit the request for approval.

Partners’ Provider Network Department reviews Provider requests to employ relative/legal guardians, to ensure that providers are following directives set forth in the NC Innovations Clinical...
Coverage Policy 8.0 and to ensure that services are delivered in accordance with the Innovations Waiver Policy.

Partners’ Provider Network Department does not determine medically necessity of services requested to be provided by the relative/legal guardian. The decision to not approve a provider to employ a relative/legal guardian, or the decision to not approve a provider to employ a relative/legal guardian for a requested number of hours, should not impact hours of service that an Innovations Waiver member has been authorized to receive. If a provider is not approved to employ a relative/legal guardian or is not approved to employ a relative/legal guardian for the number of hours requested, it remains the responsibility of the provider agency to have other staff provide services that have been authorized for the Innovations Waiver member.

Please note that all updated information regarding the Relative/Legal Guardian as Direct Support Employee Procedures are posted on the Partners website and updates are also be communicated through the Partners’ Provider Communication Bulletin.

**Provider Council**

The mission of Partners’ Provider Council is to serve as a professional representative and advocate for all service providers in the Partners catchment area. The Provider Council facilitates an open exchange of ideas; brings forward concerns and solutions while promoting collaboration and mutual accountability among providers.

The Provider Council’s Purpose is:

- To review, provide input and make recommendations to Partners related to policies, procedures, forms, activities, guidelines and other system operations and functions as identified by the Council and/or Partners.
- To make recommendations about network funding priorities and financial strategies to sustain a quality Provider Network.
- To review trends, make recommendations and disseminate information related to provider access, utilization and performance measures.
- To review and make recommendations for quality and outcome indicators and Partners use of network quality management data.
- To undertake other tasks as deemed appropriate by the Council to promote and support service providers.
The Provider Council is a crucial committee and, as such, has responsibilities to providers in representing their interests and challenges; and to members, family members and Partners in responding to standards, key indicators, initiatives and requirements.

A report from the Provider Council is a standing agenda item at the quarterly Provider webinar meetings.

Provider Council membership has been designed to represent the diversity of the network to include a minimum of 25% of the participant agencies serving members with a mental health diagnosis, 25% serving members with an intellectual and/or developmental disability and 25% serving members with a substance use disorder. The Council also strives to have a minimum of a hospital member agency and one Licensed Independent Practitioner representative.

**Provider Satisfaction Surveys**

Provider Satisfaction Surveys are completed by an outside vendor for Partners. The results of the surveys are reported back to Partners annually.

The results are reviewed for trends and reported through Partners’ Operations Team and Quality Management Team for action or planning as indicated.

**Provider Training**

Partners understands the importance of offering on-going training opportunities to providers as a mechanism to maintain professional competence and remain up-to-date with changes that occur in the behavioral healthcare industry. To that end, Partners Training Academy provides on-going and relevant training to providers.

**Partners’ Responsibilities to Providers**

- Review the provider’s performance record for any quality citations, actions that resulted in suspension of referrals, Division of Health and Safety Regulation (DHSR) findings, Provider Performance Profile scores, as well as demonstrations of quality and best practice.
- Maintain up-to-date Provider Network database and Credentialing information.
- Schedule Provider Webinars and Provider Meetings on a regular basis and post the schedule on the Partners website.
- Post electronic updates on the Partners’ Provider Knowledge Base website.
Post official LME/MCO Provider Communication Bulletins and Alerts on the Partners Provider Knowledge Base website.

Designate a Provider Network Manager and a Provider Account Specialist for each provider.

Provide technical assistance to providers as needed.

Respond to provider inquiries and provide feedback in a timely manner.

Assist providers with understanding and complying with Partners’ policies and procedures, applicable policies and procedures of the Department of Health and Human Services and federal agencies including the Centers for Medicare and Medicaid, as well as the requirements of our accreditation agency.

Provide technical assistance related to Partners contract requirements; Partners’ Provider Operations Manual requirements; the development of appropriate clinical services; quality improvement initiatives; or to assist the provider in locating sources for technical assistance.

Make available to providers upon request, the results of its Needs Assessment which identifies under/over service capacity, as well as priorities for network development.

Actively recruit network providers with a mission and vision consistent with Partners.

Support the development of best practices or emerging best practices.

Identify service gaps in the network and develop a strategy to develop those services through existing providers or by recruiting new providers for the network.

Keep network providers informed through provider meetings, electronic updates, notifications and the Partners website.

Update the Provider Operations Manual to reflect changes in requirements.

Identify training needs for providers and, if possible, facilitate or provide the training.

Qualify, credential, and re-credential providers.

Conduct on-site monitoring of providers to ensure appropriate implementation of services, practice guidelines, member health and safety, member satisfaction, positive outcomes for members and compliance with provisions of the provider’s contract.

Ensure provider and practitioner compliance with treatment record standards and confidentiality practices and follow-up on any out of compliances or complaints regarding these areas.

Monitor systems continuously within the network for fraud, waste and abuse.

Review, mediate and/or investigate complaints received regarding the quality of services provided by any provider and ensure appropriate corrections are completed, if needed.

Review any Type A or Type B citations/violation/sanctions a provider may receive from the Division of Health Service Regulation (DHSR) and determine the impact of the citations/violations/sanctions on the members served by the provider.
Provide evaluative feedback relative to proficiency in providing culturally competent services.

PROVIDERS’ RESPONSIBILITIES

- Ensure members meet medical necessity requirements for all services requested and provided.
- Ensure members have input into their treatment plans. Have members and/or their legally responsible persons (LRP) sign and date the plan whenever the plan is developed, reviewed or revised.
- Comply with all service definitions and practice guidelines for the services being provided.
- Comply with all discharge planning requirements as listed in the Clinical Coverage Policy specific to the service being provided and in APSM 45-2 Records Management and Documentation Manuals

- APSM 45-2 states, “Discharge planning begins at the time of admission for all mental health and substance use services. Service providers must think about how an individual’s service needs can be fully and effectively met in the least restrictive capacity. Movement from a facility-based service, for example, to one in the community should be a seamless transition for the individual as a result of appropriate discharge planning. The step-down process should afford the individual the lesser-restrictive level of service needed without losing the focus of treatment or interventions required to facilitate continued progress.”

- As in APSM 45-2, “When it is determined that treatment is no longer necessary or no longer meets the conditions of most appropriate and least restrictive, a discharge summary shall be completed which contains the following elements:
  
  - the reason for admission,
  - course and progress of the individual in relation to the goals and strategies in the individual PCP or service plan,
  - condition of the individual at discharge,
  - recommendations and arrangements for further services or treatment, final diagnoses, and
  - dated signature.”

- “The discharge summary shall be completed within 30 days following discharge of the individual. The discharge summary is to be filed in the client service record. Once the discharge is complete, the record may be closed in accordance with directives given in APSM 45-2, Chapter 2 – The Clinical Service Record.”
Strive to achieve best practices in every area of service.

Participate in client satisfaction surveys, provider satisfaction surveys, clinical studies, incident reporting, and outcomes requirements.

Provide culturally competent services and ensure the cultural sensitivity of employees.

Develop a cultural competency plan and comply with cultural competency requirements.

Provide interpreting services for members who may require it.

Have a clinical backup system in place to respond to all crises/emergencies for members receiving services. Part of this clinical function is to develop crisis plans that are available to the providers’ clinicians, members and their natural supports, and Partners’ Access to Care Department. The clinical backup system will provide information and directions on how to seek assistance in a crisis/emergency including coverage for posted office hours, weekends, evenings and holidays for all members being served, or to serve as First Responder as outlined in the service definition of the contract.

Demonstrate member-friendly services and attitude. Providers must have a system to ensure good communication with members and families.

Comply with the policies and procedures outlined in this Provider Operations Manual, any applicable supplements, Partners’ Communications Bulletins and the provider contract, the general conditions of the contract, and applicable state and federal laws and regulations.

Provide services in accordance with all applicable state and federal laws.

Provide services in accordance with access standards and appointment wait times as noted in the general conditions of the procurement contract.

Have a ‘No Reject’ policy for members who have been determined to meet medical necessity for the covered services being provided or as a Licensed Independent Practitioner.

Provide members with 24/7/365 telephonic availability and/or access to a clinician or qualified professional in the case of an MH/IDD/SUD crisis or emergency. This contact may not be 911. This contact also may not be a hospital or Mobile Crisis Team unless that is the service being provided under contract with Partners, or unless the provider has subcontracted with and pays such providers directly for emergency backup services. The backup contact person must:

- have the qualifications, training and capacity to navigate the range of MH/IDD/SUD crisis scenarios a member may experience;
- advise the member and assist in the coordination of care during the crisis;
- be available telephonically and assist in-person if the situation requires; and
- have immediate access to crisis plans for members who have them.
CABHAs and other enhanced service providers must comply with additional First Responder duties outlined in state policies and service definitions.

Provide timely notice to Partners and ensure a smooth transition for members who desire to change providers, or when a member is discharged due to the provider’s inability to meet his/her needs.

Document all services provided per Medicaid requirements, NC Waiver requirements and state rules.

Agree to cooperate and participate with all utilization review/management, quality management, review, appeal and grievance procedures.

Comply with contractual and/or credentialing procedures to maintain active provider status.

Comply with authorization and utilization management requirements of Partners.

Comply with the Partners re-credentialing procedures.

Participate in member satisfaction surveys, provider satisfaction surveys, clinical studies, Incident Reporting, outcome requirements, and other surveys or questionnaires related to the capacity of Partners’ Provider Network.

Cooperate fully with any review, investigation, complaint inquiry, follow-up and audit.

Provide Partners with requested records and documentation needed to resolve issues, within the timeframe specified.

Maintain systems, procedures and documentation demonstrating compliance with all applicable federal, state and local rules, laws and practices, including:

- conduct self-monitoring activities for compliance; and
- develop and implement, within given timelines, plans of correction and/or paybacks with any area found out of compliance during Partners monitoring activities.

Conduct self-monitoring activities for compliance and develop and implement plans of correction for any non-compliance identified.

Comply with North Carolina State rules for service records, confidentiality and record retention to meet treatment record standards as detailed in the Medical Records Requirements section in the Provider Operations Manual.

Ensure all billing submitted for payment is supported by documentation meeting all requirements for billing a service.

Self-initiate paybacks for services billed in error or without supporting documentation.

Maintain services at an optimal level to meet member needs by providing services in accordance with Partners’ Clinical Practice Guidelines.

Be responsive to the cultural and linguistic needs of those served.

Work on a solution-focused and collaborative basis within the network.
• Work with Partners to mediate problem areas through the designated Provider Network Specialist.
• Comply with Partners’ credentialing or qualifying procedures to become a network provider.
• Comply with Partners’ authorization and Care Coordination requirements.
• If provider contract is terminated, network operations are closed or if closing business in NC, submit a plan to transition all members receiving services to another appropriate provider within the required time period as designated for the termination/closure type.
• If provider contract is terminated, network operations are closed or if closing business in NC, submit a plan for maintenance and storage of all Medicaid records for approval by Partners or transfer copies of all Medicaid member records to Partners.
• Sign and have a fully executed Partners’ Contract Amendment for any material change to the original contract.
• Submit reports or data elements as required in the contract to remain in “Good Standing.”
• Submit reports in attachments and adhere to reporting requirements.
• Notify Partners of prospective changes in site(s), assure all Partners qualification requirements are met and any contract amendments are in place prior to delivery of contracted services.
• Attempt to first resolve any disputes with other network providers or Partners through direct contact or mediation.
• Notify Partners in advance of mergers or change in ownership.
• Keep apprised of current information through the communication offered.
• Provide services per the most recent State standards or waiver service definitions.
• Attend and participate in Provider Webinars and meetings.
• Review the Partners Provider Knowledge Base at https://providers.partnersbhm.org/ and Partners’ general website at https://www.partnersbhm.org/ for updates on a regular basis.
• Review the State websites for most up-to-date information on a regular basis.
• Notify Provider Network within five business days of any changes in credentialed status, including but not limited to, scope of licenses, changes in privileged status at other organizations, and pending malpractice claims.
• Notify Provider Network within five days of personnel changes or updates including, but is not limited to changes in capacity, inability to accept new referrals, addition of capacity or specialty services, address changes and changes in other enrollment information.
WHAT IS THE NC INNOVATIONS WAIVER?

The Medicaid 1915(c) Waiver, most commonly referred to as "NC Innovations," is a Medicaid Waiver program for members with intellectual and other developmental disabilities. It is designed to give members and families an alternative to placement in an Intermediate Care Facility (ICF). NC Innovations offers services and support options designed to help members of all ages remain in their community and to live as independently as possible. The NC Innovations Waiver helps members have a role in planning and selecting how to receive and maintain community-based services for themselves. It helps empower the member to live a more independent life.

Provider Directed Services

A provider agency is the legal employer of staff. The member or legally responsible person is responsible for choosing the provider agency. The provider agency may choose to allow the member to be involved in the hiring, firing and training of staff.

Agency with Choice

A provider agency is the legal employer of staff. The member or legally responsible person is responsible for interviewing, training, and managing staff (with oversight by the agency and a qualified professional), making recommendations to the provider agency for hiring, firing, and working with the qualified professional to complete time sheets and other documentation.

SELF DETERMINATION

Individual and Family Directed Support Options

The NC Innovations Waiver gives people with disabilities clear choice about how they receive services. Participant Direction is a meaningful option for members as well as their families. In the NC Innovations Waiver, Participant Directed Services are called Individual and Family Directed Supports. Members can direct some or all the services that are paid through NC Innovations.
funding. This gives members and families more control over the way their services are provided, including the authority to manage an Individual Budget and employee/manage workers who provide support.

The models of Participant Direction described in this manual are included in the CMS-approved North Carolina Innovations waiver. No other model of Participant Directed Services may be offered to an individual in the North Carolina Innovations waiver. All Agencies with Choice must be approved by the LME/MCO. NC Innovations Services may only cover the services defined in the waiver and only be used to provide services, supports, equipment and supplies in the service definitions approved by CMS. Provider agencies may not offer the member an expectation of “savings” to use for equipment, supplies or any other incentive or an offer of a co-employment arrangement as a condition of provision of services to that member. Supervision of services must always be provided as written in the provider qualifications of the service definition.

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**Principles of Self Determination**

The Individual and Family Directed Supports Option is based on the principles of Self-Determination. Self-Determination empowers members to gain control over selecting the services or supports that meet their unique needs. It is a process that varies from person to person according to what each individual feels is necessary and desirable to create a satisfying and personally meaningful life. It is both person-centered and person-directed.

The Principles of Self-Determination are:

- **Freedom** – The ability of an individual, together with freely chosen family and friends, to plan a life with necessary supports rather than purchase or conform to a set program.

- **Authority** – The ability of a person with a disability (with a social support network or circle if needed) to control a certain sum of money to purchase services.

- **Autonomy** – The arranging of resources and personnel -- both formal and informal -- to assist an individual with a disability to live a life in the community rich in personal and community affiliations.

- **Responsibility** – The recognition of a person’s valued role in the community through competitive employment, organizational affiliations, spiritual development, and general caring of others in the community as well as accountability for spending public dollars in ways that are life-enhancing for persons with disabilities.
• Confirmation – The recognition of the importance of the leadership of self-advocates in the Self-Determination movement.

(From the work of Nerney, T. and Shumway, D.)

Advantages of Individual and Family Directed Supports

Participant Directed Services have been successfully implemented in Home and Community Based Waivers in many states, including North Carolina. Many advantages have been reported for participants including:

• Increased independence and self-sufficiency.
• Increased choice, flexibility, and control of services.
• Improved quality of services.
• Increased opportunities for a more healthy and productive life with better personal outcomes.
• Increased satisfaction with services.
• Increased use of people that the participant knows as employees.
• Expanded information to assist in decisions around spending of resources.
• Focused assistance to make participant direction possible.
• Authority to hire, train, supervise, and, if necessary, fire employees.
• Increased partnership between participants and professionals.
• Increased meaningful relationships in the community.

Models of Individual and Family Directed Supports

Two Models of Individual and Family Directed Supports are available:

• The Employer of Record Model allows the participant or the legally responsible person for the participant to be the individual who legally can exercise authority over workers and assume the other responsibilities associated with participant direction of services. The participant or the legally responsible person is known as the Employer of Record.

• The Agency with Choice Model allows the participant or legally responsible person for the participant to work with an agency that agrees to hire employees referred by
them. The agency approves/disapproves the hiring of the referred individuals and ultimately retains the responsibility of being the employer while allowing the participant or legally responsible person to partner in managing the employee’s training and supervision. The participant or the legally responsible is known as the Managing Employer.

Both models of Individual and Family Directed Supports are available in the Partners area.

**SCREENING, APPLICATION PROCESS, AND THE REGISTRY OF UNMET NEEDS**

Members may request to be screened for the NC Innovations Waiver by contacting Partners at 1-888-235-HOPE (4673). If a member’s first point of contact is outside of the Access to Care or I/DD Department, Partners staff can assist with accessing Partners’ toll-free number for referral information. Additionally, assistance in making a referral for other needed services is available.

Procedures are followed uniformly for all members requesting or presenting as potentially eligible for NC Innovations Services. The time and date of the initial contact with Partners is recorded. Such documentation is used in the event the member is determined potentially eligible for NC Innovations Services and placed on the Registry of Unmet Needs (i.e., waiting list). If funding is not available for needed NC Innovations services at the time of screening, the person is assessed for and may receive other appropriate services or may wait until funding becomes available. If the member has Medicaid, he or she may receive medically necessary Medicaid services that are currently offered by Partners through the (b)(3) Service Array.

To determine preliminary eligibility, Partners screens members for the NC Innovations Waiver, based on the waiver eligibility criteria outlined in the NC Innovations Waiver Manual and the member’s need for waiver services.

**THE SCREENING PROCESS CONSISTS OF:**

- Initial call between individual requesting the screening for NC Innovations waiver services and the I/DD Registry and Referral Specialist. The individual is given information regarding what documentation should be submitted to I/DD Registry and Referral Specialist for review of potential eligibility criteria (i.e., Psychological Evaluation, Developmental Assessments - Children’s Developmental Services Agency (CDSA), Treatment and Education of Autistic and Related Communication Handicapped Children (TEACHH) evaluation, Speech Therapy/Occupational Therapy/Physical Therapy Evaluations, Individualized Education Plan, etc.).
Once requested information is submitted to I/DD Registry and Referral Specialist, a review of the information takes place. A letter is then sent to the individual stating one of two scenarios:

1. Potential eligibility criteria have been determined and the individual has been placed on the Registry of Unmet Needs (wait list); or
2. Potential eligibility criteria have not been met and the member will not be placed on the Registry of Unmet Need list. Then the member will be notified by letter that he/she has the right to appeal the decision.

Partners may include the administration of the Support Intensity Scale (SIS®)/ North Carolina and a Risk Assessment during the time the individual is on the Registry of Unmet Needs. If health or welfare risks are identified, Partners may or will review the assessments and decide as to whether the person’s needs can be met on the waiver. Partners’ Associate Medical Director reviews the assessments of individuals who appear to be not eligible for the waiver, including those individuals who appear to have needs that cannot be met within the waiver cost limits, and makes the final determination. Individuals who appear to meet potential level of care for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF-IID) and whose needs cannot be met on the waiver are referred and/or discussed with the Olmstead Care Coordinator for potential ICF-IID placement.

### A person with intellectual disability and/or a related developmental disability may be considered for NC Innovations Waiver funding if all the following criteria are met:

- Be a U.S. citizen or provide proof of eligible immigration status
- Be a resident of North Carolina
- Have a Social Security number or have applied for one
- Apply and be approved for Medicaid at the local Department of Social Services (DSS)
- Be in one of the Medicaid aid categories that qualifies members for the NC MH/IDD/SUD Health Plan
- The member's Medicaid County of Residence is: Burke, Catawba, Cleveland, Gaston, Iredell, Lincoln, Rutherford, Surry or Yadkin counties
- Meet the requirements for ICF-IID level of care.

### ICF-IID Level of Care (LOC)

To meet this LOC, a member must:

1. Require active treatment. (Active treatment refers to aggressive, consistent implementation of a program of specialized and generic training, treatment and health services. Active treatment does not include service to maintain generally
independent persons who are able to function with little supervision or in the absence of a continuous active treatment program.)

AND

2. Have a diagnosis of mental retardation OR a condition closely related to mental retardation as defined here:

A. Mental Retardation is a disability characterized by significant limitations both in intellectual functioning and in adaptive behavior as expressed in conceptual, practical and social skills. The mental retardation must occur before the age of 18.

B. Persons with closely related conditions refer to members who have severe, chronic disability that meets ALL the following conditions:

1. Is attributable to cerebral palsy or epilepsy;

   Or

2. Any condition, other than an intellectual disability found to be closely related to mental retardation because the condition results in impairment of general functioning or adaptive behavior like a person with intellectual disability;

3. Is manifested before the person reaches the age of 22;

4. Is likely to continue indefinitely; And

5. Results in substantial functional limitations in three or more of the following areas of life activity:
   - self-care
   - understanding/use of language
   - learning
   - mobility
   - self-direction
   - capacity for independent living
I/DD CARE COORDINATION

Care Coordination is a managed care tool that is designed to proactively intervene and ensure optimal care for Special Needs Populations. Special Needs Populations are defined by specific diagnostic, functional and/or service utilization patterns that are indicators of risk and the need for assessment to determine necessity of further treatment. The goal of the Managed Care Waiver is to first identify members and intervene to ensure that they receive both appropriate assessment and medically necessary services. Partners’ Care Coordinators perform this function to provide necessary support for members meeting the criteria defined below. The goal is to ensure that members are referred to, and appropriately engaged with Providers that can meet their needs, for MH/IDD/SUD services and primary medical care.

The following is an outline of entrance requirements for I/DD Care Coordination:

A. The member receives Innovations Waiver funding;

OR

B. The member is in an ICF-IID setting and needs coordination to transition to an alternate level of care in the community;

OR

C. The person with an intellectual or developmental disability diagnosis who is currently, or have been within the past 30 days, in a facility operated by the Department of Correction (DOC) or the Department of Juvenile Justice and Delinquency Prevention (DJJDP) for whom Partners has received notification of discharge;

OR

D. Adults and children three years of age and older, who are functionally eligible for, but not enrolled in, the Innovations Waiver, who are not living in an ICF-IID facility, diagnosed with a developmental delay/disability or diagnosed with mental retardation manifested prior to the age of 22, or who have mental or physical impairments like developmental disabilities as the result of a traumatic brain injury manifested after age 22;

AND

E. The member requires coordination between two or more agencies, including medical or non-medical providers and there are no natural supports that can provide this coordination;

AND
F. The member has at least three unmet basic needs, such as safe and adequate housing, food, legal, educational, vocational, financial, health care, or transportation for necessary services.

### Specific Requirements for Providers of North Carolina Innovation Services

- Provider agencies may not provide incentives, gifts or the expectation of savings within a budget to attract any member or legally responsible person to enroll with their agency.
- **Complete the Health and Safety Checklist on an annual basis for any staff who provides Personal Care or Respite in the home of the agency staff person.** This Checklist does not apply to staff providing services under the Relative as Direct Service Employee Policy. The form is retained in the provider agency’s Employer of Record or Agency with Choice files and uploaded into AlphaMCS. Additionally, the provider agency’s Qualified Professional (QP) and/or Employer of Record/Agency with Choice QP is required to monitor services in the staff’s home monthly.
- Participate in the development of the member’s Individualized Service Plan (ISP) including the updates.
- Recruit personnel who meet the requirements.
- Implement the services authorized in the ISP.
- Develop short-range goals, training, and interventions/task analysis/strategies for achievement of long-range outcomes in the ISP with the member and or legally responsible person, and other planning team participants that are appropriate.
- Complete quarterly progress summaries and upload into AlphaMCS.
- Assist in the coordination of services and communication with the member /family.
- Monitor services authorized by Partners to ensure consistency with the ISP.
- Review and maintain adequate documentation of services making documentation available to Care Coordinators, Partners and others as needed.
- Notify the Care Coordinator about significant changes in the member needs and service delivery.
- Submit Incident Reports to Partners per State Rule requirements and NC Innovations policy. Per NC Innovations policy Level I Incident Reports are completed and submitted for all failures to provide back-up staffing for services approved in the ISP.
- Monitor notes and billing to ensure integrity of all claims submitted to Partners for payment.
- Provide the services as specified in the provider contract.
- Respond to emergencies of members and have a back-up system in place to respond to emergencies/crisis on weekends and evenings as outlined in the NC Innovations service.
definitions. Providers of Community Living and Supports, Residential Supports and Supported Living are required to have QP staff available as Primary Crisis Services Providers for emergencies that occur with members in their care 24 hours per day seven days per week or have an arrangement (memorandum of understanding) with a Primary Crisis Services Provider.

- Provide services in accordance with applicable state and federal laws.
- Document all services provided in accordance with the DMH/DD/SAS Records Management and Documentation Manual and the *NCTracks Provider Claims and Billing Assistance Guide*.
- Ensure back-up staffing is available when the lack of immediate care would pose a serious threat to the member’s health and welfare and formal Providers are not available. If back-up staff is not available, the Provider must complete a Level I Incident Report and submit to the Quality Management Department.
- Submit documentation required for verification of employment of relatives or legal guardians and adhere to disposition of the decisions made by Partners regarding this policy.

### Documentation

Provider Agencies are responsible for the development of short range goals and task analysis/strategies prior to implementation of the service. The task analysis is a process for determining in detail the specific behaviors required of staff to assist the member with the implementation of an outcome. Task analysis is the breakdown of how a task is accomplished, including a detailed description of any unique factors involved in or required for one or more people to perform a given task. For example: a task analysis would be used to assist a member with a specific self-help or daily living skill. A strategy is a long-term plan of action designed to achieve an outcome. Strategies are used to make a problem easier to understand and solve. Short
range goals and task analysis/strategies must be reviewed with and signed by the member/legally responsible person.

**Free Choice of Providers**

Members have free choice of providers within the Partners’ Network and may change providers as often as desired. If a member’s Medicaid changes to one of the counties within the Partners’ region and is already established with a provider who is not a participant in the network, Partners makes every effort to arrange for the member to continue with the same provider if he or she so desires. In this case, the provider would be required to meet the same qualifications as other providers in the network. In addition, if a member needs a specialized Medicaid service that is not available through the network, Partners arranges for the service to be provided outside the network if a qualified provider is available. Finally, except in certain situations, members are given the choice between at least two providers. Exceptions would involve institutional services or highly specialized services that are usually available through only one facility or agency in the geographic area. A listing of Network Providers is available to members and their families for review on Partners’ website on the Provider Search webpage (https://www.partnersbhm.org/provider-search/).

The Care Coordinator can assist the family to identify providers who have:

- Geographic Availability.
- Cultural Specialty.
- Disability Specific Specialties.

**NC Innovations Guidelines for Providers, Families, and/or Members Who Are Traveling Out of State**

- Services are for members who have been receiving services from direct care staff while in North Carolina and who are unable to travel without their assistance. Direct care staff is the individual providing one-on-one paid service, support and/or supervision to the member receiving Innovations services.
- Members who live in alternative family living homes or foster homes may receive services when traveling with their alternative family living or foster family out of state under these guidelines.
- Members who are residing in residential settings can go out of state on vacation with their residential provider and continue to receive services as long as the member’s cost of care does not increase.
- Waiver services may not be provided outside of the United States of America.
- Providers must ensure that the staffing needs of all their members can be met.
- Supervision of the direct service employee and monitoring of care must continue.
- The ISP must not be changed to increase services while out of state. Services can only be reimbursed to the extent they would have been had they been provided in state, and only for the benefit of the member.
- Supported employment and other vocational services may only be used to the extent that it would have been provided in state and should not be utilized during vacation time.
- If the direct care giver is family, the typical weekly schedule may not be altered for the time spent out of state. For example, if family typically provides care on Saturday and Sunday, but the time out of state is a week, the schedule should be maintained for the time out of state.
- Respite services are not provided during out of state travel since the caregiver is present during the trip.
- If licensed professionals are involved, Medicaid cannot waive another state’s licensure laws. A NC licensed professional may or may not be licensed to practice in another state.
- Medicaid funds cannot be used to pay for room, board, or transportation costs of the member, family, or staff.
- Provider agencies, Employers of Record and Agencies with Choice assume all liability for their staff when out of state.
- The provider agency will complete and sign the request. By signing the request, the provider agency agrees with the requests and all the above conditions.
- Upon completion, the provider agency will submit the request form AND the current Individual Support Plan (ISP) short term outcomes to the appropriate I/DD Care Coordination Manager for review.

*Written prior approval of this request for their staff to accompany families/ members out of state must be received from an I/DD Care Coordination Manager within the Partners Behavioral Health Management I/DD Care Coordination Department.*

Go to [http://providers.partnersbhm.org/nc-innovations/](http://providers.partnersbhm.org/nc-innovations/) for more details and the Out of State Travel Request Form.
CONTRACTORS AND VENDORS & SUPPLIERS FOR NC INNOVATIONS WAIVER SERVICES

Vendors and suppliers direct bill Medicaid for all equipment and supplies under their Durable Medical Equipment (DME) Vendor and/or supplier number. Equipment and supplies that vendors and suppliers direct bill Medicaid through their NC Innovations number is be billed through Partners’ procurement process.

NC Innovation Waiver Services that are required to go through the Partners’ procurement process include:

- Home Modifications (S5165)
- Vehicle Modifications (T2039)
- Community Transition (T2038)
- Individual Goods and Services (T1999)
- Community Networking Transportation (H2015U2)
- Assistive Technology Equipment and Supplies (T2029)
- Conferences covered under Natural Supports Education (S5111)
- Community Networking (H2015U1)

In addition, Specialized Consultative Services provided by a contracted Specialized Consultation vendor can be billed through Partners’ procurement process.

Specialized Clinicians (speech therapists, physical therapists, occupational therapists, recreational therapists, and nutritionists) are required to be enrolled into the Partners’ provider network as a vendor and are required to be credentialed through the credentialing contracted agency before being added to the approved vendor/contractor list. In addition, evaluations for home modifications, vehicle adaptations, and equipment will only be paid for if coverage under the state Medicaid plan has been exhausted.

ENROLLMENT & CREDENTIALING OF SPECIALIZED OUTPATIENT THERAPISTS FOR SPECIALIZED CONSULTATIVE SERVICES (T2025):

If a Specialized Outpatient Therapist wishes to provide evaluations under Specialized Consultative Services, he or she may initiate the process by completing the Partners’ Request for Nomination Form and submitting it accordingly.
Clinical Operations provides oversight of the Access to Care/Call Center, Care Coordination, and Utilization Management Departments. The Clinical Operations Team defines authorization guidelines, conducts authorizations, performs utilization management, operates a 24/7 call center for access to services and oversees the crisis response system. Additionally, it researches utilization trends to use for planning, identifies areas for further study and review and develops Clinical Guidelines and written protocols.

Partners has adopted Clinical Practice Guidelines from the American Psychiatric Association and the American Academy of Child and Adolescent Psychiatry that are approved by the Partners’ Quality Improvement Committee (QIC) and its sub-committee, the Clinical Advisory Committee (CAC). Adopted Clinical Practice Guidelines are available to providers on the Partners Provider Knowledge Base.

Providers are responsible for the following Clinical Practice Guidelines adopted by Partners. Adherence to the guidelines is monitored through:

- Focused audits by Utilization Reviews
- Routine reviews of Service Authorization Requests (identifying areas of concern)
- Peer review activities
- Quality of Care Committee activities
- Clinical Advisory Committee activities
- Medical record audits by the Provider Network Department
- Program Integrity monitoring, if indicated

Partners’ Access to Care Department provides a 24/7/365 access to behavioral health screening/triage/referral service for all catchment area individuals to determine eligibility, the level of acuity, and provider preference. The Access to Care Department does not use voicemail and all calls are answered live, in real time, by an Access to Care Representative. An Access to Care Representative screens and triages each caller/individual to determine the individual’s level of acuity and need for behavioral health services. As appropriate, the individual may be enrolled. The screening and/or enrollment guides the subsequent referral to emergent, urgent, routine, or community-based services.

After the initial enrollment, those who are eligible for Medicaid or state-funded services are offered a choice, when available, of at least two appropriate providers and are referred for an
intake assessment. Information on clinical specialties of providers, locations, hours of operation and services provided are available to assist the caller/member with determining choice. The Access to Care Department maintains a comprehensive list of hospital and inpatient facilities located across North Carolina and their specialties.

Access to Care offers appointment times or walk-in availability to each eligible caller/member with the provider of choice. Choice is determined by:

1. Availability of service.
2. Proximity to member.
3. Caller’s/Member’s desire for the services the provider offers.

In an emergent situation, Access to Care facilitates an immediate face-to-face assessment and/or a referral to an appropriate crisis provider. The Access to Care Department then follows up with all emergent and urgent referrals to ensure the safety of the member and to determine whether the member has engaged in services. *Once a provider acknowledges (accepts) a referral made by Partners via AlphaMCS, the provider is expected to follow up with the referral that was made to their agency to remind the member of the scheduled appointment, re-schedule the appointment, and/or assertively reach out to those members who do not show for their initial appointments.*

*Providers are to ensure that a routinely referred member is assessed within 14 calendar days and an urgently referred member is assessed within two days.*

The Access to Care Department, along with the Quality Management Department, conducts internal quality assurance reviews designed to assure that Partners’ members receive timely access to services based on the State’s timely access requirements for emergent, urgent or routine care.

**LANGUAGE SERVICES**

Access to Care can offer professional interpreting services within seconds, in 180 languages, through Pacific Interpreters/Language Line Solutions. This service is available 24/7/365, free of charge, to assist any non-English speaking caller/member contact the Partners Access to Care Department at 1-888-235-4673.
DEAF and HARD OF HEARING

Deaf and Hard of Hearing callers/members may contact Access to Care Department in two ways.

1. Call directly by using a TTY to dial the Partners TTY number, 1-800-749-6099. The hearing-impaired caller/member is then directed to leave a message. An Access to Care representative will respond to the message within 30 minutes.

2. The hearing-impaired caller/member may also contact the Access to Care Department by using a TTY to call 711/NC RELAY and then request assistance to call the Access to Care number 1-888-235-4673. The Telephone Relay Service at 711 provides a communication assistant who facilitates the call and the conversation between the hearing-impaired person via their TTY and the Access to Care employee.

FUNDING SOURCES ACCEPTED

Access to Care enrolls (when appropriate) and/or schedules eligible individuals with the following funding sources.

1. **Indigent/Uninsured** residents of Burke, Catawba, Cleveland, Gaston, Iredell, Lincoln, Rutherford, Surry and Yadkin counties.

2. **Medicaid-B** (any Medicaid Program Code covered under the Partners Medicaid 1915 (b)(c) Waiver) members MUST have Medicaid that originates from one of the above nine counties.

ADDITIONAL FUNDING SOURCE INFORMATION

Access to Care does not enroll or schedule individuals for appointments with the following payor sources unless they are Emergent within the Partners catchment area:

1. Private Insurance
2. Health Choice
3. Tricare
4. Medicare
5. Court ordered assessments, including DWI assessments as they are not paid by state dollars.

However, if after being assessed and receiving services from one of the above payor sources, the provider determines that the member meets medical necessity for a service that is not part of the benefit package, the provider may submit an Enrollment Request via AlphaMCS and enter a comment explaining why they are requesting enrollment and what service they are requesting to
provide. The provider also needs to complete the Coordination of Benefits (COB) section on page 2 of the Enrollment. This page is entitled “Additional Clinical Information.”

**INDIVIDUALS WITH MEDICARE**

There are very few providers offering Medicare covered services in Partners’ Network. Partners continues to explore the most effective way to help those with Medicare obtain needed services.

Partners is **not able to enroll, schedule and/or refer** individuals who have only Medicare as their primary insurer for behavioral health services. However, Partners Access to Care Department will assist individuals with Medicare, by:

1. Maintaining a list of behavioral health providers within our catchment area that accept Medicare; and/or
2. Linking Medicare individuals telephonically, when possible, to a provider in the network who accepts Medicare for the purposes of scheduling an appointment; and/or
3. Offering the caller, a list of providers that accept Medicare so he or she can call and schedule their own appointment; and/or
4. Instructing the individual to contact the telephone number on the back of the Medicare card; and/or
5. Continuing to assess/triage all callers with Medicare for emergent needs. If an **emergency** exists, Partners will assist the emergent caller/individual with a referral to Mobile Crisis, EMS/911 dispatch or may direct the caller/individual to a local hospital emergency department.

**Regardless of payer source**, Partners’ Access to Care Department will assist all callers triaged as Emergent by ensuring that the emergent individual receives a face-to-face service within two hours by offering a Mobile Crisis service, referring to EMS/911 dispatch or directing the individual to a local hospital emergency department. Please see above section titled “Additional Funding Source Information” for instructions regarding enrollment for non-Medicare covered services.

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For an up-to-date list of Medicare Providers, contact the Centers for Medicare and Medicaid Services (CMS) at 1-800-633-4227 or go to [http://www.medicare.gov/physiciancompare/search.html](http://www.medicare.gov/physiciancompare/search.html).
**Enrollments Completed By Partners’ Access To Care Department**

Enrollments initiated by Partners for emergent/crisis services are **APPROVED** immediately at the time of the enrollment. Approving the enrollment automatically assigns the individual an AlphaMCS record number and the effective date of state-funded benefit coverage.

All enrollments completed by Partners’ Access to Care Department are documented as follows on Page 2/Clinical Information of the enrollment:

<table>
<thead>
<tr>
<th>Primary Disability</th>
<th>Benefit Plan (previously Target Pop)</th>
<th>Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary MH</td>
<td>AMI - ADULT</td>
<td><strong>F99 Not</strong> otherwise specified</td>
</tr>
<tr>
<td></td>
<td>CMSED - CHILD</td>
<td></td>
</tr>
<tr>
<td>Primary SA</td>
<td>ASTER – ADULT</td>
<td><strong>F19.99 Other</strong> psychoactive substance use unspecified with unspecified psychoactive substance use disorder</td>
</tr>
<tr>
<td></td>
<td>CSSAD - CHILD</td>
<td></td>
</tr>
<tr>
<td>Primary I/DD</td>
<td>ADSN – ADULT</td>
<td><strong>F79 Unspecified</strong> intellectual disabilities</td>
</tr>
<tr>
<td></td>
<td>CDSN – CHILD</td>
<td></td>
</tr>
</tbody>
</table>

Providers are able to use the newly assigned medical record number to search AlphaMCS and access demographic information on the referred member.

If, after the provider sees and assesses the member enrolled and referred by Partners, corrections need to be made in the demographics and Benefit Plan (Target Pop) and/or diagnosis, the provider must submit an **Update Request** via AlphaMCS, to make the necessary corrections for treatment and/or billing purposes.

Access to Care enters a robust clinical note in the referral slot used to schedule each member. The Provider can access the clinical note and understand why the member is seeking treatment.
**ENROLLMENTS HANDED OVER TO PROVIDER**

Enrollments initiated by Partners for members being referred to a provider for urgent or routine services are started and handed over to the provider via Alpha MCS. Once the member shows for the appointment, providers have seven calendar days to complete the handed over enrollment and submit via AlphaMCS to Partners Enrollment and Eligibility Department. The Enrollment and Eligibility Department review for accuracy and completeness. Once accuracy is verified, the enrollment is approved. Approval automatically assigns a record number and the effective date of State-Funded Benefit coverage. Any enrollments that are incomplete or inaccurate are returned to the provider for corrective action and resubmission. Any enrollments not received correctly within the seven-calendar day timeframe will be updated to be effective the day of the correct submission.

**ENROLLMENT REQUESTS SUBMITTED BY CONTRACTED PROVIDERS**

To facilitate timely access to services, ALL contracted providers are expected to complete the AlphaMCS member enrollment **correctly, in its’ ENTIRETY (two pages total)** on uninsured members in the following instances, and submit to Partners within **seven calendar days**:

When the member 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.

All Enrollment Requests must be submitted to Partners within seven calendar days of assessing and enrolling the member. **No Exceptions.**

Enrollment Requests:

- Must be complete (page 1 and page 2);
- May not contain blanks or answers of “unknown;”
- Must contain a diagnosis, Benefit Plan (Target Pop) and complete SUD details (when a SUD diagnosis is documented); and
- Must have a matching screening date, admission date and start date of diagnosis and Benefit Plan (Target Pop).

Before submitting a new Enrollment Request, the provider should **always** search AlphaMCS for the member and a current enrollment. **If an AlphaMCS number is found, providers need to ALWAYS determine if the member has an effective date for state and/or MEDICAID insurance.**

Providers may search AlphaMCS for referred or previously seen members by:
Entering first name, last name and date of birth.
Entering last name, first name and Social Security number.

Intake assessments are completed by licensed clinicians. The enrollment information may be keyed in to AlphaMCS by any employee, however the name entered into the enrollment form as the person who completed the enrollment must be the name of the licensed clinician who completed the assessment and gave the diagnosis. His or her professional credentials must be included.

Make certain the presenting problem by member age/disability -> Benefit Plan (target pop) -> diagnosis all match. For example, if the member is a child, be sure the presenting problem and member age/disability is checked for a child and that a child Benefit Plan (Target Pop) is indicated on the Additional Clinical Information, page 2.

If the “in need of detox” question is checked yes, the following must also be documented:

- withdrawal symptoms; and
- at least one SU diagnosis.

Information related to the Enrollment Comment section:

- When Partners returns an Enrollment Request pended or denied, there is always an explanation in the comment section.

- Should the Enrollment Request be returned with a note in the comment section, please do not delete the note entered by Partners when the Enrollment Request is re-submitted.

- If a reply comment is needed, enter the date and the comments directly under the note entered by Partners staff.

- Once comments are entered by Partners and/or the provider they are never to be deleted.

Provider Requests for Enrollment may not be back dated to cover dates of service when the member 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.

If the Enrollment Request is submitted to Partners via AlphaMCS after seven calendar days of the SCREENING/ADMISSION date, the date that the Enrollment was submitted to Partners is considered the effective date of the State Benefit Plan. No Exceptions.

Providers may not back date the ADMISSION DATE on a Request for Enrollment to cover dates of service after a member becomes ineligible for Medicaid coverage and before the member was appropriately enrolled in the State Benefit Plan.
The SCREENING DATE and the ADMISSION DATE of the Provider Enrollment Request must match and should be the same date that the provider completed the comprehensive clinical assessment (screening) and admitted the member.

Admission date must match screening/intake date and may not precede it.

The provider should always search AlphaMCS for the member and an enrollment thoroughly before submitting a New Enrollment Request. If an AlphaMCS number is found, it is imperative to ALWAYS determine if the member has an effective date for STATE and/or MEDICAID insurance.

Update Requests Submitted by Contract Providers

All requests for changes to a currently enrolled member’s record must be made by submitting an Update Request via AlphaMCS.

Providers should note that update requests cannot go back further than 90 days from the date of submission. If an update request is submitted outside of the 90 day period, the effective dates(s) will be changed to retro back 90 days. This applies only to diagnosis, benefit plans and substance use. State layer funding effective dates cannot be changed outside of the seven day enrollment period rule.

Prior to submitting an Update Request to change a Benefit Plan (Target Pop), check AlphaMCS to ensure that the member has a State Benefit effective date with no end date.

If a search has been done correctly and the member does not display in AlphaMCS as actively enrolled to State Benefits, an Enrollment Request must be submitted.

When submitting an update request for a change of name and/or Social Security number, providers are responsible for making certain that the name and/or Social Security number on the update request matches the member’s Social Security card prior to requesting an update of a member’s name in AlphaMCS. The provider should notify Partners via a note in the Update Request when this verification process has been completed. Otherwise, Partners returns the Update Request for appropriate verification.

When submitting an Update Request for a change in the member’s date of birth (DOB), providers are responsible for verifying the DOB requested on the Update Request matches the DOB on a valid NC ID, driver’s license or birth certificate. The provider should notify Partners via a note in the Update Request when this verification process has been completed. Otherwise, Partners returns the Update Request for appropriate verification.
State Benefit Plan (formerly Target Populations)

1. A State Benefit Plan must always be documented on the Additional Clinical Information page 2.
2. Always enter an end date for the State Benefit Plan.
3. ASTER, AMI, AMVET, ASCDR, ADSN Benefit Plans may be extended until 2099.
4. ASWOM Benefit Plan is valid for one year. Qualifiers must be reviewed annually and if the member still qualifies, a Client Update Request must be submitted to renew the benefit plan for an additional year.
5. CMSED, CSSAD, CDSN Benefit Plans may be extended until the day prior to the child’s 18th birthday.
6. GAP Benefit Plan and may be extended no longer than 60 days.
7. PRIOR to submitting an update request for a State Benefit Plan, ALWAYS check AlphaMCS to determine what Benefit Plan(s) and end dates are documented. The State Benefit Plan dates requested should not, in any way, overlap dates that are already in AlphaMCS. For example: if there is already a State Benefit Plan documented in AlphaMCS with an effective date of Dec. 15, 2012 with an end date of Dec. 14, 2013 and the end date needs to be extended, the end date cannot be extended by entering a new “overlapping” Benefit Plan with a start date of November 20, 2013 and an end date of Nov. 19, 2014.
8. Prior to adding or updating a Benefit Plan for a member, the Provider should always search AlphaMCS under Menu -> Patient Maintenance -> Docs, Assignments Tab -> Target Pop Tile, to see what State Benefit Plan (Target Populations) are already entered in AlphaMCS.

9. If the Benefit Plan, that the member needs, is not found under the AlphaMCS Target Pop tile, the provider needs to enter the appropriate Benefit Plan with an appropriate effective date and end date.
10. If the Benefit Plan, that the member needs, is found under the AlphaMCS Target Pop (Benefit Plan) tile:
   a. The provider needs to make certain the Benefit Plan has an appropriate end date.
   b. The effective date of the Benefit Plan found in AlphaMCS will ALWAYS remain the same and the provider may not make any changes to the effective date.
c. If the end date of the Benefit Plan needs to be adjusted, the provider needs to create a new entry with the same effective date that is documented in AlphaMCS for that Benefit Plan and 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 Benefit Plan, it would be necessary to create a new entry with an effective date of 3/29/2012 and an end date of 3/28/2099.

11. If a Benefit Plan with an incorrect effective date has been submitted and Benefit Plan approved and needs to be corrected, the Provider must request correction of the Benefit Plan via an additional update request. **The Provider can note this in the comment section of the Update Request.**

**ZIP CODES**

It is important to use only the five-digit zip codes. Entering the four-digit extension or zeros in place of the extension may prevent the Benefit Plan (Target Pop) from updating to NC Tracks correctly.

**ACCESS TO CARE REFERRALS TO PROVIDERS**

Providers wishing to receive direct referrals from the Partners’ Access to Care Department must:

1. Inform the Access to Care Director of their plan to use the scheduler; Participate in training on the slot scheduler offered by Partners;
2. Offer appointments to Access to Care by entering them in the AlphaMCS Slot Scheduler; **and**
3. Either employ a Psychiatrist or have an active professional referral relationship with a Psychiatrist(s) so, when medically necessary, a referred member has easy access to Psychiatric services.
WHEN SHOULD PROVIDERS REFER A MEMBER TO ANOTHER PROVIDER?

When a member is actively engaged in treatment with a Partners’ Network Provider and:

1. He or she needs a service that the current service provider does not offer; or
2. He or she is requesting a referral to a new provider for the same service.

REQUEST FOR CHANGES TO ENROLLED MEMBER RECORD

All requests for changes to a currently enrolled member’s record with active state funding must be made by submitting a Client Update Request (CUR) via AlphaMCS. Providers should note that CURs cannot go back further than 90 days from the date of submission. If a CUR is submitted outside of the 90-day period, the effective date(s) will be changed to retro back 90 days. This applies only to diagnosis, benefit plans and substance use. State layer funding effective dates cannot be changed outside of the seven-day enrollment period rule.

If you have questions, please contact Becky Ford, Enrollment and Eligibility Supervisor, by emailing bford@partnersbhm.org or calling 336-527-3211.

THE ALPHA MCS SLOT SCHEDULER - SCHEDULING APPOINTMENTS

Access to Care schedules appointments when:

1. Callers/members are accessing the system for the first time;
2. Callers/members call requesting to change or add a provider and have not been successful initiating a provider to provider referral; and/or
3. Attempting to schedule a hospital discharge appointment for an individual who appears to be an active member and the member has not received services in more than 60 days.
Hospital Discharge Appointments

Hospital discharge appointments for ACTIVE members should be scheduled by the member’s provider, rather than Access to Care. When Access to Care is contacted by a hospital for a hospital discharge appointment FOR AN ACTIVE MEMBER, Access to Care:

- Will call the provider and requests the provider to offer the member an appointment; and
- Will refer the member to Care Coordination.

Provider Portal & Management of the Slot Scheduler

Providers using the Slot Scheduler to receive direct referrals enter appointments on a consistent basis. The appointment description includes the following information:

a. Funding source, State Benefits or Medicaid
b. Child/Adolescent/Adult
c. Disability: MH/IDD/SUD
d. The start time and expected duration of the appointment
e. Other – any other pertinent restrictions or information that the provider wants Access to Care staff to share with the member being referred

Providers maintain their schedules so there are always appointments available for the next 14-21 days.

Providers must acknowledge (accept) all referrals made to them via the Slot Scheduler within 24 hours or next business day, by checking the acknowledgement checkbox in the referral.
Providers unable to acknowledge (accept) the referral email Access to Care at AccessStaff@partnersbhm.org and inform Access to Care that the member needs to be scheduled with another provider and why.

Providers that acknowledge and accept a referral are also expected to resolve the referral slots at the time of the appointment by entering the “status” of the referral to include (show, no show, cancelled, re-scheduled etc.) as soon as possible at or just after the time of the appointment. This is very important and crucial to Partners ability to track information for required reporting.
Access to Care tracks the slot resolution process and notifies providers of all unacknowledged and/or unresolved slots via email daily. Providers are expected to respond by acknowledging and/or resolving all unmanaged slots.

Providers who desire regular referrals from Partners receive them by entering available slots into the AlphaMCS Slot Scheduler. When there are no available slots in the Slot Scheduler and Access to Care makes a referral (such as a phone referral) to a provider outside the Slot Scheduler, the provider is expected to enter a corresponding slot into the AlphaMCS Slot Scheduler for Access to Care to use so the referral may be tracked for resolution.

Providers are expected to follow up on all ROUTINE members referred to them by Access to Care who have been acknowledged (accepted) and who no show for their appointments within 24 hours to re-schedule and engage them in services.

**Accessing Routine Services**

A ROUTINE member is any individual who presents with mild risk or incapacitation in one or more area(s) of safety, or physical, cognitive, or behavioral functioning related to MH/IDD/SUD problems.

The Access to Care standard for Routine Services is to arrange for face to face assessment or treatment services within 14 calendar days of contact. The geographic access standard for services
is 30 miles or 30 minutes driving time in urban areas, and 45 miles or 45 minutes driving time in rural areas.

**ROUTINE REFERRAL PROCESS**

1. The Access to Care Staff collects demographic information from the caller/member and searches for the member in the AlphaMCS System.
2. Members triaged as Routine are scheduled with a face-to-face appointment within 14 calendar days of initial contact or offered an opportunity to walk into an Open Access or walk-in clinic. This includes all members who request and qualify for services and have no evidence of acute need or imminent crisis. Members are scheduled for their initial appointment with a Clinical Home Provider of their choice through the AlphaMCS Slot Scheduler. Once the referral is made and acknowledged (accepted) by the provider, all further scheduling is done by the provider.
3. Whenever possible, eligible members triaged as Routine are offered a list of available providers from which they can select their choice of Clinical Home.
4. The standard for scheduling state and/or community hospital discharges is within seven days.
5. All routine referrals are tracked and resolved for attended, no show, reschedule or cancellation by the provider with oversight by the Partners.
6. Partners’ Network Providers are held to the following standard regarding appointment wait time for ROUTINE referrals:
   - Scheduled → one hour
   - Walk-in → within two hours

**Accessing Urgent Services**

An Urgent member is any individual who presents with moderate risk or incapacitation in one or more area(s) of physical, cognitive, or behavioral functioning related to MH/IDD/SUD problems.

The Access to Care Standard for Urgent Care is to arrange for face to face services within two days of contact. The geographic Access to Care standard for services is 30 miles or 30 minutes driving time in urban areas, and 45 miles or 45 minutes driving time in rural areas.

**URGENT REFERRAL PROCESS**

1. A member’s clinical need may be considered URGENT if, but not limited to the following:
   - The member is reporting a substance use-related problem;
   - The member is being discharged from an inpatient substance use treatment facility; or
1. The member seems at risk for continued deterioration in functioning and/or becoming Emergent if not seen face to face within two days.

2. All callers triaged as Urgent are managed by an Access to Care licensed clinician.

3. The Urgent member is seen face to face within two days of contact if the member is experiencing a more slowly evolving crisis and a catastrophic outcome is not imminent. The member may be experiencing or expressing hopelessness, helplessness, or other intense feelings or life stressors. Providing rapid access to care is likely to avert the development of a behavioral health emergency. This level of acuity includes members who are intoxicated or in withdrawal seeking treatment whose motivation for treatment might be enhanced by rapid entry to services.

4. Members triaged as having Urgent needs are offered choice for face-to-face assessments within two days. If the member can contract for safety, he or she is provided an appointment and choice for Clinical Home in the Partners’ Provider Network or offered an opportunity to walk in to an Open Access or walk in-clinic. An appointment is made through the AlphaMCS Slot Scheduler and contact is then made with the provider of choice via a phone call and/or an email generated through the Slot Scheduler. If the member is already active in the Partners’ Network, every attempt is made to engage and link the member back to his or her own Clinical Home/First Responder, for crisis intervention and resolution.

5. The Access to Care Clinician reminds the member that the Partners’ Access to Care Center is available 24 hours a day and instructs the member to call the Access to Care number by telephone at any time 24/7/365 should his or her situation escalate and require immediate attention.

6. Partner’s Access to Care Department continues to follow-up with any Urgent contact until it is ascertained that the member has been able to receive the care that is most appropriate to meet his or her clinical needs. All Urgent referrals are tracked and resolved for attended, no show, reschedule or cancellation by the provider and Partners.

7. **Partners’ Network Providers are held to the following standard regarding appointment wait time for URGENT Referrals:**
   - Scheduled Appointment → one hour
   - Walk-in → within two hours

**ACCESSING EMERGENT SERVICES**

An Emergent member is any individual, regardless of eligibility or payer source, who has a moderate or severe risk related to safety or supervision, or

1. Member is at moderate or severe risk for substance use withdrawal symptoms; or
2. Member presents a mild, moderate, or severe risk of harm to self or others; or
3. Member has severe incapacitation in one or more area(s) of physical, cognitive, or behavioral functioning related to MH/IDD/SUD problems.

The Access to Care standard for Emergency Services is to arrange for face to face services within two hours or immediately for life-threatening emergencies. The geographic Access to Care standard for services is 30 miles or 30 minutes driving time.

**EMERGENT REFERRAL PROCESS**

1. The Emergent member is one who is experiencing an acute BEHAVIORAL health crisis which requires immediate intervention. The crisis may involve sudden and intense disturbance in thinking, mood, or relationships. There may be imminent danger to the member or others, intense and disturbing delusions, command hallucinations, or a gross inability to care for self. The Emergent member includes those who are intoxicated or in active withdrawal and are or will be at serious risk for self-harm/safety if unable to access services without immediate assistance.

2. All calls that are deemed to be Emergent are managed by an Access to Care licensed clinician. The Access to Care Clinician determines through clinical screening whether the member presents an immediate danger to self or others. If the member is an imminent danger to self or others, the Access to Care Clinician implements the appropriate crisis intervention procedures as an attempt to stabilize the member. The clinician attempts to determine whether there are any available supports for the caller and when possible, speaks to them directly for assistance.

3. The Emergent member is kept on the line without being put “on hold” and the crisis is followed by an Access to Care Clinician until the Emergent member is considered safe and has been able to receive the care that is most appropriate to meet his/her clinical needs.

4. Emergent members are seen face-to-face within two hours or directly linked to 911 depending on severity of need, imminent danger, and medical needs so that face to face care is provided immediately for life-threatening emergencies.

5. Members triaged as emergent who are not actively engaged with a Partners’ Network Provider are immediately referred to Mobile Crisis, 911, emergency services or the nearest Emergency Department. Those who are already active with a provider are linked back to their Clinical Home agency for First Responder crisis intervention and resolution. Mobile Crisis is always available to a First Responder for consultation and/or crisis response assistance when appropriate.

6. Members are informed of the availability and types of Crisis Services in the Partners’ area.
through the *Partners’ Member Handbook*, various print materials, Community Collaborative meetings, System of Care Coordination efforts, website postings and local media.

### Crisis/First Responder

1. Members who are actively engaged with a Partners’ Network Provider are screened for acuity and linked to their Provider/Clinical Home Provider/First Responder by telephone. All providers, particularly providers of Enhanced Services, are required to provide First Responder services for their members. NC Innovations providers of Residential Supports, Supported Living and Community Living and Supports are First Responders, as providers of Crisis Services – Primary Response. The Person-Centered Plan must include a well-developed crisis plan, identify the Clinical Home, and identify the means **BY WHICH THE MEMBER CAN ACCESS THEIR FIRST RESPONDER** and/or a provider contracted by their provider to deliver crisis care after business hours.

2. If the member is in crisis, the First Responder may initially respond with a phone call. **However, prior to the member accessing a higher level of care or receiving Mobile Crisis, the provider/First Responder must respond face-to-face to assess the member and attempt to resolve the crisis.**

3. Members triaged as EMERGENT, require crisis intervention and do not have a service provider, are referred directly to an appropriate crisis service based on their acuity.

4. Based on the member’s acuity and present problem, Access to Care staff may:
   - Dispatch Mobile Crisis
   - Request police assistance
   - Contact 911 for immediate assistance
   - Send the member directly to the nearest emergency crisis facility

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**Partners’ Network Providers are held to the following standard regarding Appointment Wait Time for EMERGENT Referrals:**

Providers will see all Emergent referrals within two hours for non-life-threatening emergencies.

If the emergency is life threatening, the provider should seek assistance from the appropriate law enforcement, emergency medical services (EMS) or fire and rescue services so that an immediate face-to-face response is rendered.
Partners utilizes the AlphaMCS Information Technology system to receive requests for authorization. The information is entered into a Service Authorization Request (SAR), which includes:

- Provider name and site code for where services are to be offered.
- Authorization date range.
- Services requested per Benefit Plan (Medicaid B, Medicaid C, Medicaid B3, and State).
- Guardian/relationship to member.
- Member’s disability: MH, IDD, SU.
- ASAM level is recommended for all members with a substance use and co-occurring disorders that include a substance use disorder diagnosis.
- LOCUS/CALOCUS /CANS scores for members are recommended for members with a mental health diagnosis only and co-occurring disorders that include a mental health diagnosis.
- NC-SNAP or Supports Intensity Scale for Individuals with Intellectual or Developmental Disorder.
- Primary Care Physician and release of information
- Medications dosage, frequency and compliance with medications.
- ICD-10 Diagnoses.
- Substance use details.
- Justification for services (provider comments).
- Uploaded documents as indicated on the current benefit plan.
- Providers can see reviewer comments in comments section. If additional information is requested and it is possible, three calendar days are allowed for a response to the request. Failure to do so could lead to the request being administratively or clinically denied.

Partners’ Utilization Management (UM) Department’s function is to make authorization decisions by conducting initial, continuing care and retrospective reviews of services based on whether medical necessity is substantiated in the request for authorization. The UM Department utilizes guidelines based on the North Carolina Division of Medical Assistance (DMA) Clinical Coverage Policies and Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH) State Funded Service Definitions. Partners does not offer incentives to Utilization Management employees or providers to deny (reduce, terminate or suspend) limit or discontinue medically necessary services to any member. There are no financial rewards for UM decision makers that would discourage approval of services. Decisions made by Partners’ UM are based only on the appropriateness of care, the service requested, and existence of coverage. State-Funded Services utilize Benefit Plan Eligibility criteria that crosswalk from the member’s diagnosis, age, disability group and other designated criteria. The State Benefit Plan then crosswalks to the
Array of Services available to members that meet the requirements of a specific Benefit Plan. The State Benefit Plan Eligibility criteria has been revised, effective as of August 1, 2014 to coincide with the changes in the Diagnostic and Statistical Manual-5 (DSM-5), also effective August 1, 2014. Providers are strongly encouraged to review the criteria for a DSM-5 diagnosis and all State Benefit Plan requirements. A State Benefit Plan does not apply to members who are only receiving Medicaid services. The most current version of State Benefit Plan Criteria can be found on the NC Division of MH/DD/SAS website.

**AUTHORIZATION PROCESS**

**Inpatient Behavioral Health Facilities**

Hospitals that have State-funded or Three-Way Contracts must complete the *Special Project Enrollment Form* and submit to Partners’ Access to Care department. The submission of this form will ensure the member is enrolled for benefits with Partners. For authorization and reimbursement, patients must be enrolled with Partners. Enrollment status can be determined by checking the AlphaMCS system or calling Access to Care at 1-888-235-4673.

Partners UM reviews all Inpatient Service Authorization Requests (SARs). Utilization Management (UM) staff are available 8 a.m. to 7 p.m., seven days per week, including weekends and holidays. Inpatient/Acute UM staff can be contacted at 704-842-6434.

A SAR begins with the admission day and does not include the day of discharge. Hospital staff are responsible for determining the number days authorized and when the next SAR is due.

**Submitting Inpatient Requests**

Information requested on the *Inpatient Review Form* is required with each SAR. [https://providers.partnersbhm.org/hospitals-working-partners/](https://providers.partnersbhm.org/hospitals-working-partners/)

The Inpatient Review Form can be completed and attached to the SAR. If the form is completed and attached, then that information does not need to be duplicated in the SAR justification.
However, if the Inpatient Review Form is not completed and attached, then the information requested on that form needs to be documented in the SAR justification.

The Initial or Continued Stay SAR information will be reviewed, and the requested service will be approved if Medical Necessity criteria (CCP 8B) for inpatient Hospitalization has been established. If further clinical information is needed, UM staff will attempt to call the hospital to obtain additional information. If UM is unable to approve based on the information received, the request will be referred for a Peer Review. In the result of an Adverse Decision, a provider can request a Peer to Peer Review within five business days by calling the UM Appeals Department, 704-884-2650.

If it is after traditional business hours (i.e.: after 5 p.m.), UM will attempt to set up a Peer to Peer review. If there is no Hospital UR coverage and/or UM cannot obtain an attending physician’s contact information, a Peer Review may be done without consultation. In the result of an Adverse Decision, a provider can request a Peer to Peer Review within five business days by calling the UM Appeals Department, 704-884-2650.

Hospital Utilization Staff will need to check the AlphaMCS system to determine the number of days authorized and when the next review is due.

| Initial Inpatient Requests |

Always refer to the Medicaid and State-funded Benefit Plans for the most up-to-date information on recommended/required documents and benefit service limits: [https://providers.partnersbhm.org/benefit-grids/](https://providers.partnersbhm.org/benefit-grids/)

**Medicaid (101)**

Service Authorization Requests (SARs) should be submitted **within 48 hours of admission**. Hospitals can request up to **three days for Medicaid, 101** for initial authorization. A SAR begins with the day of admission and does not include the day of discharge.

Clinical Coverage Policy 8B, allows a hospital **up to 48 hours from time/date of admission** to notify a LME/MCO of the admission. If Initial 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 medical staff determine medical necessity is not met, the request may be fully or partially denied.
If SARs are submitted after the first 48 hours, UM will review for the 48 hours prior to the submission date of the SAR and will not process days outside of that 48-hour timeframe.

**IMD Medicaid (160)**

Medicaid beneficiaries age 21-64, who meet medical Necessity for inpatient care may be treated at an Institute for Mental Disease (IMD) **up to 15 days per calendar month**.

Effective July 1, 2018, Hospitals can submit a Service Authorization Requests (SAR) **within three business days of discharge**, for the entire Length of Stay (LOS). Hospitals do have the option of seeking authorization upon admission.

Refer to Partners Medicaid and State Benefit Grids, located at https://providers.partnersbhm.org/benefit-grids/ for the most up-to-date benefit limits and documentation requirements.

*For 0160- IMD admissions spanning two consecutive months, the total length of stay may exceed 15 days, but no more than a 15-day LOS each month is eligible for authorization for Mental Health IMD admissions. Effective July 1, 2019, Substance Use IMD Length of stay may exceed 15 days per month.

**Three (3)-Way (YP821, YP821SA, YP822, YP822SA)**

Authorization is required for Initial State and Three-Way Funded Service Authorization Requests (SARs) **within three calendar days of admission**.

Three-Way providers have **up to three calendar days, after midnight of the day of admission** to submit a Service Authorization Request (SAR). Partners Utilization Management staff will review the documentation and SAR for medical necessity back to the date of admission. If Medical Necessity is met, the request will be approved beginning with the first day of admission. If Medical Necessity is questionable, the request will be reviewed by Partners medical staff. If the medical staff determine medical necessity is not met, the request may be fully or partially denied.

A **SAR begins with the day of admission and does not include the day of discharge.**

Refer to Partners Medicaid and State Benefit Grids https://providers.partnersbhm.org/benefit-grids/ for most up-to-date benefit limits and documentation requirements.
Continued Stay (Concurrent) Inpatient Requests

PRIOR AUTHORIZATION IS REQUIRED for any Continued Stay Service Authorization Requests (Medicaid, 101; State, YP820; or Three Way YP821/SA, YP822/SA). Continued stay SARs will not be reviewed retroactively. A SAR must be submitted in the Alpha MCS on the last day of the current authorized time-frame or on the first day service is continued.

Refer to Partners Medicaid and State Benefit Grids [https://providers.partnersbhm.org/benefit-grids/] for most up-to-date benefit limits and documentation requirements.

**Medicaid IMD (160):**

Hospitals do have the option of submitting continued stay SARs during a LOS. In that case, A Service Authorization Request (SAR) must be submitted in the AlphaMCS on the last day of the current authorized time-frame or on the first day service is continued. Continued stay SARs will not be reviewed retroactively.

Refer to Partners Medicaid and State Benefit Grids. [https://providers.partnersbhm.org/benefit-grids/] for most up-to-date benefit limits and documentation requirements

**Exceptions for Inpatient Benefit Plan Limits**

Always refer to the Medicaid and State-funded Benefit Plans for the most up-to-date information on required/recommended documents and benefit service limits: [https://providers.partnersbhm.org/benefit-grids/]

**Involuntary Commitment (IVC) Admissions:**

Partners recognizes when an involuntary commitment leads to a member being admitted to a psychiatric inpatient unit, the facility needs time to fully assess the need for the commitment to stand or be dismissed. Since the law related to involuntary commitments legally allows the facility to take up to 72 hours to complete their evaluation, **UM will authorize the initial three days for these admissions.**

If the third day of the authorization falls on a Saturday or Sunday, Partners will allow the request to extend to Monday as outlined below.
Weekends

Effective June 20, 2019, Partners began allowing an exception for SARs with a length of stay covering including a weekend day. Specifically, hospitals submitting SARs with an end date of Saturday can request one additional day to extend the maximum allowed days requested to four (allowing a request for Thursday, Friday, Saturday and Sunday). A continued stay SAR must be submitted on or by end of Inpatient business day hours on Monday. SARs will be reviewed for Medical Necessity.

UM inpatient/acute staff will still be available seven days a week including holidays. If a hospital needs or chooses to submit a SAR during that time, UM inpatient/acute staff will be available from 8 a.m. until 7 p.m.

Monday Holidays

Effective April 24, 2019, Partners has begun a similar exception for holidays that are on a Monday. Hospitals can submit a SAR for one additional day (maximum four-day length of stay request) to make a request through a holiday weekend. For example, if a three-day SAR is submitted with a start day of Friday, hospitals can request Friday, Saturday, Sunday and the Monday-holiday. A continued stay SAR must be submitted on or by end of Inpatient business day hours on Tuesday. SARs will be reviewed for Medical Necessity.

Alternative Methods for Requesting Authorization (No Computer Access)

For efficiency and to minimize reimbursement/claims issues, it is strongly recommended that all requests be submitted in the AlphaMCS system used by Partners UM. Providers may contact the Service Desk, 704-842-6431, to request login information and assistance.

For circumstances when AlphaMCS cannot be utilized, Service Authorization Requests can be processed:

1) Live Review By Phone: Hospital Staff will need to call 704-842-6434, to reach a UM Inpatient/Acute staff between the hours of 8 a.m.-7 p.m., daily, Sunday-Saturday. The UM staff will collect information detailed on the Inpatient Review Form;

Medicaid Hospitals without a contract with Partners

Hospitals are expected to follow the established processes for requesting services through AlphaMCS system. To begin the process, hospitals that are outside of Partners’ catchment area and do not have a contract with Partners need to complete and submit the *Out of Network Hospital Member specific Agreement* and *Inpatient Review Form* to a secure email address at Providers@partnersbhm.org.

If the hospital does not have access to AlphaMCS, Initial and Concurrent Service Requests can be submitted via Manual SARs. These should be emailed to providers@partnersbhm.org.

**RETROACTIVE MEDICAID SERVICE AUTHORIZATION REQUESTS**

**Provider Alert-February 26, 2020**

EFFECTIVE February 24, 2020, Partners Utilization Management Department will review requests for Retroactive Medicaid requests within 90 days from the Modified Date in NC TRACKS. This is a change from the 30 day timeframe posted in the *February 2019 Provider Bulletin #90*. All Retroactive Service Authorization Requests (SAR) must be submitted to UM for medical necessity review. For further questions on Retroactive Medicaid requests, please contact the MHSU UM Workgroup at 704-842-6436 or MHSU UM Acute Team Workgroup at 704-842-6434.

**POST STABILIZATION SERVICES**

Partners is financially responsible for post-stabilization services obtained within or outside the entity that are pre-approved by a plan provider or other entity representative. Partners is financially responsible for post-stabilization care services obtained within or outside the LME/MCO that are not pre-approved by a plan provider or other LME/MCO representative but administered to maintain the member’s stabilized condition within one hour of a request to the entity for pre-approval of further post-stabilization care services.
Partners is financially responsible for post-stabilization care services obtained within or outside the LME/MCO that are not pre-approved by a plan provider or other LME/MCO representative, but administered to maintain, improve or resolve the member’s stabilized condition if Partners does not respond to a request for pre-approval, the LME/MCO cannot be contacted, or the LME/MCO representative and the treating physician cannot reach an agreement concerning the member’s care and a plan physician is not available for consultation. Partners, in this situation, must give the treating physician the opportunity to consult with a plan physician and the treatment physician may continue with care of the patient until a plan physician is reached.

Financial responsibility of the LME/MCO for post-stabilization care services if not pre-approved ends when:

- A physician enrolled with the LME/MCO with privileges at the treating hospital assumes responsibility for the member’s care;
- A physician enrolled with the LME/MCO assumes responsibility for the member’s care through transfer;
- A LME/MCO representative and the treating physician reach an agreement concerning the member’s care; or
- The member is discharged.

**OUTPATIENT, COMMUNITY BASED AND RESIDENTIAL SERVICES**

Services are expected to be requested on or before the start date. The following are exceptions:

- Basic Outpatient Services to include but not limited to Individual, Family and Group Therapy visits are unmanaged.
- Emergency/Crisis Services
- Services that indicate a “pass-through” in the service definition
- Codes agreed upon by Partners as not requiring authorization and indicated on the Medicaid and State-Funded Benefit Plans, located on the Partners website.

Requests for authorization must be reviewed and a decision rendered within 14 calendar days of submission of the request. Expedited requests are available when reviewing authorization within the standard time frame (14 calendar days) could seriously jeopardize the member’s life, health, or ability to attain, maintain or regain maximum functioning. Expedited requests are addressed within 72 hours for a prospective or initial and concurrent request. Concurrent requests are reviewed in 24 hours if received 24 hours or more prior to the end-time of the previous
authorization or 72 hours if received less than 24 hours from the end-time of the previous authorization.

Partners must decide and provide notice within 14 calendar days of receiving a standard request for authorization of service with a possible extension of an additional 14 calendar days if:

- The member or provider requests an extension, or
- Partners can demonstrate to North Carolina Division of Health Benefits that there is need for additional information and the delay is in the member’s best interest.

Partners must decide and provide notice within 72 hours of receiving an expedited request for authorization. Expedited requests occur when following the standard timeframe could seriously jeopardize a member’s life, health or ability to attain, maintain or regain maximum function. There is also the option of an extension of an additional 14 calendar days if:

- The member or provider requests an extension on behalf of the member, or
- Partners can demonstrate to North Carolina Division of Health Benefits that there is need for additional information and the delay is in the member’s best interest.

**DOCUMENTS REQUIRED FOR AUTHORIZATIONS**

Specialty Outpatient Services:
* Service Authorization Request:
  - Person Centered Plan (Treatment Plan) or
  - Basic Treatment Plan
  - Service Order
  - Other documents required per Service Description
  - Comprehensive Clinical Assessment (CCA) or other evaluation

Enhanced Benefits (Including Residential and PRTF):
  - Service Authorization Request (SAR)
  - Person Centered Plan
  - Comprehensive Clinical Assessment (CCA) or other evaluation
  - Other Documents required by DHB Clinical Coverage Policy and state and federal regulations
  - For PRTF, a Certificate of Need (CON) is required prior to admission
  - Service Order

Innovations/ICF-IID Facilities:
  - Service Authorization Request (SAR)
  - Individual Supports Plan (ISP)
- NC Support Needs Assessment Profile (NC-SNAP) or Supports Intensity Scale (SIS)
- Innovations Level of Care Form (replaces MR-2)
- ICF-IID requires updated Level of Care (LOC) every six months
- Any psychological testing specialty or medical assessments that apply

### ADDITIONAL REQUIREMENTS FOR VALID OR COMPLETE REQUESTS

A Valid Request for Medicaid Members must contain:

- Member Name/Address/DOB/MID
- Identification of Service or Procedure Code
- Name and NPI of Provider to perform service
- Date the service is requested to begin
- Consistent information throughout the request (i.e. name and MID matching)
- Behavioral health diagnosis must be covered by the benefit plan
- All required signatures on forms required by statute, and/or any documents or forms required by State or Federal statute
- A valid ICD-10 diagnosis

If present, the following elements will keep a request from being processed:

- Duplicate Requests (the later of the two to be UTP)
- Per diem service and dates/units that do not match
- Service Authorization Request for a service that does not require authorization
- Incorrect Service Code (e.g., requesting ALL for non-therapy package)
- Retrospective request that does not meet criteria in policy
- Service Exclusions for Adults
- Member is not enrolled or registered in Alpha
- Request for something not covered in behavioral health (i.e. long-term nursing care, diagnostic imaging, glasses)-try to link to appropriate vendor
- SAR submitted more than 30 days prior to start date
- Contract issues

The SAR will be marked as an Incomplete Request and an *Administrative Denial is issued* if any of the information as requested (see list below) is not received.

- Comprehensive Crisis Plan (CCP) when applicable
- CCA where indicated in Clinical Coverage Policy
- PCP/Service Order/ISP, or if the documents are incomplete, missing pages, or services/service units don’t match Innovations budget
- Attestation Statement for members required to have Child and Family Team (CFT) meetings or assignment of Treatment Accountability for Safer Communities (TASC) manager
- LOC Forms
- NC SNAP or SIS
- Individual Budget (Innovations) is correct and complete
- Attestation of the previous Level of Care Form and supporting documentation for ICF-IID member.
- Risk Support Needs Assessment (Innovations)
- Documentation for ICF-I/DD
- Letters of medical necessity, required quotes, MD orders (Innovations)
- Orders, Individual/Family Support Documents (self-direction only, Innovations)
- All required signatures on forms (PCPs, ISP, Redetermination and Freedom of Statement)
- Certificate of Need (CON)

*Service Exclusions for Children under 21 years of age and covered by Medicaid must be reviewed under Early and Periodic Screening, Diagnostic and Treatment (EPSDT).*

When the request is missing items (from the list above) that result in an incomplete request, Partners’ UM staff communicates what is missing to the provider. If this information is not received within three calendar days, the request is deemed an Administrative Denial with appeal rights.

If all the required information has been submitted and the request is complete, but the information is illegible or there is still insufficient clinical information to determine medical necessity, the initial reviewer attempts to collect the needed information from the provider within the applicable prospective, concurrent, and retrospective timeframes. If the provider does not respond within three calendar days to the request, the request will be denied as an Administrative Denial with appeal rights.

Requests for authorization must be reviewed and a decision rendered within 14 calendar days of submission of the request. Expedited requests are available when reviewing authorization within the standard time frame (14 calendar days) could seriously jeopardize the member’s life, health, or ability to attain, maintain or regain maximum functioning. Expedited requests are addressed within 72 hours for an initial request. Concurrent requests that are expedited are reviewed in 24 hours, if received 24 hours or more prior to the end-time of the previous authorization or 72 hours if received less than 24 hours from the end-time of the previous authorization.

**DISCHARGE REVIEW**

Providers do not need to submit Discharges for Medicaid Basic Benefit only services.
• Providers MUST submit Discharges for members with **only State funded** services
• Providers MUST submit Discharges for members with **only Enhanced Medicaid** services
• Providers MUST submit Discharges for members with **State & Medicaid** services

Providers must submit a Discharge Request via the Discharge Module in AlphaMCS for State-funded Benefit members. This includes members who have State only funded services as well as State and Medicaid funded services.

When initiating discharges for members having substance use issues, the required SU fields below (noted by yellow box beside the field) must be completed by the provider initiating the discharge. In the event the discharge is determined to be a full discharge by the LME/MCO, all existing diagnosis, SU fields, target pops and state insurances will be end dated with the discharge date. A discharge reason of “other” or “unknown” must include comments by the provider.

If the member is transferred to another provider, the following must be documented in the comments section:
• designation that it is a transfer and
• name of the provider receiving the transfer.
**CLINICAL HOME**

Clinical Home is usually designated by enhanced services. When there is a combination of enhanced and basic services, providers must coordinate this function. All services for a member are required to be on one service plan.

**SECOND OPINION**

A Medicaid member has the right to a second opinion if the member or legally responsible person does not agree with the diagnosis, treatment, or the medication prescribed. The Partners’ Clinical Operations Department arranges for a second opinion.

Members are informed of the right to a second opinion in the Partners’ Member Handbook, which is made available to them at the time of enrollment.

**DECISIONS TO DENY/REDUCE/SUSPEND/TERMINATE A MEDICAID SERVICE**

There are times when a member’s request for services is denied or partially denied by Partners’ Utilization Management Department. Denials, partial or full, that are based on medical necessity criteria have appeal rights. An Administrative Denial is issued due to incomplete information and has appeal rights.

Detailed information about Due Process and Prior Approval Procedures can be accessed via the Division of Medical Assistance website. [https://medicaid.ncdhhs.gov/providers/programs-services/prior-approval-and-due-process](https://medicaid.ncdhhs.gov/providers/programs-services/prior-approval-and-due-process)

<table>
<thead>
<tr>
<th>Denial</th>
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<td>An “action” is a decision that results in a denial, reduction, suspension or termination of a request for services. An action is defined as:</td>
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<tr>
<td>• The denial or limited authorization of a requested service, including the type or level or service;</td>
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<td>• The reduction, suspension or termination of a previously authorized service;</td>
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<td>• The denial, in whole or in part, or payment for a service;</td>
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<td>• The failure to provide services in a timely manner, as defined by the State;</td>
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<tr>
<td>• The failure of Partners to act within the timeframes provided in 42 C.F.R.438.408(b); and</td>
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For a rural area resident with only one LME/MCO, the denial of a member’s request to obtain services outside the Network.

A denial could occur if the criteria are not met to support an initial or continuing authorization request for a service. Prior to issuing a Denial, or an Adverse Benefit Determination for Clinical Reasons, there is an attempt to request additional information through AlphaMCS and/or by calling the provider directly. A Clinical Denial is not issued by an UM Reviewer but is referred for Peer Review by an MD or Licensed Psychologist prior to denial. Members or legally responsible persons receive a Notice of Adverse Benefit Determination by trackable US Mail that is sent within 14 days of the submission of a routine request. The Notice of Adverse Benefit Determination explains the decision in language easily understood by the member or legally responsible person and how to request a Reconsideration Review (Appeal). The Notice of Adverse Benefit Determination also offers the member and provider the option to request the clinical rationale for the decision in writing. In addition to the Notice of Adverse Benefit Determination, Providers are notified electronically via AlphaMCS email alert of the decision. During this time, Partners does not provide payment for the requested service in dispute unless the provider’s previous authorization has not expired.

The provider is offered the opportunity to request a Peer to Peer conversation with a Peer Reviewer within five business days of the adverse decision. The provider is also able to offer additional information during the Peer Review or it can be attached to a new authorization request. Authorizations cannot be retroactively approved prior to the receipt of new information.

Reconsideration/Appeal - Level I

An “appeal” is defined as the request for review of an Action.

Under the North Carolina MH/DD/SAS Health Plan 1915(b) and NC Innovations Waiver 1915(c) based on Code of Federal Regulations (CFR) 438.400, which can be viewed at http://www.lawserver.com/law/country/us/cfr/42_cfr_438-400, members or legally responsible persons who have received a denial or reduction of service (action) will get a Notice of Adverse Benefit Determination, which informs them of the decision and also that they are entitled to appeal that decision through the Partners Appeal process. A form is included in the Notice of Adverse Benefit Determination that informs the member or legally responsible person how to request an appeal.

To begin the process, the member, legally responsible person, or provider (when making the request on the behalf of the member or legally responsible person or supporting the member or legally responsible person at their request, for which written consent is required) must request
Reconsideration within 60 days of the date of the Notice of Adverse Benefit Determination. Although a provider cannot request an appeal for the member, the member can have providers participate in the appeal process. A provider’s participation is valuable and may make a difference in the outcome at any junction of the appeal process. Partners ensures there is no punitive action taken against a provider who requests or supports a member’s appeal. Providers should communicate their willingness to participate with the member or legally responsible person.

If the member or legally responsible person needs assistance, the letter asks them to call the Appeals Department at 704-884-2650. To request an Appeal Review, the Appeal Request must be completed and returned by fax, mail, in person or requested orally with follow up in writing for standard appeal requests. Oral expedited appeal requests require no written request. Directions related to contacting the Appeals Department at Partners are included in the Notice of Adverse Benefit Determination.

Member or legally responsible persons or other authorized representatives have the right to review any information used as part of the appeal process.

This information may be requested, free of charge, through the Appeals Department at 704-884-2650.

The standard appeal must be completed and the written notice issued to the member or legally responsible person within 30 calendar days of Partners’ receipt of the request for an appeal. The member has the option of an expedited appeal process. Partners must inform the member of the limited time (72 hours) available for presentation of information in person and in writing when an expedited appeal is requested. If Partners denies a request for an expedited appeal, Partners must transfer the appeal to the standard timeframe of no longer than 30 days from receipt of the request for appeal and give the member prompt oral notice that the request for an expedited appeal has been denied, followed by written notice within two calendar days. The notice must include action taken, reason for action, and rights and procedures for the member to request reconsideration of the decision.

Both the standard appeal timeframe of 30 days and the expedited appeal timeframe of 72 hours can be extended for an additional 14 calendar days if:

- The member (or provider on behalf of the member with written consent) requests the extension, or
• If Partners demonstrates to the Division of Health Benefits (DHB) that there is need for additional information and the delay is in the best interest of the member. For an extension of an Expedited or Standard Appeal, not requested by the member, Partners must inform the member in writing of the reason for the delay within two calendar days and make prompt and reasonable effort to inform orally.

Extensions can be requested orally as well as in writing.

Providers receive written notification of the appeal decision, both electronically through AlphaMCS and through the mail (USPS). A Partners Appeal or Reconsideration Review is an impartial review of Partners’ decision to reduce or deny the request for Medicaid services. A Licensed Psychiatrist or Psychologist who has appropriate clinical expertise in treating the member’s condition or disorder, and who was not previously involved in Partners’ initial decision, determines the Appeal/Reconsideration decision.

The member or legally responsible person must complete the local appeal process with Partners before requesting a hearing with the Office of Administrative Hearing (OAH.)

Steps to File an Appeal Request

To request an appeal, the member or legally responsible person or the provider (when making the request on the behalf of the member or legally responsible person or supporting the member or legally responsible person at their request, for which written consent is required) must complete and return the Partners’ Reconsideration Review Request by one of the following methods:

- **In person:** Partners Behavioral Health Management
  
  901 S. New Hope Rd
  
  Gastonia, NC 28054

- **By fax:** 704-884-2720

- **By telephone:** 704-884-2650 (which must be followed up with in writing for a standard Appeal request)

- **By mail:** Partners Behavioral Health Management
  
  Appeals Unit
  
  901 S. New Hope Road
  
  Gastonia, NC 28054
Partners provides help to any member (or member’s LRP) who requests assistance in filing an appeal. Partners acknowledges receipt of the appeal in writing via a letter to the appellant dated the next working day following receipt of the appeal for written and oral requests. The member, legal guardian or representative may submit additional information at any time during the appeal process using the methods outlined above.

Upon completion of the appeal decision, if the member or legally responsible person disagrees with the Partners’ Appeal decision, the member or legal representative can then appeal the decision to the Office of Administrative Hearing (OAH) by filing a Request for Hearing, also known as the State Fair Hearing process.

### Continuation of Benefits

When a member receiving Medicaid-funded services is denied a service, he or she is eligible for continuation of benefits per 42 CFR 438.420 when:

- the Reconsideration is requested within ten days from the date the Notice of Action is mailed or the intended effective date of Partners’ proposed action;
- the Reconsideration involves the termination, suspension or reduction of a previously authorized service;
- the service was ordered by an authorized provider;
- the original period covered by the original authorization has not expired; and
- the member requests a continuation of benefits.

If, at the member’s or legally responsible person’s request, Partners continues or reinstates the member’s benefits while the appeal is pending, the benefits must be continued until one of the following occurs:

- the member or legally responsible person withdraws the appeal;
- ten days after the Notice of Action indicating an Upheld or Partially Upheld decision is mailed, unless the recipient requests a State Fair Hearing within those ten days; or
- a State Fair Hearing decision is made against the member.

If the final resolution of the Appeal is adverse to the member, that is, upholds Partners’ action, then Partners may recover the cost of the services furnished to the member while the appeal is pending, to the extent that they were furnished solely because of the requirements of this section.

Members who need assistance related to an Appeal may call the Appeals Department at 704-884-2650.
**Expedited Appeal Review Process**

An Expedited Appeal Review may be requested by the member /guardian (or the provider in making the request on the member’s/legally responsible person’s behalf or supporting the member’s/guardian's request), if it is indicated that taking the time for a standard review could seriously jeopardize the member’s life, health or ability to attain, maintain, or regain maximum function. This request can be made verbally or in writing to the Appeals Department. Oral expedited appeal requests do not require a written appeal to follow. Specific contact information is listed on the Notice of Action letter.

If an Expedited Request is received, it is reviewed to determine if there is sufficient evidence to support the need for this type of request or the Expedited Request is requested by a physician. If so, an Appeal Review is completed with verbal and written notification issued to the member or legally responsible person and provider within 72 hours.

If there is not sufficient evidence to require an Expedited Request and the Expedited Request was not requested by a physician, the member or legally responsible person receives verbal notice of the denial of their request for an Expedited Appeal Review and written notice by the next business day. The process follows the standard appeal timelines.

**Office of Administrative Hearing (OAH)**

If the decision of the Peer Review is upheld by the Reconsideration/Appeal, the member has the option of an appeal to the OAH if requested within 120 days of the date on the Reconsideration/Appeal Letter. The form to request the appeal is included in the Notice of Resolution Letter to the member or legally responsible person. Upon receipt of the request, OAH will offer the member or legally responsible person the option of mediation or an appeal before an Administrative Law Judge. If mediation is chosen, one of the mediators who are a part of The Mediation Network of North Carolina will contact the member or legally responsible person to offer an opportunity to mediate the disputed issue(s) to resolve the pending appeal informally. If the member or legally responsible person accepts mediation, it is usually scheduled to be completed within ten days of the date of the OAH Appeal request.
If the issue(s) is resolved at mediation, the appeal is withdrawn and services will be provided pursuant the Mediation Agreement. The decision because of mediation is final and binding. The outcome of mediation can be settlement, withdrawal or an impasse. If the member or legally responsible person does not accept the offer of mediation or the mediation results in an impasse, the case proceeds to a formal hearing and will be heard by an Administrative Law Judge with the OAH. This is referred to as the State Fair Hearing process.

The State Fair Hearing is conducted by an Administrative Law Judge (ALJ) at the OAH. The hearing is scheduled to occur by telephone unless the member or legally responsible person requests to attend in person. The member or legally responsible person receives notice of the date, time and location of the hearing. The hearing is scheduled at the member’s or legally responsible person’s convenience in a location close to the member or legally responsible person.

### Appeals Filed After February 1, 2013

- The Administrative Law Judge (ALJ) makes the final decision. The final decision must contain findings of fact and conclusions of law.
- OAH prepares the official record that includes notices, pleadings, motions, questions and offers of proof, objections, and rulings; evidence presented; matters officially noticed; and the ALJ’s final decision.
- Either party (Partners or the member or legally responsible person) may file an appeal of the final decision in the Superior Court of Wake County or the county where the party resides.
- Appeals must be filed within 120 days after issuance of the written decision.
- The Superior Court Judge decides the case based on the decision and official record.
- If the petitioner contends the ALJ decision violates constitutional provisions, is more than the statutory authority or jurisdiction of the agency or ALJ; made upon unlawful procedure; or affected by other error of law, review is de novo.
- If the petitioner contends the ALJ decision was not supported by substantial competent evidence or was arbitrary/capricious/abuse of discretion, the whole-record test applies.
If the final resolution of the appeal is not decided in the member’s favor, (meaning Partners or DHHS action is upheld), Partners may recover the cost of the services furnished to the member while the appeal is pending.

**Non-Medicaid Service Appeal Process**

Non-Medicaid services are not an entitlement. Non-Medicaid service decisions regarding termination, reduction, suspension or denial of Non-Medicaid services are handled within the Utilization Management Appeals Unit. If the member or legally responsible person disagrees with the Non-Medicaid service decision, he or she may complete the Non-Medicaid Appeal form that accompanies the decision and return it to the Partners’ Utilization Management Appeals Unit within 15 working days of the date of the Notice of Decision Letter.

The UM Appeals Unit acknowledges receipt of the appeal in writing to the member or legally responsible person and to the provider. The acknowledgement letter is mailed the next business day.

The Non-Medicaid Service Appeals process maintained by Partners provides an opportunity for the member or legally responsible person, ordering/treating provider, and/or facility rendering service to submit information related to the case, including any documents, records, written comments, or other information that may be helpful in processing the appeal.

Peer Reviewers who process the appeal consider all the information received from the member or legally responsible person ordering/treating provider and/or facility rendering service, regardless of whether the information was presented during the initial clinical review.

The member or legally responsible person receives a Clinical Review Decision conducted by a Licensed Psychiatrist or Psychologist that has appropriate clinical expertise in treating the member's condition or disorder within appropriate timeframes.

Timeframes for the appeal process, which are in accordance with the requirements of the NC Division of Mental Health/Developmental Disabilities/Substance Use Services (DMH/DD/SAS) and URAC (the external accrediting body) are documented in Partners’ Policies and Procedures and are available upon request, to any member or legally responsible person, provider or facility rendering service.

If the appeal decision is to uphold the original non-certification, the written notification explains that there is an opportunity to appeal the decision to the Division’s Non-Medicaid Appeals Panel, as well as the process for doing so.
**Non-Medicaid Appeal Request to DHHS**

If a member or legally responsible person disagrees with the Non-Medicaid service Reconsideration decision, he or she may appeal by submitting the Non-Medicaid Appeal Request Form to the Division of MH/DD/SAS. This form is included with the Notice of Non-Medicaid Service Appeal Determination Decision Upheld letter.

The internal Partners’ Non-Medicaid Service Appeal process must be completed prior to filing the Appeal Request form with the Division. The DMH/DD/SAS Hearing Office must receive the member’s appeal within 11 calendar days from the date on the Partners’ Notice of Action Request for Non-Medicaid Services Letter [10A NCAC 271 .0600-.0609]. If the 11th day falls on a weekend or holiday, the deadline is the next business day. Verbal appeals are not accepted.

The Non-Medicaid Appeal Request is reviewed by a Hearing Officer designated by DMH/DD/SAS. Hearing Officers issue their findings and decisions within 60 days of Hearing to both the member or legally responsible person and Partners’ CEO. When the findings and decisions are received, Partners issues a final decision based on those recommendations in writing within ten days. This decision is final and there are no further appeal rights as set forth in NC GS 143B-147(a) (9). (See first paragraph under Final MCO Decision - Level IV heading above.)

**RECEIVING SERVICES DURING THE NON-MEDICAID APPEAL PROCESS**

Partners has the option of authorizing other appropriate Non-Medicaid services. Services may be authorized for the duration of the Reconsideration process at Partners’ discretion. Other community resources may also be referred to the member for support.

When a member or legally responsible person files an appeal for the denial of a service, Partners is under no obligation to provide the requested service during the appeal process.

**PARTNERS’ RESPONSIBILITIES TO PROVIDERS**

- Provide accurate and timely response to SARs:
  - Standard Requests are reviewed within 14 calendar days of receipt to include notification of the decision.
  - Expedited Requests are reviewed within 72 hours of receipt to include notification of the decision.
- Ensure members receive medically necessary services.
- Ensure members who need services are listed in the system.
† Inform providers of those members receiving Care Coordination/Care Management.

† Complete telephonic or on-site visits to monitor the health and safety of the member receiving Care Coordination/Care Management.

† Assess the satisfaction of members served.

† Monitor implementation of the ISP or PCP.

† Communicate with providers on any additional assessments needed.

† Develop and share ISPs; communicate any recommendations for development or revisions on the PCP/ISP.

† Educate members receiving Care Coordination/Care Management about Medicaid transportation.

† Share natural and community resources for referrals and linking.

YOUR RESPONSIBILITIES AS A PARTNERS’ PROVIDER

† Have a grievance/complaint process to address any concerns of the member and the member’s families related to the services provided.

† Share the grievance/complaint process with members upon enrollment and upon request.

† Advise members and families that they may contact Partners directly about any concerns or grievances.

† Maintain accurate documentation on all grievances received, including date received, points of grievances, and resolution information.

† Publish and make available the toll-free Partners’ Access to Care telephone number for members and family members, as well as the telephone number for the Disability Rights of North Carolina.

† Cooperate fully with all investigative requests; refusal to comply with any grievance follow-up or investigation is a breach of contract.

† Develop and implement policies and procedures for receiving and handling complaints and grievances.
Incorporate results of grievances or complaints into the internal QA/QI committee to assure systemic issues related to the complaints are being addressed.

Develop and implement a process to inform members/families of policy and procedures on complaints.

Be responsive to complaints and cooperate with any Partners’ Department in investigating and resolving complaints within timeframes established by Partners.

Provide to Partners copies of supporting documentation and evidence regarding your agency’s investigation (i.e. PCP’s, service notes, service orders, etc.) as well as citations of statutes and rules pertinent to each allegation or complaint to resolve issues.

Comply with NC law (NC GS §122C-18) regarding retaliation against a person for complaining to a member advocate.

Provide and comply with face-to-face emergency care within two hours (Emergent Request) after a request for care is received by provider staff initiated by member; the provider must provide face-to-face emergency care immediately for life threatening emergencies.

Provide and comply with initial face-to-face assessments and/or treatment within two days (Urgent Request) after the day and time a request for care is received by provider.

Provide and comply with initial face-to-face assessments and/or treatment within 14 calendar days (Routine Request) of the date a request for care is received by provider.

Provide return telephone calls within one hour, 24 hours a day, and seven days a week.

Be responsive and comply with emergency referrals within one hour, 24 hours a day, and seven days a week.

Maintain systems and procedures to ensure members with scheduled appointments are being seen within the required wait times of 60 minutes after the appointed meeting.

Maintain systems and procedures to ensure members who walk in are being seen within the required wait time of two hours after their arrival.

For emergency providers, staff must provide emergency face-to-face care within the required wait time of two hours after the request; for care that is initiated by the member; life threatening emergencies shall be managed immediately.
Ensure that there are no barriers to treatment, system navigation is friendly, and the screening process is the same no matter where members present to be seen.

Maintain systems and procedures to screen and triage members’ needs, whether by phone or walk-in and schedule that person for an appointment within required timeframe.

Be as clear as possible in requests for information or services to enable our Access to Care Center to help you in the most efficient and effective way possible.

Add service openings in the Registry of Unmet Needs available in AlphaMCS, Provider Portal.

Search for, review and place members who are appropriate for the vacancy based on the criteria entered.

Submit Service Authorization Requests (SARs) with the proper clinical information at least 14 calendar days prior to the end date of the current authorization to allow for Utilization Management activities and authorization prior to beginning services.

Submit continuing SARs on a timely basis to allow for Utilization Management activities and authorization prior to beginning services. Emergency Authorizations are available but should only be used when necessary to provide for member health, safety and well-being.

Submit an Expedited Request for emergency/acute care within 48 hours of admission.

Maintain services at an optimal level to meet member needs by providing services in accordance with Partners’ Clinical Practice Guidelines.

Participate actively in a Person-Centered Planning process with others serving the member to develop a comprehensive PCP.

Development of treatment and/or habilitative programs that are in accordance with the person-centered plan.

Communicate with the Care Coordinators/Care Managers about the needs of members being supported.

Notify the Care Coordinator/Care Manager of any changes, incidents, other information of significance related to the member supported.

Ensure that members are appropriately linked to primary health care.

Assist with referrals to natural and community supports.
Follow-up with a phone call whenever a member who is considered a high-risk member misses an urgent or emergent appointment; send a letter if unable to contact the member by phone and document within the member’s chart all attempts to reach him or her.

Contact Partners’ Care Coordinators/Care Managers whenever a member receiving Care Coordination/Care Management misses two appointments.

Contact Partners’ Care Coordinators/Care Managers for members on an outpatient commitment order who fail to keep any appointment.

PARTNERS BENEFIT PLAN

MEDICAID WAIVER ELIGIBILITY

THE NC MH/DD/SAS HEALTH PLAN [1915(B) WAIVER]

Eligibility for members meeting the criteria listed below is required. Children are eligible beginning the first day of the month following their third birthday for 1915(b) services.

Members who currently receive Social Security Insurance (SSI), Special Assistance to the Blind, Work First Family Assistance, or Special Assistance for the Aged or Disabled are automatically eligible for Medicaid.

The following criteria must be met for a member to be eligible for inclusion in the waiver:

- Be a U.S. citizen or provide proof of eligible immigration status;
- Be a resident of North Carolina;
- Have a Social Security number or have applied for one;
- Apply and be approved for Medicaid at the local Department of Social Services (DSS) Office;
- Be in one of the Medicaid aid categories that qualifies individuals for the NC MH/DD/SAS Health Plan; and
- The member’s Medicaid county of residence is one of the following:
  - Burke
  - Catawba
  - Cleveland
  - Gaston
  - Iredell
  - Lincoln
  - Rutherford
  - Surry
  - Yadkin

THE NC INNOVATIONS WAIVER [1915(C) WAIVER]

Subject to available funding and program requirements, a person with an Intellectual/Developmental Disability who meets ICF-IID Level of Care criteria may be considered...
for NC Innovations Waiver funding. Refer to the Clinical Coverage Policy 8-E for the ICF-IID level of care criteria.

When an application is made, the applicant is screened for eligibility and is placed on the Registry of Unmet Needs (waiting list). The applicant may be considered for NC Innovations funding if all the following criteria are met:

- The member resides in an ICF-IID facility or is at high risk for placement in an ICF-IID facility. High risk for ICF-IID institutional placement is defined as a reasonable indication that member may need such services soon.
- The member’s health, safety, and well-being can be maintained in the community under the NC Innovations program.
- The member requires NC Innovations services.
- The member, his/her family, or guardian desires participation in the NC Innovations Waiver program rather than institutional services.
- The member’s County of Residence is one of the following:
  - Burke
  - Gaston
  - Rutherford
  - Catawba
  - Iredell
  - Surry
  - Cleveland
  - Lincoln
  - Yadkin
- The member will use one waiver service per month.

Once funding becomes available, the potential applicant who qualifies for the NC Innovations Waiver is assigned a waiver “slot.” If he or she is not a current Medicaid beneficiary, the potential NC Innovations applicant is referred to the local Department of Social Services (DSS) office to initiate a Medicaid application. The Medicaid eligibility is based on the assets and income of the applicant, whether he or she is a child or an adult.

To receive NC Innovations, the applicant must be approved for Medicaid under one of the following coverage groups:

- Medicaid to the Aged (M-AA);
- Medicaid to the Blind (M-AB);
- Medicaid to the Disabled (M-AD);
- Health Coverage for Workers with Disabilities (HCWD) Basic Group;
- IV-E Adoption Assistance and Foster Care (I-AS) 42. CFR 435.115(e)(2);
- State Foster Care (H-SF);
- State/County Special Assistance to the Aged (S-AA); or
- State/County Special Assistance to the Disabled (S-AD).
An NC Innovations Level of Care Eligibility Determination form and the Medical Evaluation attachment must be completed by the appropriate professionals. These completed forms are reviewed to determine if ICF-IID Level of Care criteria are met and Prior Approval for NC Innovations is given. An Individual Support Plan is completed and NC Innovations services may be requested at that time.

**EVIDENCED-BASED PRACTICES**

Evidence-Based Practices are interventions, treatments, and programs that are proven effective in producing specific positive outcomes. These methods are based in solid research and study to produce positive changes in individuals.

Partners encourages our network providers to adopt and use Evidence-Based Practices as part of the treatment array. The use of evidence-based practices ensures that we are offering the best available treatment and services to our members.

The following are some evidence-based practices that Partners encourages providers to adopt and use.

**MULTISYSTEMIC THERAPY (MST)**

The purpose of Multisystemic Therapy (MST) is to keep youth in the home by delivering an intensive therapy to the family within the home. Services are provided through a team approach to beneficiaries and their families.

MST is a service designed to address the identified needs of children and adolescents with significant behavioral problems who are transitioning from out of home placements or are at risk of out-of-home placement and need intensive interventions to remain stable in the community. MST includes a variety of therapeutic and crisis interventions 24 hours a day, seven days a week, for those with mental health or substance use issues. MST has solid evidence of effectiveness as a treatment for problematic substance use in adolescents and is promoted by NIDA (National Institute on Drug Abuse). Services are available in-home, at school, and in other community settings. The duration of MST intervention is three to five months. MST involves families and other systems such as the school, probation officers, extended families, and community connections.

For additional details on Evidenced Based Practices please check Partners web page at [Partners Behavioral Health Management Evidence Based Practices](#).
**Assertive Community Treatment Team (ACTT)**

Assertive Community Treatment (ACTT) consists of professionals who use a team approach to meet the needs of those with severe and persistent mental illness. Teams are composed of, at minimum, a licensed behavioral health clinician, psychiatrist, nurse, substance use specialist, vocational specialist and peer specialist. ACTT serves as the single point of responsibility in addressing all the needs for those whose functioning is impaired by a serious mental illness. It is intended to help those who with a significant history of hospitalization, homelessness, and/or incarceration. A fundamental feature of ACTT is that the majority services are provided outside of an office, and in the member’s home or other community environment. ACTT teams have staff available 24 hours a day, seven days a week and 365 days a year.

**Family Centered Treatment (FCT)**

Family Centered Treatment® (FCT©) is a comprehensive evidence-based model of intensive in-home treatment for children and adolescents and their families. Designed to prevent out-of-home placement (i.e.: residential, hospital, correctional facility placement) of the youth. FCT is a family-system model that works intensively with family members to positively impact each member of the family. FCT uses four stages; joining, restructuring, value change and generalization, to improve family functioning. Individualized therapeutic interventions in the family/home setting to treat the youth and his/her family. FCT therapists strengthen family members’ problem-solving skills, including how they communicate, handle conflict, meet the needs for closeness, and manage the tasks of daily living.

FCT is delivered by an assigned therapist who is supervised by a trained FCT supervisor. A distinctive aspect of FCT is that it has been developed because of frontline practitioners’ effective practice. FCT is one of few home-based treatment models with extensive experience with youth with severe emotional and behavioral challenges, dependency needs, and mental health diagnosis as well as histories of delinquent behavior, otherwise known as crossover youth. In addition, FCT is extremely cost-effective and stabilizes youth at risk and their families.
Partners recognizes that people often experience multiple problems. To provide coordinated care, Partners ensures that members are connected to a Behavioral Health Home that provides all the needed services and supports.

Care Coordination is an administrative function, not a service. It is available to members in all three disability groups (mental health, intellectual/developmental disabilities, and substance use). Mental Health and Substance Use (MH/SU) Care Coordination activities involve identifying the needs of the members then coordinating and linking to behavioral health/rehabilitative treatment services and supports.

**PURPOSE AND VISION OF MENTAL HEALTH/SUBSTANCE USE CARE COORDINATION**

The purpose of Partners’ MH/SU Care Coordination Department is to connect members to the right care at the right amount at the right time. By improving member care, the member outcomes improve, thus reducing cost.

**CARE COORDINATION GOALS**

- Promote recovery in the least restrictive environment and community integration.
- Collaborate with members, providers and natural supports for crisis planning.
- Impact hospital admissions through reducing/mitigating barriers to discharge and connecting to community providers.
- Foster whole person integrated care.

**What Does Care Coordination Do?**

- Connect members, who are currently hospitalized or at high risk for hospitalization and not engaged in treatment, to a behavioral health/clinical provider in the community.
Participate in discharge planning for members in state hospitals, community hospitals, facility-based crisis, psychiatric residential treatment facility (PRTF), child and adolescent residential level III, alcohol and drug use treatment centers, and detox.

Ensure that members discharged from inpatient/residential facilities have a scheduled appointment with a community Provider within seven calendar days of discharge.

Contact members who do not attend scheduled follow up appointments to reschedule services within five calendar days.

Verify compliance with Outpatient and Substance Use Commitment Orders.

Provide education about available behavioral and physical health services and community resources/supports.

Link members to needed psychological, behavioral, education, and physical evaluations.

Connect members to medical care by coordination with Community Care North Carolina (CCNC) Care Coordinators in accordance with CCNC-LME protocols and the Four Quadrant Care Management Model.

Review members’ assessments/evaluations, health history, Person Centered Plan (PCP) and crisis plan to reinforce that members receive:
  - An appropriate clinical assessment;
  - Collaborative and individualized treatment planning; and
  - Access to clinical and medical specialists.

Facilitate warm hand-off and good rapport between providers and members.

Organize providers and other key stakeholders to address the special needs of members to create and maintain proactive plans of care.

Identify the gaps in needed services and intervene to ensure the member receives appropriate care, as well as align resources with member’s needs and preferences.

Measure results of intervention and treatment, including reduction in high-risk events and use of high cost services.

Work collaboratively with members, families, providers, and stakeholders to improve outcomes for the member.

Member education is a key component of MH/SU Care Coordination. MH/SU Care Coordination recognizes the importance of working with members and providers to promote self-direction in the person’s recovery. To that end, member education includes:

- Crisis management resources
- Provider education on self-management of whole person care
- Community and Partners’ resources
How is Care Coordination Different from Case Management?

Care Coordination is not a service; however, there are individual contacts to assure connectivity to needed services and supports. Care Coordination does not replace the role of the provider. The focus instead is providing oversight of the member’s continuum of care. The goal is managing and stretching limited resources, as well as assuring the best quality care possible to achieve the member’s service goals. Care Coordination can also provide consultation to clinicians both within and outside of the provider network regarding alternative and creative approaches to care. Care Coordination contact is done by telephone and face to face.

Enhanced Services that provide Case Management as part of the service are:

- Intensive In-Home
- Multi-systemic Therapy
- Family Centered Treatment
- High Fidelity Wraparound
- Community Support Team
- Assertive Community Support Team
- Critical Time Intervention

Who is Eligible for MH/SU Care Coordination?

Members who meet Special Healthcare Needs Population and High Risk/High Cost Criteria are eligible for MH/SU Care Coordination.

ADMISSION CRITERIA

Child Mental Health

Children who have a diagnosis within the diagnostic ranges defined below:

<table>
<thead>
<tr>
<th>Diagnosis or Disorder Classification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disorders due to General Medical Condition</td>
</tr>
<tr>
<td>Psychotic Disorder, Psychotic Disorder NOS</td>
</tr>
<tr>
<td>Mood Disorders, Anxiety Disorders, Dissociative Disorders, Factitious Disorders, Somatoform Disorders, Unspecified Mental Disorder</td>
</tr>
<tr>
<td>Sexual and Gender Identity Disorders</td>
</tr>
<tr>
<td>Eating Disorders, Tic Disorders, Sleeping Disorders</td>
</tr>
</tbody>
</table>
Acute Stress Disorder
PTSD
Depressive Disorder NOS, Impulse-Control Disorders Not Elsewhere Classified
Oppositional Defiant Disorder
Reactive Attachment Disorder
Neglect, Physical or Sexual Abuse of Child (victim)
Physical or Sexual Abuse of Child (perpetrator)

**AND** Current CALOCUS Level of VI,

Is child in or in need of inpatient setting or a Psychiatric Residential Treatment Facility (PRTF-secure 24 behavioral health facility)?

**OR** who are currently, or have been within the past 30 days, in a facility (including a Youth Development Center and Youth Detention Center).

**Adult Mental Health**

Adults who have a diagnosis within the diagnostic ranges of:

<table>
<thead>
<tr>
<th>Diagnosis or Disorder Classification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Schizophrenic &amp; Schizoaffective Disorders</td>
</tr>
<tr>
<td>Major Depressive, Bipolar &amp; Mood Disorders</td>
</tr>
<tr>
<td>Brief Psychotic Disorder</td>
</tr>
<tr>
<td>PTSD</td>
</tr>
</tbody>
</table>

**AND** Current LOCUS Level of VI

Is adult in or in need of inpatient 24-hour mental health care?

**SUBSTANCE USE DISORDER**

- Members with a substance use disorder diagnosis **AND**
  - Current ASAM PPC Level of III.7 or higher.
  - Child/Adolescent in or in need of inpatient settings or PRTF.
  - Adult in or in need of detox or 24-hour substance use treatment.
  - Pregnant and substance use disorder diagnosis.

**OPIOID USE DISORDER**

- Members with an opioid dependence diagnosis **AND** who have reported to have used drugs by injection within the past 30 days.
CO-OCCURRING DIAGNOSES

- Members with both a mental illness and a substance use disorder diagnosis AND current CALOCUS/LOCUS of V or higher, OR current ASAM PPC Level of III.5 or higher.
- Members with both a mental illness diagnosis and an I/DD diagnosis AND current LOCUS/CALECUS of IV or higher.
- Members with both an I/DD diagnosis and a substance use disorder diagnosis AND current ASAM PPC level of III.3 or higher.

MEDICAID SPECIAL HEALTHCARE NEEDS:

AT RISK FOR CRISIS:

- When crisis services are the first contact with behavioral health system and there is a need for assistance in continuing ongoing care.
- Discharged from an inpatient psychiatric unit, facility-based crisis, child residential level III, or PRTF.

TRANSITIONS TO COMMUNITY LIVING (TCL) OR DEPARTMENT OF JUSTICE SETTLEMENT:

LME-MCOs must provide “transition planning” and Care Coordination follow along for the TCL identified population. The priority populations identified in the settlement includes the following:

- Members who are living in adult care homes who have a diagnosis of serious and persistent mental illness; and
- Members who are referred to adult care homes with a diagnosis of serious mental illness.

CCNC INDIVIDUAL:

High behavioral health needs and at least one chronic/serious physical health condition:

HIGH RISK/HIGH COST:

High Risk Members are those who:

- Have used emergent crisis services three or more times in the previous 12 months.
- Are not engaged with a behavioral health provider AND have been discharged from:
  - A state facility (developmental centers, alcohol and drug use treatment centers, psychiatric inpatient);
- Hospital (behavioral health admission or ED);
- Emergency services (Mobile Crisis Management Team or Facility Based Crisis Center); or
- Have had an Outpatient Commitment in the past.

**High Cost Members** are members whose treatment plan incurs costs in the top 20% for all members in a disability group.

**DUAL DIAGNOSIS YOUTH WITH COMPLEX NEEDS:**
1. Medicaid eligible children ages 5 and under 21; **and**
2. Who have been diagnosed with a developmental disability (including Intellectual Disability and/or Autism Spectrum Disorder) and a mental health disorder; **and**
3. Who are at risk of not being able to return to or maintain placement in a community setting; **and**
4. **Exhibit one or more** of the following risk factors:
   - Exhibiting behaviors that are a danger to self or others now; and/or
   - Been expelled or is at risk of expulsion from school due to disruptive or dangerous behaviors; and/or
   - Experienced incidents for crisis such as frequent ED visits, out of home placements, involvement with criminal justice system, or involuntary commitments.

**PRIORITIZATION OF MEMBERS INVOLVED WITH MH/SU CARE COORDINATION AND SUBSEQUENT LEVEL OF INTERVENTION FOR CARE COORDINATION ACTIVITY:**
The prioritization and level of intervention for care coordination activity is used to determine caseload assignment, ratios, as well as guide care coordination activities in meeting members’ needs and goals.

**CONTINUED STAY AND DISCHARGE CRITERIA***:
A member no longer meets MH/SU Care Coordination criteria when the services have been determined to be effective and the member is stable or stabilizing as evidenced by:

1. **First inpatient care episode**
   a. For members in basic services - after 30 days and has attended at least one appointment with community provider.
   b. For members in enhanced services – following a minimum three appointments over 30-day timeframe, as confirmed by paid claims or collaboration with provider and member.
2. Crisis Events:
   a. Claims reviewed.
   b. Crisis plan in place and member has copy and understands the plan.
   c. Zero crisis events in Emergency Department.
   d. Zero crisis events with mobile crisis when NOT connected to clinical home.
   e. Crisis events in community were appropriate use of first responder or clinical home crisis services, as identified in crisis plan. A debriefing, or concerted effort to hold a debriefing, of the crisis event with member, guardian and community provider occurred and crisis plan was reviewed and modified as necessary.

3. Housing issues are staffed and determined to be managed through a community service or provider. No behavioral health issues are impacting housing and need further coordination of care.

4. If high cost member service cost has decreased over a period, based on claims review from time of entry to care coordination to discharge.

5. Successfully complete Outpatient Commitment or SU Commitment Order.

6. If the member is on Outpatient Commitment and meets all other discharge criteria, the member will then be tracked with minimum contact.

7. Despite multiple attempts to engage the member, the member continues to refuse MH/SU CC services (in these cases, a staffing with the regional supervisor):
   a. Was a member out of minutes on cell phone? Was appropriate timeframe before a second call?
   b. Did you check the Community Care of North Carolina (CCNC) provider portal and/or care manager for updated information?
   c. Was the uploaded information in AlphaMCS reviewed?
   d. Was the provider contacted for updated information?

*Each case is considered on an individual basis and a member may not have to meet all the criteria above to be discharged.

**CARE REVIEW**

The primary role of the Care Review process is to support Child and Family Teams who are considering out of home placements for members. Care Review Teams consist of community
stakeholders who are familiar with a variety of local resources and supports. It is recommended and considered best practice to consult with the Care Review Team when placement in a Residential Level III, IV, Psychiatric Residential Treatment Program (PRTF), or any out of state placement is being considered. The Care Review Team explores all possible service options available to the youth in his/her home community to ensure least restrictive options are considered. Out of home placements are considered the last resort as a treatment option and are only considered if the appropriate level of treatment cannot be delivered in or near the home due to safety reasons, or if deemed clinically appropriate.

During the Care Review meeting, Child and Family Teams should provide rationale for out of home placement by addressing the following:

- All attempts at non-residential treatment options have been considered and/or exhausted;
- Specific outcomes can only be met in a residential treatment facility; and
- A plan for discharge back into the natural home or less restrictive environment has been completed.

Care Review Team meetings occur monthly and need to be scheduled in advance. In the event of an emergency, a Care Review Team meeting can be scheduled at other times.

**COMPLEX CASE MANAGEMENT**

Complex Case Management (CCM)

Partners operates a Complex Case Management program to ensure the provision of intensive, individualized case management supports and goal-setting for members who have complex needs and require a variety of resources to manage health and improve quality of life.

The eligibility criteria for the Complex Case Management include, but may not be limited to the following:

- The Member is a child (20 years of age or younger)
- AND the Member has one or more of the following:
  - Two or more hospitalizations within the most recent 12 months
  - Received Residential Level III and/or PRTF services within the most recent 12 months.

To schedule a Care Review Team meeting, send an email to: carereviewteam@partnersbhm.org.

To make a referral or obtain more information, call 1-888-235 HOPE (4673).
Providers may refer members to the program or the member may self-refer to Complex Case Management by contacting Access to Care at 1-888-235 HOPE (4673) or by completing a self-referral form available on the Partners website.

**FREQUENTLY ASKED QUESTIONS**

**Q. How are members identified and referred for MH/SU Care Coordination?**
A. Members are identified by reviewing data reports. Referrals – both internal and external – may be made using the Care Coordination Referral Form.

**Q. Do all members active to MH/SU Care Coordination receive the same level or intensity of intervention/activities?**
A. The prioritization and level of intervention for Care Coordination activity determines caseload assignment and ratios. There are three levels of intervention/intensity of Care Coordination activities: light, medium, and high.

**Q. How is MH/SU Care Coordination structured?**
A. Partners’ has an implementation plan with specific strategies. The team is varied with licensed and qualified (non-licensed) behavioral health professionals. There is clearly defined role delineation between licensed MH/SU Care Coordinator and qualified professionals (QP). All cases are assigned by the MH/SU Care Coordination supervisor or Lead Care Coordinator.

**Q. How long is MH/SU Care Coordination involved with a member?**
A. The average length of involvement for most members in Care Coordination is 90 days. The goal is for MH/SU Care Coordination to intervene, ensure member is connected and receiving the right treatment in the right amount and the right time, then step out.

**Q. How do I know if a member has a Care Coordinator?**
A. The provider may contact MH/SU Care Coordination or Access to Care staff to search AlphaMCS for assignment. In addition, providers may send inquiries to MHSA_CC@partnersbhm.org.

**Q. When should providers expect contact from a Care Coordinator?**
A. MH/SU Care Coordinators are likely to contact the provider soon after the initial appointment to ensure the member attended the appointment. Other reasons Care Coordinator may contact the provider include convening a treatment team meeting, inquiring about the status of a member, following up on compliance with Outpatient Commitment Order/Substance Use Commitment Order, coordinating treatment with other providers, etc. The MH/SU Care
Coordinator is mindful of the provider’s schedule and time. Partners CC staff contact providers by telephone first, face to face when convenient or schedule time in advance.

Q. Are members required to have Care Coordination?
A. Care Coordination is voluntary, and the member may refuse at the first contact or at any time while he or she is active to Care Coordination.

Q. Who do providers contact with concerns about Care Coordination?
A. Providers may contact Partners and ask to speak with the supervisor, program manager or director in MH/SU Care Coordination or send an email to MHSA_CC@partnersbhm.org, which are routed to the appropriate supervisor.

Q. What is the licensed MH/SU Care Coordinator and QP role delineation?
A. MH/SU Licensed Care Coordinators are responsible to:
   1. Review clinical records.
   2. Determine the level of Care Coordination intervention based on individual acuity.
   3. Identify providers/stakeholders/advocates in treatment planning process.
   4. Identify barriers to treatment and recommend solutions.
   5. Screen for general physical health conditions and behavioral needs and refer for needed services, including Comprehensive Clinical Assessment to determine Level of Care.
   6. Ensure that a PCP is completed by the behavioral health home with the input of the member, family, and all other service and support providers.
   7. Measure results of intervention and treatment, including reduction in high risk events and inappropriate service utilization, recommending evidence-based practices.
   8. Coordinate referrals for medical care with the CCNC-Care Managers.

MH/SU QP/Care Coordination Specialists perform administrative Care Coordination functions, including:
   1. Education about all available MH/IDD/SUD services and additional supports and resources, such as transportation, vocational and physical health provider;
   2. Linkage to needed psychological, behavioral, education and physical health care services;
   3. Facilitate communication among providers;
   4. Work with the licensed Care Coordinator in identifying the gaps in needed services and intervening to ensure that member receives appropriate care;
   5. Coordinate meetings and make phone calls to monitor member’s attendance and engagement in treatment; and
6. Assist in the coordination of services for the member across the system and with other systems of care, including primary care, schools, System of Care Community Liaisons, Family Partners and/or Peer Support Specialists.

Q. **What are the functions of liaisons in the MH/SU Care Coordination Department?**

A. The liaisons fall into the following categorical functions:

A. **Hospital/Inpatient/Residential Facility Liaisons** - The primary purposes of Care Coordination Liaisons are to operate as the Care Coordination Liaison at designated state psychiatric facilities, community hospitals, facility-based crisis centers, and child residential facilities and perform care coordination functions between Partners and these facilities. The functions include coordinating services for hospital discharges at state and local hospitals, detox facilities, facility-based crisis centers, and child residential facilities with a variety of funding sources and/or indigent care. In addition, Care Coordination Liaisons assist members with mental health or substance use issues navigate the system, access needed services, and develop member support systems.

B. **Alcohol and Drug Abuse Treatment Center (ADATC)/SA/Facility Liaisons** - ADATC/SA/Facility Liaisons function as the Substance Use (SU) Care Coordinator for the MH/SU Care Coordination Unit. They are charged with providing Care Coordination to members who are suffering from chemical dependency and severe mental illness. Care Coordination efforts include:

1. Identifying high-risk substance use members in need of services.
2. Assisting members navigate the NC system with the goal of improving outcomes.
3. Facilitating admissions and discharges with ADATC and other local and regional substance use treatment facilities.
4. Linking members with available community resources.
5. Connecting incarcerated members to needed treatment.

Please note: Similar Care Coordination efforts may be provided by this position to members residing in area homeless shelters.

C. **Transitions to Community Living (TCL) Team** - The TCL Initiative is based on the settlement agreement between North Carolina and the U.S. Department of Justice. It intends to ensure that North Carolina willingly meets the requirements of the Americans with Disabilities Act, the Rehab Act and the Olmstead decision, that services are provided to members in the most integrated setting, prevent inappropriate institutionalization and provide adequate and appropriate services.
The goal of TCL is to ensure that members with Severe Mental Illness (SPI) or Severe and Persistent Mental Illness (SPMI) in or possibly admitted to an adult care home or state psychiatric hospital, are fully informed about community-based living options, including transition to supportive housing, rental subsidies and/or other qualifying assistance. The intended outcome is decreased hospitalization or institutionalization and community integration. The Partners’ TCL Team aims to promote individual growth, recovery, self-determination, community integration and maximize strengths. TCL staff meet with identified members and assess specific needs, goals and preferences with a person-centered approach to transition members to the most integrated and appropriate community setting. Members identified for the TCL Program have access to housing slots in accordance with the state’s priority list.

Identified TCL members receive In-Reach, transition/diversion and/or Follow-Along services.

D. **In-Reach** involves educating the member about community services, supports and supportive housing. In-Reach activities can be done by correspondence, telephone or face-to-face meeting with the member.

**Transition/diversion** helps members receive assistance with identification of community-based living options and supports, development of a community integration plan/transition plan and facilitation of a successful transition into the community.

**Follow-Along** services ensure that the transitioned member’s needs are met as identified in the community integration plan/transition plan. This includes ensuring stable housing, clinical/behavioral supports, social/community activities and health/safety needs.

E. **Transition Coordinators** are Qualified Professionals (QP) and/or licensed clinicians.

Transition Coordinators function as the lead for the transition process and ensures that any member who expresses a desire to move to an integrated community setting is provided with necessary services and supports. The Transition Coordinator is responsible for completing the Transition Planning Tool and convenes a transition planning meeting with the member, guardian and all involved stakeholders.

F. **In-Reach Specialists** are Certified Peer Support Specialists. In-Reach Specialists provide administrative functions such as ongoing education to members about all community-based options, including supported housing, supportive services, financial benefits and rental subsidies. In-Reach Specialists are responsible for identifying housing preferences,
assisting members in decision making, accompanying members to visit housing options and providing linkages to ongoing peer support services. In-Reach Specialists work in collaboration with the Transition Coordinator.

G. **Care Coordinators** are Qualified Professionals (QP) and/or licensed clinicians. Care Coordinators perform the Follow-Along monitoring activities for the TCL member who has transitioned to community living. The Care Coordinator provides Follow-Along services to a TCL member for a minimum of 90 days or until the member is fully supported with appropriate services and supports in the community. The Care Coordinator convenes the post-transition meeting with the member, guardians, service providers and other involved stakeholders.

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**Outpatient Commitment & Substance Use Commitment Orders**

Partners maintains administrative records on all members from the catchment area who are placed on Outpatient Commitment status. The administrative records are secured in Partners’ Care Coordination Department, including the name or names of their treatment provider(s), copy of the Outpatient Commitment Order, and documentation of care coordination contacts to verify the member’s compliance with the Outpatient Commitment Order. Partners follows Outpatient Commitment Law as set forth in **GS 122C-273; 274 and GS 122C 290; 293.**

**The Process for Monitoring Outpatient Commitment Orders**

1. The treating provider is in contact with the member at the clinically appropriate level for the member’s needs. The clinically appropriate Level of Care is established by the treatment team and specified in the Individual Service Plan or the Person-Centered Plan.
2. If the provider believes that the member no longer meets criteria for Outpatient Commitment (OPC), a physician may complete form DMH 5-79-01 “Notice of Commitment Change,” and notify the court so that commitment can be terminated.
3. The treating provider notifies the Care Coordinator when the member on Outpatient Commitment does not attend a scheduled appointment and does not contact the provider to reschedule the appointment. The treatment provider and Care Coordinator discuss the issue and decide when a Request for Transportation Order (AOC-SP-220) is issued.
4. If the member fails to comply, but does not clearly refuse to comply, the provider may request to order the member is taken into custody for a face to face evaluation. The treatment provider does this by completing a Request for Transportation Order (AOC-SP-220). The Clerk of Court then issues an order for a law enforcement officer to bring the member to the designated outpatient treatment physician for examination.
5. If a member fails to comply or clearly refuses to comply with all or part of the prescribed treatment, and the member continues to meet commitment criteria, the provider makes all reasonable efforts to solicit the member’s compliance. Such efforts are documented in a letter to the court by the clinician (provider). This letter, an examination signed by an MD or PhD, and a request for a supplemental hearing (AOC-SP-221) are sent to the Clerk of Court of the supervising county. The Care Coordinator offers technical assistance to the treatment provider in making this request.

6. In the absence of a community treatment provider, the Care Coordination Department may initiate court involvement by seeking approval from Partners Chief Medical Officer, Partners medical staff, or other Partners-approved clinicians.
   a. Upon request, the Clerk of Court schedules a hearing (within 14 days), and notifies the petitioner, the member (respondent), his or her attorney, if any, and the treatment provider.
   b. The court determines if the member has failed to comply with the Outpatient Treatment Order. The court may order an examination to determine the necessity of outpatient or inpatient commitment; may re-issue or change the Outpatient Commitment Order; or may discharge the respondent (member) and dismiss the case.

7. At least 15 days before the end of the Outpatient Commitment period, the physician determines if the member continues to meet criteria for commitment. If the physician determines the member does meet criteria for continuation of Outpatient Commitment, he or she notifies the court and a re-hearing is scheduled. If the physician determines the member no longer meets criteria for Outpatient Commitment, he/she notifies the court that in turn, dismisses the case and the respondent (member) is discharged.

8. The physician responsible for management and supervision of the Commitment and treatment for a substance use member may prescribe or administer appropriate and reasonable treatment either on an outpatient basis or in a 24-hour facility.

9. Care Coordinators make reasonable efforts to monitor member progress, link with courts, and inform appropriate parties of changes in member commitment status, such as transfers to other states and counties, or when the location of respondent becomes unknown.

10. MH/SU Program Assistants work with the MH/SU Care Coordinators for proper tracking. OPC information is submitted to the Care Coordination administrative assistant directly by the Clerks of Court.
GETTING PAID

**FINANCE/CLAIMS DEPARTMENT**

Electronic Connectivity Requirements

The AlphaMCS computer system is web-based software which requires providers to have connectivity to the internet. The provider agrees to use AlphaMCS software to provide Partners with the following information to include, but not limited to:

1. request and manage authorizations,
2. enter and transmit claims, and
3. maintain required pieces of the Client Data Warehouse (CDW).

Providers that are authorized to assess a referred member will submit all required data elements electronically after the last assessment to Partners.

**MEDICAID CLAIMS FILING REQUIREMENT**

Payment Schedule

Medicaid Providers – [https://www.nctracks.nc.gov/content/public/providers.html](https://www.nctracks.nc.gov/content/public/providers.html)

Partners follows the DHB Cutoff and Check Write Schedule for Payments.

Claims Adjudication

Medicaid Providers – [https://www.nctracks.nc.gov/content/public/providers.html](https://www.nctracks.nc.gov/content/public/providers.html)

Providers billing under Partners’ Provider Number shall follow the state process regarding billing enrollment protocols.

Direct enrolled Medicaid Providers refer to: [https://www.nctracks.nc.gov/content/public/providers.html](https://www.nctracks.nc.gov/content/public/providers.html)

For claims and billing assistance please refer to the [NCMMIS Provider Claims and Billing Assistance Guide](https://www.nctracks.nc.gov/content/public/providers.html)

Providers receiving federal funding must comply with Title VI obligations. These providers are obligated to provide equal access and benefits to those with Limited English Proficiency (LEP).
Providers must develop and implement a system to provide those services so LEP persons can have meaningful access to them. This includes, but is not limited to:

1. Contracting with a telephone interpreting service.
2. Hiring bilingual staff.
3. Engaging community volunteers, or
4. Hiring interpreters.

CLAIMS SUBMISSIONS AND CLAIMS INQUIRIES:

Providers must submit claims through the AlphaMCS Provider Portal through an approved 837 submission or direct entry onto CMS 1500 forms for outpatient services or UB04 for hospital inpatient/ED services.

1. Timeframes for Claims Submissions:

All claims must be submitted within 90 days of the date of service to ensure payment, unless otherwise specified in provider’s contract. Claims filed outside of requirement will be denied for payment. Claims based on retroactive Medicaid eligibility must have authorization requested within 90 days and submit claims within 90 days of the date modified in NCTracks for eligibility date range. Claims department should be contacted prior to submitting claims.

2. Process for Submission of Replacement and Voided Claims:

- Replacement claims:
  Providers may submit replacement claims for originally processed claims within 90 days of the processed date, not to exceed 180 days from day of service. Replacement claims submitted outside these guidelines will be denied due to timely filing requirements. Replacement claims originally denied for timely filing will continue to deny.

- Instructions for claims submitted through AlphaMCS:
  In box 22 on the CMS1500, 7 should be selected for a replacement claim and the original claim header number found on the Remittance Advice (RA) where the claim was paid as the reference number.

- Instructions for claims submitted via an 837-transaction set:
  In Loop 2300 – Claims segment/5th element (CLM05-03), 7 (code for resubmission) should be submitted along with a REF segment with “F7” as the reference code identifier and the claims number found on the RA as the reference number. For example:

  \[CLM*01319300001*500***11::7*Y*A*Y**02******N=REF*F8*111111~\]
Once the replacement claim has been received the original claim will deny/recoup and the replacement claim will be processed according to the Partners billing guidelines and edits.

- **Submission of Voided Claims:**
  Providers may submit voided claims for originally paid claims. Billing days for a voided claim is 180 days from the date of service.

- **Instructions for claims submitted through AlphaMCS:**
  In box 22 on the CMS1500, 8 should be selected for a void/cancel claim and the original claim header number found on the RA where the claim was paid as the reference number.

- **Instructions for claims submitted via an 837-transaction set:**
  In Loop 2300 – Claims segment/5th element (CLM05-03), 8 (code for resubmission) should be submitted along with a REF segment with “F8” as the reference code identifier and the claims number found on the RA as the reference number. Voided claims will be reversed from the Partners system and the original claim payment will be recouped on the next EFT transaction date.

3. **Claims Submissions through AlphaMCS**

Providers are contractually required to submit billing electronically through the Partners system. AlphaMCS is a web-based system that is available to Partners providers upon completion of a Trading Partner Agreement (TPA). Billing through the AlphaMCS system is either by direct entry of data where an electronic CMS1500 or UB04 form is accessed and billing information is entered and submitted to Partners for reimbursement. The AlphaMCS Provider Portal Manual gives very specific instructions on what is needed to complete a claims form.

4. **837 Claims Submissions:**

Detailed instructions are provided in the AlphaMCS Claims Guide, a user manual for electronic 837 submissions. This manual gives specific instructions on what is required to submit claims electronically to Partners. The testing and approval process are in this manual.

The HIPAA compliant ANSI transactions are standardized; however, each payor has the ability to insist on use of specific loops or segments. The purpose of the Claims Guide is to clarify those...
choices and requirements so that Providers can submit accurate HIPAA transactions. Partners only accepts HIPAA compliant transactions as required by law.

837 files should be submitted through the Provider Portal of the AlphaMCS system via the transactional upload queue.

Partners provides the following transaction files back to providers:

- 999 acknowledgment file.
- 824 line by line acceptance/rejection file.
- 835 file, which is an electronic version of the remittance advice (RA)

These files are available in the download queue in the Provider Portal of AlphaMCS.

- Multiple occurrences of Same Service in a Day: When a specific service is rendered multiple times in a single day, the service should be bundled and billed using multiple units rather than as separate line items. This will prevent a duplicate billing denial.
- Authorizations: As described in the authorization section of this manual, authorizations are for specific members, providers, types of services, date ranges, and for a set number of units. Providers’ denial due to not being consistent with the authorization.
- National Provider Identifier (NPI): Providers are required to obtain an NPI number to submit billing on the CMS1500 and UB04 forms. The NPI and taxonomy code are required for claims to be accepted and processed. Failure to comply will result in denied claims.

PAPER CLAIMS

- Providers may submit paper claims for a limited amount of time until transition can be made to direct entry of claims into the AlphaMCS system or through submission of an approved 837 file. Providers are required to submit a completed CMS1500 or UB04 form with the correct data elements.
- A remittance advice is available in the RA Section of AlphaMCS. This document reports whether billed services have been approved or denied for payment.
- Paper Claims should be faxed to the Partners Claims Department at 704 854-4203.

PROVIDER BILLING OF PATIENTS WHO ARE MEDICAID RECIPIENTS

Based on 10A NCAC 22J .0106:
“(a) A provider may refuse to accept a patient as a Medicaid patient and bill the patient as a private pay patient only if the provider informs the patient that the provider will not bill Medicaid for any services but will charge the patient for all services provided.

(b) Acceptance of a patient as a Medicaid patient by a provider includes, but is not limited to, entering the patient’s Medicaid number or card into any sort of patient record or general record-keeping system, obtaining other proof of Medicaid eligibility, or filing a Medicaid claim for services provided to a patient. A patient, or a patient’s representative, must request acceptance as a Medicaid patient by:

1. presenting the patient’s Medicaid card or presenting a Medicaid number either orally or in writing; or
2. stating either orally or in writing that the patient has Medicaid coverage; or
3. requesting acceptance of Medicaid upon approval of a pending application or a review of continuing eligibility.

(c) Providers may bill a patient accepted as a Medicaid patient only in the following situations:

1. for allowable deductibles, co-insurance, or co-payments as specified in 10A NCAC 22C .0102; or
2. before the service is provided the provider has informed the patient that the patient may be billed for a service that is not one covered by Medicaid regardless of the type of provider or is beyond the limits on Medicaid services as specified under 10A NCAC 22B, 10A NCAC 22C, and 10A NCAC 22D; or
3. the patient is 65 years of age or older and is enrolled in the Medicare program at the time services are received but has failed to supply a Medicare number as proof of coverage; or
4. the patient is no longer eligible for Medicaid as defined in 10A NCAC 21B.

(d) When a provider files a Medicaid claim for services provided to a Medicaid patient, the provider shall not bill the Medicaid patient for Medicaid services for which it receives no reimbursement from Medicaid when:

1. the provider failed to follow program regulations; or
2. the agency denied the claim on the basis of a lack of medical necessity; or
3. the provider is attempting to bill the Medicaid patient beyond the situations stated in Paragraph (c) of this Rule.

(e) A provider who accepts a patient as a Medicaid patient shall agree to accept Medicaid payment plus any authorized deductible, co-insurance, co-payment and third-party payment as payment in
full for all Medicaid covered services provided, except that a provider may not deny services to any Medicaid patient on account of the individual's inability to pay a deductible, co-insurance or co-payment amount as specified in 10A NCAC 22C .0102. An individual's inability to pay shall not eliminate his or her liability for the cost sharing charge. Notwithstanding anything contained in this Paragraph, a provider may actively pursue recovery of third party funds that are primary to Medicaid.

(f) When a provider accepts a private patient, bills the private patient personally for Medicaid services covered under Medicaid for Medicaid recipients, and the patient is later found to be retroactively eligible for Medicaid, the provider may file for reimbursement with Medicaid. Upon receipt of Medicaid reimbursement, the provider shall refund to the patient all money paid by the patient for the services covered by Medicaid with the exception of any third-party payments or cost sharing amounts as described in 10A NCAC 22C .0102.”

COORDINATION OF BENEFITS

1. Federal and state regulations require Medicaid to be the payer of last resort.

2. Providers are required to collect all first- and third-party funds before submitting Medicaid claims to Partners for reimbursement.

3. Third-party payers are any other funding sources that can be billed to pay for the services provided to the member. This can include worker's compensation, disability insurance or other health insurance.

4. Third-party payers, including Medicare and private health insurance carriers, must process the claim before Partners processes a Medicaid claim.

5. Providers must report any payments or denial reasons from third-party payers on Medicaid claims filed with Partners. Medicaid claims submitted without third-party information will be denied.

6. Partners pays Coordination of Benefit claims according to the "lesser of" methodology. If the Medicaid allowed amount is more than the third-party payment, Partners will pay the difference up to the contracted allowed amount. If the other insurance payment is greater than the Partners contracted amount, no additional amount will be paid.

7. Partners will not pay for any service that could have been paid for by Medicare or other private insurance plans had the beneficiary or provider complied with the plan's
requirements. Examples of common private plan non-compliance denials include, but are not limited to:

- Failure to get an authorization referral from a primary care physician
- The provider is a “Non-participating provider” in the first and/or third-party plan.
- Failure to obtain prior approval

8. Partners will not reimburse providers for covered services provided by clinicians who are non-paneled or not enrolled under the recipient’s third-party coverage plans.

9. If the provider is not enrolled or have paneled staff with the primary payer, the provider should refer the member to an eligible provider of third-party covered services.

10. First-party payers are the clients/member or their guarantors.

* Partners applies the same guidelines when processing claims for State-funded services.
* Providers are not required to bill Medicare/TPL for service codes that are listed on the current bypass list.

**All claims are required to identify amounts collected from both first and third parties and only request payment for any remaining amounts.**

1. **Eligibility Determination Process by Provider:**

   Providers should conduct a comprehensive eligibility determination process whenever an individual enters the service delivery system. Periodically (and no less than annually), providers should update the eligibility information to determine if there are any first or third-party liabilities for this individual. It is the responsibility of the provider to monitor this information and to adjust the billing accordingly. First and Third-Party insurance should be added to the member’s record by doing a Client Update in the AlphaMCS system.

2. **Obligation to Collect**

   Providers should make good faith efforts to collect all first and third-party funds prior to billing Partners. First Party charges should be shown on the claim whether they were collected or not. The AlphaMCS system can deny and or adjust the claim based upon what should have been collected.

3. **Reporting of Third Party Payments**

   Providers are required to record on the claim form either the payment or denial information from a third-party payer. Copies of the Explanation of Benefits (EOB) from the insurance company should be retained by the provider if they submit electronic billing. If a paper claim is submitted, it is required that a copy of the EOB be submitted with the claim.
form. Providers are required to bill any third-party insurance carriers. This includes worker’s compensation, Medicare, EAP programs, etc. Providers must wait a reasonable amount of time to obtain a response from the insurance company. Providers may submit claims to Partners up to 180 days from the date of service in the event of Coordination of Benefits has occurred. If a member receives retroactive insurance, submit claims within 90 days of the date added in NCTracks for consideration. Claims department should be contacted prior to submitting claims.

**Denial Process**
Services provided without pre-authorization will be denied. Any denied but correctable claim may be resubmitted within 90 days of the date of denial.

**Hospital Billing**
Please refer to the *Hospital Behavioral Health Facility Instruction Manual* or guidelines found on the Partners website for additional information.

**Prompt Pay Provision**
Partners follows prompt pay guidelines. Partners reviews all claims or invoices within 18 calendar days after receipt. Partners either approves or denies payment for all or portions of the billed services or request additional information. Partners pays all approved or undisputed portions of claims/invoices for services performed by the provider within 30 calendar days after approval. Such payment constitutes full and final payment of the approved or undisputed portions of the claims or invoices.

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**Billable and Claims Processing Issues:**
1-877-864-1454 ext. 6486 or claimsdepartment@partnersbhm.org

**Finance Issues, EFT, and Payment Issues:**
1-877-864-1454, ext. 2516

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**ELIGIBILITY AND ENROLLMENT**

**Eligibility Determination**
Members who have their services paid for in whole or in part by Partners must be enrolled in the Partners system.
It is the responsibility of each provider to make a complete and thorough investigation of a member’s ability to pay prior to requesting to enroll that person into the Partners system. This requires that the provider determine the following:

- If the member has Medicaid or whether the member may be eligible for Medicaid.
- If the member has Medicare or any other third-party insurance coverage.
- If there is any other payer involved workers compensation, EAP program, court ordered services paid for by the court, etc.
- If the member meets Partners’ criteria for use of local or state funds to pay for services. The criteria is the lack of Medicaid or other third-party insurance and the inability of the member or family to pay for a portion of healthcare services.
- If the member has already been enrolled in the Partners’ system.

If the member has Medicaid or has been previously enrolled with Partners, he or she is financially eligible for Medicaid reimbursable services from Partners. If the individual is not yet enrolled, then the provider must provide the data necessary to enroll the individual. Enrollments can be performed electronically through the AlphaMCS Provider Portal or by contacting Partners at (toll-free) 1-877-864-1454.

Providers should assist individual who may be eligible for Medicaid funding in applying for Medicaid through their county Department of Social Services.

**Key Data to Capture during Enrollment**

All providers are required to ensure enrollment data is up-to-date based on the most current Partners Enrollment Procedures and training.

Submission of authorizations and claims prior to completing enrollment data will result in denials of authorizations and claims.

The Medicaid information must be provided when requesting an enrollment. If the member has any other third-party insurance, including Medicare, this information must also be included in the enrollment request. Members whose services are paid in part by third party insurance can be enrolled if Partners is to be a secondary payer.

**EFFECTIVE DATE OF ENROLLMENT**

Enrollment in the Partners system must be done prior to providing services except in emergency situations. It is the provider’s responsibility to complete the eligibility determination process, including verification of previous enrollment in the Partners system and to complete the
enrollment process prior to providing services. Events with service dates prior to an enrollment date will be denied.

Crisis services provided in an emergency are an exception to this rule. In these cases, the provider must enroll the member within seven days and indicate the date of enrollment as the date that the emergency services were provided.

**MEMBER ID**

The Member ID Number identifies the specific member receiving the service and is assigned by the Partners information system. The member must be enrolled in the Partners system to obtain this number. All claims submitted with incorrect member ID numbers or for members whose enrollment is no longer active will be denied.

**REPORTING OF THIRD PARTY PAYMENTS**

Providers must bill any third-party insurance coverage. This includes workers compensation, Medicare, EAP programs, etc.

Providers are required to record on the claim either the payment or denial information from a third-party payer. Copies of the Electronic Remittance Advice (ERA) or Explanation of Benefits (EOB) from the insurance company should be retained by the provider if they submit electronic billing. If paper claims are submitted to Partners, the provider is required to submit copies of the ERA or EOB with the claim form to Partners.

Providers must wait a reasonable amount of time to obtain a response from the insurance company. However, it is important that providers not exceed the 180-day coordination of benefits timely filing rule before submitting claims. If an insurance company pays after a claim has been submitted to Partners, the provider must notify and reimburse Partners.

**PROCESS TO MODIFY**

If there are known changes to the member’s income or family status, the provider is required to update records and adjust the payment. Members who become Medicaid eligible for Medicaid covered services and payments should be adjusted immediately when this is determined.

At least on a quarterly basis (every 90 days), the member’s ability to pay should be verified and adjustments made by completing a Client Update in AlphaMCS Provider Portal, as necessary.
The member’s income and family status are managed by providers and first party liability must be reported on claims. This is a compliance issue that will be audited.

**Eligibility for Benefit Determination**

Prior to being entered in the Partners system, each member must have completed the financial eligibility process to establish any third-party coverage and to establish the ability to pay for services. It is the responsibility of each provider to make a complete and thorough investigation of an individual’s ability to pay prior to requesting to enroll that person into the Partners’ system. If the individual is not a Medicaid recipient and does not meet the guidelines used by the provider to determine ability to pay, the person should not be enrolled in Partners’ system.

**Authorizations Required for Payment**

**SYSTEM EDIT S**

The Partners information system is specifically designed to search for authorization data prior to paying claims. It has edits that are verified, therefore, the provider must be very attentive to what has been authorized to ensure maximum reimbursement.

**AUTHORIZATION NUMBER AND EFFECTIVE DATES**

Each authorization has a unique number, a start date, and an end date. Only services with dates of service within these specific time frames will be paid. Dates and/or units outside these parameters will be denied.

**SERVICE CATEGORIES OR SPECIFIC SERVICES**

Each authorization indicates specific categories of services or in some cases very specific services that have been authorized. Each service is validated against the authorization to make sure that the service matches the authorization. Services that are outside of these parameters are denied.

**UNITS OF SERVICE**

Each authorization indicates the maximum number of units of service that are being authorized. As each claim is being processed, the system checks to make sure that the units being claimed fall within the units of services authorized. The system denies claims that exceed the limits.

Providers need established internal procedures to monitor units of service against authorizations to avoid having claims denied due to exceeding units of service.
EXCEPTIONS TO AUTHORIZATION RULE

There are certain services that pay without an authorization. These services are limited in scope and in the total number to a member, not to a provider. Once the annual limit is reached for a member, then all services without an authorization, regardless of the provider of the service, are denied. Providers must be constantly aware of and track on this issue to avoid denied claims.

Clean Claims

A clean claim is defined as a claim that has all the required data elements, is submitted in the correct format and meets the terms of the contract between Partners and the provider.

SERVICE CODES AND RATES - CONTRACT PROVISIONS

Provider contracts include a listing of services which they are eligible to provide. Providers are reimbursed at the Partners published rates for the service being provided unless otherwise stated in their contract. Providers must only use the service codes in their contract or reimbursement is denied as non-contracted services. Providers can submit claims for more than the published rates, but only the published or contracted rate is paid. If a provider submits a service claim for less than the published rate, the lower rate is paid.

It is the provider’s responsibility to monitor the publishing of rates and to make the necessary changes to their billing systems.

PAYMENT OF CLAIMS AND CLAIMS INQUIRIES

Providers must submit claims through AlphaMCS Provider Portal or submit an electronic 837 file unless their contract specifically states an alternative method. Providers are encouraged to produce routine billings on a weekly or bi-weekly schedule.

TIMEFRAMES FOR SUBMISSION OF CLAIMS

All claims must be submitted within 90 days of the date of service to ensure payment, unless otherwise specified in the provider’s contract. Claims submitted outside of the allowable billing days are denied.

Formats & Other General Rules to Follow Include:

- NC Innovations Services, Outpatient Therapy, Residential (state-funded) and other daily and periodic services must be submitted using the ANSI 837P (Professional) format or the electronic CMS 1500 form if billing through AlphaMCS Provider Portal.
Inpatient, Therapeutic Leave, Residential Services (Medicaid-funded), Out-Patient Revenue Codes and ICF Services must be submitted using the ANSI 837I (Institutional) format or the electronic UB04 form if billing through AlphaMCS Provider Portal.

**MULTIPLE OCCURRENCES OF SAME SERVICE IN A DAY**

When a specific service is rendered multiple times in a single day, the service must be bundled and billed using multiple units rather than separate line items. This prevents a duplicate billing denial.

**AUTHORIZATION**

As described in the authorization section of this manual, authorizations are for specific members, providers, types of services, date ranges, and for a set number of units. Providers are responsible for maintaining internal controls within their information systems to avoid a denial due to inconsistency with the authorization.

**NPI (NATIONAL PROVIDER IDENTIFIER)**

Providers are required to obtain an NPI number to submit billing on the CMS1500 and UB04 forms. The NPI number and taxonomy code are required for claims to be accepted and processed. Failure to comply with these guidelines will result in denied billing.

Providers should visit [https://nppes.cms.hhs.gov/NPPES/Welcome.do](https://nppes.cms.hhs.gov/NPPES/Welcome.do) and follow the instructions on the website to obtain an NPI number. Providers apply either as an organization (TFC) or as an individual (associate/provisionally licensed). They should choose the taxonomy that best identifies their type/specialty and then they will receive their NPI number from NPPES in a couple of days.

**PARTNERS’ RESPONSIBILITIES TO PROVIDERS**

- Certify funding for all contracts in accordance with G.S. 159.
- Review and approve all financial commitments made by Partners.
- Assign and monitor maximum funding for contracts.
- Monitor grant funds.
- Monitor retroactive Medicaid eligibility and recovery of funds.
- Manage claims processing and pay clean claims within Prompt Pay Guidelines.
- Issue payments and Remittance Advices (RAs) on paid and denied claims.
- Recover funds based on audit findings.
- Audit providers for Coordination of Benefits.
Investigate and respond to member grievances and complaints related to provider services.
Review provider’s documentation of complaints, grievances and their resolutions and ensure providers incorporate these complaints into their Quality Assurance /Quality Improvement process.
Determine when complaints should be forwarded to Quality Management Department for targeted monitoring review.
Determine if complaints are substantiated, partially substantiated, unsubstantiated, resolved or unresolved.
Ensure timeframes for scheduling member appointments comply.
Ensure provider agencies follow the “No Wrong Door” policy.
Ensure providers do not take adverse actions against real or suspected complainant(s) and to clearly understand this activity will be acted upon by Partners accordingly.
Notify complainant and provider of their appeal rights if there is a disagreement with the results of Partners action on complaints.
Ensure complaints related to licensed facilities, use, neglect and exploitation, etc., are reported to the appropriate agencies, local Department of Social Services (DSS), Division of Health Service Regulations.

PROVIDER’S RESPONSIBILITIES

Verify member insurance coverage at the time of referral/admission or each appointment; and on a quarterly basis.
Determine the member’s ability to pay based on citizenship, income and availability/coverage of other insurance for all designated non-Medicaid services based on your agency’s contract requirements.
Bill all first and third-party payers prior to submitting claims to Partners.
Report all first party required fees and third-party payments and denials on the claim.
Submit clean claims electronically within 90 days of the date of service unless otherwise stated in your contract.
Identify all billing errors to the Partners Claims Department.
Manage your agency’s Accounts Receivable.
Submit all documentation which is required for federal, state, or grant reporting requirements; this includes, but is not limited to, required enrollment demographics that must be reported to the State of North Carolina by Partners.
CLAIMS AUDITS AND INVESTIGATIONS; REPORTING FRAUD AND ABUSE

PROVIDER RESPONSIBILITIES FOR REPORTING FRAUD, WASTE AND ABUSE

Providers are responsible for reporting any suspicions or knowledge of fraud, waste or financial abuse (FWA) to Partners Alert Line. Medicaid fraud and abuse is planned deception or misrepresentation that results in a benefit such as payment or coverage. Examples of Medicaid fraud and abuse includes, but is not limited to:

- A member does not report all income when applying for Medicaid.
- A member does not report other insurance when applying for Medicaid.
- A non-Medicaid recipient uses a Medicaid recipient’s card with or without the recipient’s permission.
- A provider’s credentials are not accurate.
- A bill for services that were not rendered.
- A provider performs and bills for services not medically necessary.

You can anonymously report fraud or financial abuse. However, to conduct an effective investigation we may need to confidentially contact you. If you ask for confidentiality, your name will not be shared with anyone who is being investigated. (In rare cases involving legal proceedings, we may have to reveal who you are.) Reports can be made by calling the Alert Line at 866-806-8777 or reporting online through www.partnersbhm.alertline.com.

PROVIDER SELF-AUDIT AND REPAYMENT

Inappropriate payments made to providers within the Partners network inflates the costs of providing care to Medicaid and other publicly-funded beneficiaries. Partners encourages providers to conduct self-audits and report identified overpayments. Partners retains its right and responsibility to identify and recover overpayments or take any other action available under law when it identifies overpayments.

Providers must submit written notification to the Partners’ Finance Department of any inappropriate payments identified and must clearly indicate the claim specific information and findings, preferably a copy of the specific claim detail with a minimum of the following data:

1. Member Name (Last, First, MI)
2. Medicaid ID #
3. Date of Service

For more information, go to Partners Self-Audit Protocol for Providers.
4. Procedure Code
5. Individual Claim # (ICN)
6. Provider #
7. Amount Billed
8. Amount Paid
9. Paid Date
10. Refund Amount
11. Reason for Error

Partners’ reserves the right to apply penalties and interest to any overpayments made to providers in which full repayment is not received within 30 calendar days.

**PREPAYMENT CLAIMS REVIEW**

Partners is committed to paying providers timely and accurately for all clean claims. Prepayment claims review is a process in which the payment of a provider’s submitted claims is temporarily pended in the payment system until review by the Program Integrity Department for supporting documentation. Our Prepayment Claims Review process ensures that claims presented by providers meet contract requirements and federal and state laws and regulations.

The Program Integrity Department identifies providers for possible prepayment claims review through various methods (e.g., data mining, complaints). Prior to placing a provider on prepayment claims review, the Program Integrity Director reviews each case and consults with our Provider Network and Finance departments, as indicated, to understand all aspects of the provider and billing practices. Grounds for placement on Prepayment Claims Review include:

- Credible allegation of fraud
- Identification of aberrant billing practices as a result of investigations
- Data analysis by Partners
- Failure of provider to timely respond to a document requested by Partners
- Multiple substantiated cases in a 12 month period, including:
  - Providers who have four or more service related allegations submitted for payment during the previous 12 months
  - Providers who have a clean claims compliance rate of less than 70% and four or more service related allegations
- Providers who have a claims denial rate of more than 15%

Once a provider is flagged for prepayment claims review, claims that are identified to be paid through our adjudication process are pended for further examination. When a provider is placed on prepayment claims review, they will be notified by certified mail.
We check the claim to ensure it meets all applicable requirement, including, but not limited to, compliance with:

- Federal and state laws and regulations
- North Carolina Department of Health Benefits policy
- Medical necessity requirements
- Prior authorization requirements
- Licensure and certification requirements

All claims confirmed as compliant are promptly processed for payment. If the claim cannot be confirmed as compliant, it is denied.

Providers are removed from prepayment claims review when:

- The provider has met the prepayment claims review claim accuracy rate of 70% for three consecutive months within six-month period.
- A tentative restraining order (TRO) to halt the prepayment claims review is received.
- The provider’s contract is terminated and claims submission has ceased.

**PROGRAM INTEGRITY DEPARTMENT**

One of the responsibilities of Partners is to protect the Provider Network -- and the members, patients and others we all serve with taxpayer dollars -- from health care FWA. The Program Integrity Department helps Partners meet its responsibilities to ensure that funds are utilized for the appropriate level and intensity of services through preventative and detective activities designed to reduce fraud, waste and financial abuse as well as ensure compliance with federal, state, and local laws, rules and regulations. The Department is charged with these responsibilities in accordance with 42 Code of Federal Regulations (CFR) part 455, and all applicable policies and procedures.

The Program Integrity Department carries out its responsibilities through the conduct of proactive and reactive audits and investigations that may result in referrals of potential fraud to NC DHB, issuance of a tentative notice of overpayment (TNO) and/or issuance of a warning letter. TNOs may be issued because of:

- Failure to comply with state, federal, Medicaid or other revenue source requirements; or
- Payment for a service or a portion of a service that should have been disallowed; or
- Payment for a claim that was fraudulently billed.

Overpayments are not always intentional or fraudulent but must still be identified and recovered.

To report Fraud, Waste or Abuse go to [Partners Alert Line](#) or call 866-806-8777
Program Integrity Department’s functions include using data analysis, performing audits and conducting investigations. Data analysis proactively identifies trends in claims data that may be indicative of fraud or financial abuse. Information developed by Program Integrity’s data analyst is provided to auditors or investigators who use it to start work or in furtherance of existing work.

Program Integrity’s audits are proactive reviews of paid claims to ensure compliance with all federal and state laws, rules, regulations and contract requirements. Specifically, auditors will validate the presence of information to support billing of services.

Program Integrity Investigations are typically reactive in nature and are based on allegations of fraud or financial abuse regarding services rendered by Partners’ providers.

**Role of Finance Department**

The Finance Department assists Program Integrity with the review of financial reports, financial statements, and accounting procedures. The Finance and Program Integrity Departments work collaboratively with the provider in the collection of any overpayments deemed final.

**REPORTING TO STATE AND FEDERAL AUTHORITIES**

Partners is obligated to report each case of potential health care fraud. Information reported to NC DHB Office of Compliance and Program Integrity must include, but is not limited to, the following:

- The provider’s name and number.
- The source of the complaint.
- The type of provider.
- The nature of the complaint.
- The approximate range of dollars involved and the legal and administrative disposition of the case.

Potentially fraudulent billing may include, but is not limited to:

- unbundling services.
- billing for services by non-credentialed or non-licensed staff.
- billing for a service the provider never rendered or for which documentation is absent or inadequate.

**OVERPAYMENT REPAYMENT PROCESS/PAYBACKS**

If an identified overpayment is deemed final, which occurs when a provider either completes the Partners dispute resolution process described in this manual or the time to dispute the TNO
Partners Behavioral Health Management Provider Operations Manual

expires unexercised, it must be paid back to Partners. Program Integrity works with the Finance Department in the recovery of funds.

It is the policy of Partners to recoup the amount owed from current and/or future claims. For paybacks that exceed outstanding claims, Partners invoices the provider the amount owed. The provider then has 30 calendar days from the date of the final determination of overpayment to pay the total amount owed. Balances that exceed 30 days from the date of final determination are subject to a 10 percent penalty, monthly accrued at an interest rate as set by the Secretary of the NC Department of Revenue and possible collection fees and other activities as permitted by law. Failure to timely repay an overpayment is a breach of contract and grounds for termination from Partners’ network and/or other sanctions. As a result, Partners takes this program integrity responsibility seriously and works diligently and collaboratively with providers to ensure fair and accurate processes and outcomes.

QUALITY MANAGEMENT

The Quality Management (QM) Department has oversight for quality assurance and improvement activities throughout the Partners’ system. The department facilitates a Global Continuous Quality Improvement system that includes all network providers.

The Partners’ Quality Improvement/Quality Assurance (QI/QA) Program helps to ensure Partners meets its regulatory and contractual responsibilities through continuous and systematic measurement and improvement of program systems and processes.

The focus of the QM Department is to systematically use performance information and data to drive improved member outcomes, training, and support. This department assists in guiding and supporting business decisions as well as creating a system of continual integrity and readiness for external review agents such as the Department of Health and Human Services (DHHS), External Quality Review (EQR) Oversight, national accrediting bodies and other agents.

In addition to assurance of an effective QA/QI program, the QM Department is responsible for, but not limited to:

- Oversight and training of the North Carolina Treatment Outcomes and Program Performance Systems (NCTOPPS) for the Partners’ catchment area.
- Coordination, facilitation, evaluation, and reporting of various member and provider satisfaction surveys to include but not limited to the Perception of Care Survey and the
Provider Satisfaction Survey.

- Provider monitoring and incident report management.
- Key performance indicator reporting and evaluation.
- Internal auditing of Partners’ departments.
- Serve on various internal and external committees and workgroups, including facilitation of the provider-led Global Continuous Quality Improvement Committee.
- Coordinate and facilitate various mandated external reviews of Partners, including but not limited to national accreditation, State and Medicaid contractual compliance reviews and External Quality Reviews (EQR).
- Monitoring and internal reporting of the Department of Health and Safety Regulation (DHSR) findings.
- Monitoring and reporting of provider’s failure to provide Innovations Waiver back-up staffing.

**Continuous Quality Improvement**

Partners expects network providers to perform continual self-assessment of services and operations, as well as develop and implement plans to improve member outcomes. Providers are required to follow all Quality Assurance and Improvement standards outlined in North Carolina Administrative Code as well as the Provider Contract and Provider Operations Manual. The assessment of need as well as the determination of areas for improvement should be based on valid and reliable data. The providers’ Quality Improvement system, as well as systems used to assess services, plans and initiatives for improvement, along with their effectiveness, are evaluated by Partners.

**Quality Improvement Projects**

A Quality Improvement Project (QIP) is an endeavor to measure improvement and quality of service delivery and/or outcomes of care provided by providers. The data collected from the Quality Improvement Projects aid in improving overall service delivery to members. Data collection and analysis may require the provider to make changes, modifications, and/or improve processes and service delivery.

Providers should demonstrate a Continuous Quality Improvement (CQI) process by identifying Quality Improvement Projects per fiscal year (July-June). Partners may request a sample of the provider’s CQI outline, intervention strategies and findings and/or results annually. QIPs are designed...
to meet the regulatory standards for the provider organization’s national accrediting body, DHB, and DMH/DD/SAS rules.

It is the expectation that providers utilize all the following factors for selected Quality Improvement Project(s):

- Quality assessments are based on process and outcome indicators and not solely relying on inputs;
- Quality Improvement Projects (QIPs) include measurable goals, projected timeframes for meeting goals, identifying barriers, implementing interventions as necessary; and
- Quality outcomes are built into the regular functioning of service delivery for members and families served.

Partners may make use of the data analysis for various quality assurance functions, i.e. to review patterns and trends, creating interventions which develop opportunities for provider education, evaluation, and monitoring. Interventions developed and implemented within the provider network improve clinical care and service delivery to members.

**REGULATORY COMPLIANCE**

Partners’ Regulatory Compliance Unit is responsible for compliance relating to healthcare fraud, waste, and financial abuse, health information management and HIPAA. The Regulatory Compliance Unit provides education and training to providers on a variety of regulatory compliance-related topics.

<table>
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<tr>
<th>Primary Areas Covered by Regulatory Compliance</th>
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<tr>
<td>Regulatory Compliance deals with the prevention, detection, investigation, resolution and reporting of suspected healthcare fraud, financial waste and abuse, HIPAA Privacy, and HIPAA Security violations.</td>
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<tr>
<th>Corporate Compliance Plan</th>
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<tr>
<td>Provider agencies must develop a Corporate Compliance Plan that includes procedures designed to guard against healthcare fraud and abuse. The plan must include, but is not limited to the following:</td>
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- An internal audit process to verify that services billed were furnished by appropriately credentialed staff and that those services were appropriately documented.
- The plan ensures that staff performing services under the Partners’ contract have not been excluded from participation in Federal Health Care Programs under either Section 1128 or 1128A of the Social Security Act. Routine monitoring of applicable exclusion listings must be
incorporated into the plan.

- Written policies, procedures and standards of conduct that articulate the agency’s commitment to comply with all applicable state and federal standards for the protection against healthcare fraud and financial abuse.
- The designation of a compliance officer and compliance committee.
- A training program for the compliance officer and agency employees.
- Systems for reporting suspected healthcare fraud and financial abuse by employees and members and non-retaliatory protections for those reporting.
- Provisions for internal monitoring, auditing, and reporting.
- Procedures for responses to detected offenses and for the development and implementation of corrective action plans.
- Reporting to monitoring and law enforcement agencies, including Partners, as appropriate and required by state and local law and federal regulations.

MEDICAL RECORD REQUIREMENTS

Each provider must adhere to the regulations set forth in the following:

- The NCTracks Provider Claims and Billing Assistance Guide
- APSM 45-1: Confidentiality Rules
- APSM 10-5: Records Retention and Disposition Schedule DMH/DD/SAS Provider Agency
- Clinical Coverage Policies
- NC MH/DD/SAS Health Plan and NC Innovations Waivers
- HIPAA Privacy and Security Regulations, including the HITECH Act and Omnibus Rule
- Provider Procurement and State-funded Contract with Partners

It is expectation of Partners that all information developed or received by the provider about the member during treatment would be included in the service record.

Information needed for reimbursement purposes may at times be filed in the clinical service record, but this is not required. Providers should record and retain billing records and related information according to the specific requirements of the payors involved.
Many service definitions included in the Clinical Coverage Policies contain documentation requirements that are specific to those services. For this reason, refer to each service definition to ensure compliance with the documentation requirements specific to that definition.

The links listed here should be used to obtain detailed implementation information regarding the MH/IDD/SUD service definitions.

Some longstanding State-defined service definitions also contain certain documentation requirements.

The official posting of many of the MH/IDD/SUD service definitions is found within the various clinical coverage policies published by DHB.

These definitions are located on the Clinical Coverage Policy page of the NC Department of Health and Human Services website, which includes, but is not limited to, the following clinical coverage policies:

- A4 Services for Individuals with Mental Retardation/Developmental Disabilities, and Mental Health/Substance Abuse Co-Occurring Disorders
- 8A Enhanced Mental Health and Substance Abuse Services
- 8C Outpatient Behavioral Health Services Provided by Direct-Enrolled Providers
- 8D-1 Psychiatric Residential Treatment Facilities for Children under the Age of 21
- 8D-2 Residential Treatment Services

During routine monitoring, the medical record is reviewed to ensure the record contains the following at a minimum:

1. Demographics (member name, gender, race, date of birth, Medicaid ID number, service record number)
2. Member's treatment plan including goals
3. Service progress/treatment notes that are individualized and specific to the date the service was delivered, the duration of the service billed and the signature of the person who delivered the service
4. Confidentiality of recipient information
5. Service orders
6. Consent for treatment
7. Reason for admission
8. Evidence that the recipient meets entrance criteria per the service definition
9. Presenting problem at admission
10. Mental status at admission
11. Psychiatric history
12. Special status situations and suicide risk
13. Medical history
14. Developmental/education history for minor
15. Medications
16. Allergies and adverse reactions
17. Preventive services/risk screening
18. Documentation of clinical findings and evaluation of each visit
19. Admission/discharge date

It is the provider’s responsibility to stay abreast of the requirements for delivering the services they are credentialed and contracted to provide in the Partners’ Provider Network.

If a Medicaid Provider contract is terminated, closes network operations or closes its business in North Carolina, a maintenance and storage plan must be submitted for approval by Partners or copies of Medicaid medical records must be turned over to Partners. Partners’ Health Information Management Department must be notified immediately of any decisions made by a provider to terminate contract, close network operations or close a NC business to coordinate the proper handling and transferring of medical records.

**HIPAA INCIDENT REPORTING**

- Providers are required to adhere to regulations regarding HIPAA standards. In the instance of a HIPAA breach/violation, Partners must be notified within 24 hours of the occurrence.

- Providers may report incidents by calling the Regulatory Compliance Alert Line at 1-866-806-8777 or by logging on to Partners’ Regulatory Compliance Alert Line Program: https://partnersbhm.alertline.com. (Confidential, easy-to-use, and always available).

- Providers are responsible for notifying all members in writing who are potentially affected by any HIPAA breach/violation according to state and federal requirements, including the HITECH Act and Omnibus Rule.
PARTNERS’ RESPONSIBILITIES TO PROVIDERS

- Ensure providers and practitioners compliance with treatment record standards and confidentiality practices and follow-up on any out of compliances or complaints regarding these areas.
- Ongoing monitoring of systems within the network at large to monitor for healthcare fraud and financial abuse as well as HIPAA compliance.
- Review critical incidents that occur within the network and ensure that all appropriate follow-up has been completed and that rights of members have been protected.
- Monitor data from across the network and evaluate for trends and patterns to consider in planning.
- Provide training and technical assistance to the provider network regarding regulatory compliance.

PROVIDER’S RESPONSIBILITIES

- Cooperate fully with any review, investigation, complaint inquiry/follow-up and audit.
- Provide to Partners requested records and documentation needed to resolve issues within the timeframe specified.
- Maintain systems, procedures and documentation that demonstrates compliance with all applicable federal, state and local rules, laws and practices, including:
  - Conducting self-monitoring and auditing activities for compliance;
  - Develop and implement, within given timelines, plans of corrections and/or financial recoupment (paybacks) with any area found out of compliance; and
  - Maintain internal systems, procedures and documentation that demonstrate compliance with Partners requirements as outlined in the contract and this manual.
- Comply with North Carolina state rules for service records, confidentiality and record retention to meet treatment record standards as detailed in the Medical Records Requirements section of the Provider Operations Manual.
- Notify Partners of any concerns or complaints in regard to the services provided by the LME/MCO and work with the Partners toward resolution.
- Develop and implement a system of continuous quality improvement which includes, at a minimum, the development of systems to self-evaluate services, systems to evaluate data collected and to identify needed areas of improvement.
- Implement strategies to address areas of improvement and continual evaluation and refinement of processes.
- Submit documentation of all incidents including requested follow-up documentation,
as defined by state rules, to Partners within required timelines and cooperate fully with follow up as determined by Partners.

- Notify in writing all members who are potentially affected by a HIPAA breach/violation.

**CLINICAL PRACTICE GUIDELINES**

Medical necessity must be met for all services. Medical Necessity is defined as services that are viewed as medically necessary to diagnose or treat a behavioral health condition. Services must also meet criteria supplied by Clinical Coverage Policies appropriate to the specific service. These policies can be found at [DMA NC DHHS Behavioral Health Clinical Coverage Policies](#) and also through the [Service Definitions](#) page on Partners website.

Partners develops clinical practice guidelines for behavioral health management of its members that are consistent with national or professional standards and covered benefits. The following guidelines are reviewed and updated annually by Partners’ Clinical Advisory Committee. It is expected that all network providers will follow the below guidelines and requirements as delineated in contracts.

The following resources and links are provided as assistance in locating clinical practice guidelines and are not designed to be a comprehensive list for providers. Clinical Practice Guidelines can also be found on [Partners' Provider Knowledge Base](#) website under Clinical Tools.

**HELPFUL WEBSITES**

Contracted Providers must keep abreast of rule changes at the state level, attend workshops and trainings to maintain clinical skills and/or licensure, be knowledgeable on evidenced based or emerging practices, and be current on coding and reimbursement. Partners provides many resources to assist providers in meeting these requirements. We will communicate information regarding workshops through a variety of mediums and will offer trainings or technical assistance as needed.

The following resources and links are provided as assistance and are not designed to be a comprehensive list for providers.

<table>
<thead>
<tr>
<th>Advocacy:</th>
<th>National Alliance on Mental Illness (NAMI)</th>
<th><a href="http://www.nami.org">www.nami.org</a></th>
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<tr>
<td></td>
<td>ARC NC</td>
<td><a href="http://www.arcnc.org">www.arcnc.org</a></td>
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<tr>
<td>Association/Resource</td>
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<tr>
<td>Autism Society of NC</td>
<td><a href="http://www.autismsociety-nc.org">www.autismsociety-nc.org</a></td>
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<tr>
<td>Exceptional Children’s Assistance Parent Center</td>
<td><a href="http://www.ecac-parentcenter.org">www.ecac-parentcenter.org</a></td>
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<tr>
<td>NC Council on Developmental Disabilities</td>
<td><a href="http://www.ncdd.org">www.ncdd.org</a></td>
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<td>NC Able Act</td>
<td><a href="http://www.able-now.com">www.able-now.com</a></td>
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<tr>
<td>Brain Injury Association of NC</td>
<td><a href="http://www.bianc.net">www.bianc.net</a></td>
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<tr>
<td>Alcoholics Anonymous</td>
<td><a href="http://www.aanorthcarolina.org">www.aanorthcarolina.org</a></td>
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<tr>
<td>Narcotics Anonymous</td>
<td><a href="http://www.ncregion-na.org">www.ncregion-na.org</a></td>
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<tr>
<td>Celebrate Recovery</td>
<td><a href="http://www.celebraterecovery.com">www.celebraterecovery.com</a></td>
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<tr>
<td>Associations:</td>
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<tr>
<td>American Academy of Child and Adolescent Psychiatry</td>
<td><a href="http://www.aacap.org">www.aacap.org</a></td>
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<tr>
<td>American Academy of Psychoanalysis and Dynamic Psychiatry</td>
<td><a href="http://www.aapsa.org">www.aapsa.org</a></td>
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<tr>
<td>American Association for Geriatric Psychiatry</td>
<td><a href="http://www.aagponline.org">www.aagponline.org</a></td>
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<tr>
<td>American Association of Marriage and Family Therapy</td>
<td><a href="http://www.aamft.org">www.aamft.org</a></td>
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<tr>
<td>American Association of Pastoral Counselors</td>
<td><a href="http://www.aapc.org">www.aapc.org</a></td>
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<tr>
<td>American Psychiatric Association</td>
<td><a href="http://www.psych.org">www.psych.org</a></td>
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<tr>
<td>American Psychological Association</td>
<td><a href="http://www.apa.org">www.apa.org</a></td>
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<td>American Psychological Society</td>
<td><a href="http://www.psychologicalscience.org">www.psychologicalscience.org</a></td>
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<td>Autism Society of America</td>
<td><a href="http://www.autism-society.org">www.autism-society.org</a></td>
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<tr>
<td>National Association of Protection and Advocacy Systems (NAPAS)</td>
<td><a href="http://www.protectionandadvocacy.com">www.protectionandadvocacy.com</a></td>
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<tr>
<td>National Association of Psychiatric Health Systems</td>
<td><a href="http://www.naphs.org">www.naphs.org</a></td>
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<tr>
<td>National Association of Social Workers</td>
<td><a href="http://www.socialworkers.org">www.socialworkers.org</a></td>
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<tr>
<td>National Association of State Mental Health Program Directors (NASMHDPD)</td>
<td><a href="http://www.nasmhpd.org">www.nasmhpd.org</a></td>
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<tr>
<td>National Institute of Mental Health</td>
<td><a href="http://www.nimh.nih.gov">www.nimh.nih.gov</a></td>
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<tr>
<td>NC Council (named changed to i2i Center)</td>
<td><a href="https://i2icenter.org/">https://i2icenter.org/</a></td>
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<tr>
<td>North Carolina Substance Abuse Professional Practice Board</td>
<td><a href="http://www.ncsappb.org/">http://www.ncsappb.org/</a></td>
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<tr>
<td>United States Psychiatric Rehabilitation Association</td>
<td><a href="http://www.uspra.org">www.uspra.org</a></td>
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<tr>
<td>Behavioral Healthcare Resources:</td>
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<tr>
<td>Behavioral Healthcare Institute</td>
<td><a href="http://www.behavioralhealthcareinstitute.com">http://www.behavioralhealthcareinstitute.com</a></td>
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<tr>
<td>Council for Affordable Quality Healthcare (CAQH)</td>
<td><a href="http://www.caqh.org">www.caqh.org</a></td>
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<tr>
<td>CARF</td>
<td><a href="http://www.carf.org">www.carf.org</a></td>
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<tr>
<td><strong>Partner Organizations</strong></td>
<td><strong>Website</strong></td>
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<tr>
<td>International Center for Clubhouse Development</td>
<td><a href="http://www.iccd.org">www.iccd.org</a></td>
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<tr>
<td>Latino Behavioral Healthcare Institute</td>
<td><a href="http://www.lbhi.org">www.lbhi.org</a></td>
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<tr>
<td>Manisses Communication</td>
<td><a href="http://www.manisses.com">www.manisses.com</a></td>
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<tr>
<td>National Center for Child Traumatic Stress (NCCTS)</td>
<td><a href="http://www.NCTSNet.org">www.NCTSNet.org</a></td>
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<tr>
<td>National Committee for Quality Assurance (NCQA)</td>
<td><a href="http://www.ncqa.org">www.ncqa.org</a></td>
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<tr>
<td>North Carolina Foundation for Alcohol and Drug Studies</td>
<td><a href="http://www.ncfads.org">www.ncfads.org</a></td>
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<tr>
<td>Open Minds</td>
<td><a href="http://www.openminds.com/">www.openminds.com/</a></td>
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**Individual and Family Resources:**

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<tr>
<th><strong>Organization</strong></th>
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<tr>
<td>Association for Person in Supported Employment (APSE)</td>
<td><a href="http://www.apse.org">www.apse.org</a></td>
</tr>
<tr>
<td>Children and Adults with Attention-Deficit/Hyperactivity Disorder</td>
<td><a href="http://www.chadd.org">www.chadd.org</a></td>
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<tr>
<td>Federation of Families for Children's Mental Health</td>
<td><a href="http://www.ffcmh.org">www.ffcmh.org</a></td>
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<tr>
<td>NMHA-Individual Supporter Technical Assistance Center</td>
<td><a href="http://www.ncstac.org/">www.ncstac.org/</a></td>
</tr>
<tr>
<td>National Empowerment Center</td>
<td><a href="http://www.power2u.org">www.power2u.org</a></td>
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**Cultural Competence:**

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<tr>
<th><strong>Organization</strong></th>
<th><strong>Website</strong></th>
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<tr>
<td>Association of Gay and Lesbian Psychiatrists</td>
<td><a href="http://www.aaglp.org">www.aaglp.org</a></td>
</tr>
<tr>
<td>Indian Country (The nation’s leading American Indian news source)</td>
<td><a href="http://www.indiancountry.org">www.indiancountry.org</a></td>
</tr>
<tr>
<td>Latino Behavioral Health Institute</td>
<td><a href="http://www.lbhi.org">www.lbhi.org</a></td>
</tr>
<tr>
<td>Medline Plus (with health information in 40+ languages)</td>
<td><a href="http://www.medlineplus.gov">www.medlineplus.gov</a></td>
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<tr>
<td>National Asian American Pacific Islander Mental Health Association</td>
<td><a href="http://www.naapimha.org">www.naapimha.org</a></td>
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<tr>
<td>National Latino Behavioral Health Association</td>
<td><a href="http://www.nlbha.org">www.nlbha.org</a></td>
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<tr>
<td>National NAMI (With NAMI en Español, and NAMI Multicultural Center Resources webpage)</td>
<td><a href="http://www.nami.org">www.nami.org</a></td>
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<tr>
<td>National Organization of People of Color Against Suicide</td>
<td><a href="http://www.nopcas.org/">www.nopcas.org/</a></td>
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<tr>
<td>Native Web (resources for indigenous cultures around the world)</td>
<td><a href="http://www.nativeweb.org">www.nativeweb.org</a></td>
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<tr>
<td>NCLR – National Council of La RAZA (the largest Latino civil rights and advocacy organization in the U.S.)</td>
<td><a href="http://www.nclr.org">www.nclr.org</a></td>
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<tr>
<td><strong>Developmental Disabilities:</strong></td>
<td><strong>Website:</strong></td>
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<tr>
<td>Autism Speaks Family Services</td>
<td><a href="http://www.autismspeaks.org">www.autismspeaks.org</a></td>
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<tr>
<td>Center for Study on Autism</td>
<td><a href="http://www.autism.org">www.autism.org</a></td>
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<tr>
<td>Centers for Medicare and Medicaid</td>
<td><a href="http://www.cms.gov">www.cms.gov</a></td>
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<tr>
<td>Council for Exceptional Children (CEC)</td>
<td><a href="http://www.cec.sped.org">www.cec.sped.org</a></td>
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<tr>
<td>Exceptional Children’s Assistance Center</td>
<td><a href="http://www.ecac-parentcenter.org">www.ecac-parentcenter.org</a></td>
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<tr>
<td>Family Support Network of North Carolina</td>
<td><a href="http://www.fsnnc.org">www.fsnnc.org</a></td>
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<tr>
<td>NC Division of Health and Human Services</td>
<td><a href="http://www.dhhsnc.org">www.dhhsnc.org</a></td>
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<td>The Arc of the United States</td>
<td><a href="http://www.thearc.org">www.thearc.org</a></td>
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<td>The Arc of NC</td>
<td><a href="http://www.arnc.org">www.arnc.org</a></td>
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<tr>
<td>The Autism Society of NC</td>
<td><a href="http://www.autismsociety-nc.org">www.autismsociety-nc.org</a></td>
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<tr>
<td>The Beach Center/Family Training</td>
<td><a href="http://www.beachcenter.org">www.beachcenter.org</a></td>
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<td>US Department of Health and Human Services – Substance Abuse and Mental Health Services Administration</td>
<td><a href="http://www.samhsa.gov/">www.samhsa.gov/</a></td>
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<td>Centers for Medicare and Medicaid</td>
<td><a href="http://www.cms.hhs.gov">www.cms.hhs.gov</a></td>
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<td>Medicare</td>
<td><a href="http://www.medicare.gov">www.medicare.gov</a></td>
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<td>National Council on Disability</td>
<td><a href="http://www.ncd.gov">www.ncd.gov</a></td>
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<td>National Institute on Alcohol Abuse and Alcoholism</td>
<td><a href="http://www.niaaa.nih.gov/">http://www.niaaa.nih.gov/</a></td>
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<tr>
<td>National Institute on Drug Abuse</td>
<td><a href="http://www.nida.nih.gov">www.nida.nih.gov</a></td>
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<tr>
<td>United State Department of Housing and Urban Development</td>
<td><a href="http://www.hud.gov">www.hud.gov</a></td>
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<th><strong>Federal Government:</strong></th>
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<tr>
<td>North Carolina State:</td>
<td><strong>Website:</strong></td>
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<tr>
<td>North Carolina Department of Health and Human Services</td>
<td><a href="http://www.dhhs.state.nc.us">www.dhhs.state.nc.us</a></td>
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<tr>
<td><strong>North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services</strong></td>
<td><a href="http://www.dhhs.state.nc.us/mhdds">www.dhhs.state.nc.us/mhdds as</a></td>
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<td><strong>North Carolina Coalition to End Homelessness</strong></td>
<td><a href="http://www.ncceh.org">www.ncceh.org</a></td>
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<tr>
<td><strong>North Carolina Division of Medical Assistance</strong></td>
<td><a href="http://www.dhhs.state.nc.us/dma/">www.dhhs.state.nc.us/dma/</a></td>
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<tr>
<td><strong>North Carolina Housing Coalition</strong></td>
<td><a href="http://www.nchousing.org">www.nchousing.org</a></td>
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<tr>
<td><strong>North Carolina Housing Finance Agency</strong></td>
<td><a href="http://www.nchfa.com">www.nchfa.com</a></td>
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**Other State Sites:**

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<tr>
<th><strong>New York State Office of Mental Health</strong></th>
<th><a href="http://www.omh.state.ny.us">www.omh.state.ny.us</a></th>
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<tbody>
<tr>
<td><strong>South Carolina Department of Mental Health</strong></td>
<td><a href="http://www.state.sc.us/dmh/">http://www.state.sc.us/dmh/</a></td>
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Revised 06/25/2020
Web Links revised 3/19/2020