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MEMORANDUM

TO:

Legislative Oversight Committee Members	Commission for MH/DD/SAS
Local CFAC Chairs	State CFAC
NC Council of Community Programs	NC Assoc. of County Commissioners
County Managers	County Board Chairs
State Facility Directors	LME Directors
LME Board Chairs	DHHS Division Directors
Advocacy Organizations	Provider Organizations
MH/DD/SAS Stakeholder Organizations	NC Assoc. of County DSS Directors

FROM: William W. Lawrence, Jr., MD

Leza Wainwright

SUBJECT: Implementation Update #48

Billing Reminder for CS Services	MMIS Upgrade for Adult Enhanced Services
MOS for Adults receiving CS	New EOB Codes
Medicaid Payment/Billing Issues	Service Rate Changes
Suspension of Medicaid Benefits	Facility Based Crisis Services for Children
Retrospective Reviews for Enhanced Services	CAP/MR-DD Update

Billing Reminders for Community Support Services

Authorization and billing for Community Support Services is assigned to a specific provider number, is site specific and is predicated upon the assumption that the site is responsible for the delivery and accountability of the services rendered and billed. Alternative billing actions are unacceptable. Any such activity will be referred for investigation and constitutes a violation of the Division of Medical Assistance (DMA) Provider Enrollment Agreement, on the part of both the provider seeking to avoid the sanctions and any other provider that may be involved in the alternative billing scheme. This information was originally communicated to Community Support providers on November 5, 2007, as part of the Implementation Update #36, which can be found on the Division of Mental Health, Developmental Disabilities and Substance Abuse Services Enhanced Services Implementation Update web page at:
http://www.dhhs.state.nc.us/mhddsas/servicedefinitions/servdefupdates/index.htm

Maintenance of Service for Adults Receiving Community Support Services

Please note that Maintenance of Service authorizations for adults receiving Community Support Services are limited to 32 units per week as of August 1, 2008.

Medicaid Payment or Billing Issues
Providers with problems regarding payments, billing or NPI questions should direct their questions to EDS at 1-800-688-6696 or 919-851-8888. If the issue is not resolved, providers can then make a referral to DMA for follow up.

Suspension of Medicaid Benefits for Incarcerated Recipients and Recipients in Institutions for Mental Diseases
Effective September 1, 2008, if a Medicaid recipient age 21 through 64 enters an Institution for Mental Disease (IMD) or a Medicaid recipient of any age becomes incarcerated, his benefits will be suspended through the end of his current Medicaid certification period. Note: Federal regulations define an "IMD" as a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care and related services.

For an incarcerated recipient, Medicaid only covers medical services received during an inpatient hospital stay. When the recipient is released from incarceration, he should report his release to the Medicaid caseworker at the county Department of Social Services (DSS). If the certification period has not expired, the Medicaid case may be reactivated. An eligibility redetermination will be completed at the end of the certification period. If the recipient is still incarcerated, he is ineligible.

For a recipient in an IMD, age 21 through 64, Medicaid does not cover any services during the suspension period. When the recipient is discharged from the IMD he should report his discharge to the Medicaid caseworker at the county Department of Social Services (DSS). If the certification period has not expired, the Medicaid case may be reactivated. An eligibility redetermination will be completed at the end of the certification period. If the recipient is still in the IMD, he is ineligible.

The only exception to the suspension of benefits is for a recipient who turns age 21 while residing in an IMD. A recipient who is in an IMD when he turns age 21 can receive Medicaid payment for IMD services, if medically necessary, through the month of his 22nd birthday.

Providers may use the Automated Voice Response system to check the eligibility status of these recipients. The telephone number is 800-723-4337.

Retrospective Reviews for Enhanced Services
ValueOptions can process requests for retrospective review of Enhanced Services (including Community Support) only when such requests are due to retroactive Medicaid eligibility. Providers should write "REQUEST DUE TO RETROACTIVE MEDICAID ELIGIBILITY" prominently on the first page of the ITR. ValueOptions has 60 days to make a determination once all information and retroactive eligibility have been confirmed. All relevant documentation must be submitted with the request (e.g., the Person Centered Plan applicable to the dates requested). Fax requests to 919-461-0679, Attention: Retro Review Department or mail to ValueOptions, Retrospective Review Department, P.O. Box 13907, RTP, NC 27709-13907.

Medicaid Management Information System Upgrade for Adult Enhanced Services: Diagnostic Changes
In an effort to reflect accuracy in billing, the diagnosis codes for clients receiving Adult Enhanced Services are being updated. For Medicaid, this applies to recipients 21 years and older. The Medicaid Management Information System (MMIS) will be updated with DSM-IV-TR diagnostic codes. For Medicaid-eligible children under age 21 continued use of both DSM and ICD-9 diagnosis coding will be allowed.

There will be four Diagnosis Lists applied to Enhanced Behavioral Health Services as follows:

- The Child Diagnosis List which was applied in November 2007 will be expanded to all Medicaid child claims (under age 21) with the exception of Opioid Treatment
- Opioid Treatment (H0020) will allow only related opioid diagnoses for all individuals.
- A new Mental Health/Substance Abuse Diagnosis List will be applied to all services designed to meet the needs of these clients.
- A Substance Abuse Diagnosis List has been developed for services specific to this population.

For State funded service, the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS) will update the applicable ICD-9 Diagnostic Codes on the Diagnosis/Target Populations Crosswalk found on the IPRS web site. Providers will need to ensure that diagnostic codes used in the reimbursement process match the current clinical application of coding.

New Explanation of Benefits (EOB) Codes

With the MMIS upgrade, there will be new Explanation of Benefit (EOB) codes reflected in the Remittance Advice (RA) forms received after September 1st. The following are the new codes you may encounter:

- EOB 9074 – "Enhanced service not allowed same day as other enhanced mental health service"
- EOB 9075 – "Exceeds the maximum 4 units allowed per 30 day period"
- EOB 9076 – "Exceeds the maximum 1 unit (1 day) per date of service"
- EOB 9077 – "Units cutback to allow the maximum of 4 units per 30 day period"
- EOB 9078 – "Enhanced benefit service not allowed same day as other enhanced mental health service"
- EOB 9079 – "Enhanced benefit service not allowed same date of service as other periodic mental health service"
- EOB 9080 – "Enhanced benefit service not allowed same day as inpatient service billed by provider type and specialty combinations 064/082 or 065/082"
- EOB 9082 – "Enhanced benefit service not allowed same day as other enhanced mental health service"
- EOB 9083 – "Enhanced service not allowed same day as Psych Resident Treatment Facility service"
- EOB 9084 – "Enhanced service not allowed same date of service as inpatient hospital service"
- EOB 9086 – "Units cutback to allow the maximum of 480 units per calendar year"
- EOB 9108 – "Units cutback to allow the maximum of 1 unit per day"

Service Rate Changes

The Department has approved the following rate changes effective October 1, 2008. These rates apply to Medicaid and state-funded services delivered on or after that date.

Service Code	Service Description	Service Unit	Current Rate	New Rate
H0015	Substance Abuse (SA) Intensive Outpatient Program	per diem	$131.93	$148.52
H2035	SA Comprehensive Outpatient Treatment Program	per hour	$ 45.76	$ 51.20
H0012 HB	SA Non-Medical Community Residential Treatment	per diem	$145.50	$175.91
H0013	SA Medically Monitored Community Res. Treatment	per diem	$265.25	$272.99
H0010	Non-Hospital Medical Detoxification	per diem	$325.88	$367.57
H0014	Ambulatory Detoxification	per 15 min	$ 20.43	$ 23.99
H0020	Opioid Treatment	per event	$ 19.17	$ 18.74
H0040	Assertive Community Treatment Team	per event	$323.98	$301.35
H2011	Mobile Crisis Management	per 15 min	$ 31.79	$ 34.37
S9484	Professional Treatment Services in Facility Based Crisis	per hour	$ 18.78	$ 17.99
T1023	Diagnostic Assessment	per event	$169.06	$261.13
H0035	Partial Hospitalization	per diem	$121.69	$149.38
H2017	Psychosocial Rehabilitation	per 15 min	$ 2.90	$ 3.03
H2015 HT	Community Support Team	per 15 min	$ 16.52	$ 17.26

Child and Adolescent Day Treatment services are currently being reviewed.

Please continue to look for bulletin articles and refer to DMA's website at http://www.ncdhhs.gov/dma/fee/mhfee.htm for additional rate updates which will be posted as changes are made. Providers must always bill their usual and customary charges.

Facility Based Crisis Services for Children

With the approval of the Enhanced Services in March 2006, the Centers for Medicaid and Medicare (CMS) dictated that Facility Based Crisis services were no longer applicable to Medicaid recipients under age 21. Despite an appeal of this decision and the approval of DMA's EPSDT policy, there remains a prohibition of this service for Medicaid recipients in this age range. This does not apply to State funded services.

CAP-MR/DD Update

Plan of Care/Continued Need Review and Authorization Requirements

There are two issues that require attention by Case Management agencies and Local Management Entities (LMEs). The first is related to the requirement of the submission of Plan of Care (POC)/Continued Need Review (CNR). As noted in the

training completed by DMA and DMH/DD/SAS, ***submission for Continued Need Reviews must occur by the first day of the month of the birth month beginning with February, 2007*** **CNRs.** The following is the link to information provided at the training specifying the requirements: http://www.ncdhhs.gov/mhddsas/cap-mrdd/value-options-timeline-update-12-4-06.pdf.

The second issue is related to the submission of ***all the required documentation*** with the POC/CNR. The documentation required for each POC/CNR is a psychological evaluation, NC SNAP (full document) and other assessments to support the POC/CNR document. Please refer to Implementation Update 42, dated April 07, 2008 which provides additional detail on the requirements for submission of a POC/CNR document.

If the CNR is forwarded to Value Options after the 1st day of the birth month and there are corrections, the information submitted is not complete or additional information is required, there is no guarantee that the authorization needed for the submitted CNR will be done before the expiration of the current authorization. This causes multiple problems, most importantly the potential for denial of authorization of services and frustration for participants and their families; in addition to unnecessary use of time and resources for everyone involved.

ValueOptions has begun notifying the LMEs and DMH/DD/SAS of specific Case Managers and their respective agencies who have submitted CNRs after the due date. Both the DMA and the DMH/DD/SAS consider these serious issues and request the LMEs and case management agencies make every effort to resolve these issues. DMH/DD/SAS will work with the LMEs to track and monitor the LMEs' efforts to resolve these issues with case management agencies. Case management agencies have the responsibility to adhere to the requirements to ensure services are provided for those participants for whom they serve. The LMEs have the responsibility to monitor providers and take corrective action as needed to ensure participants receive services in a timely manner.

Submission of the Proposed Waivers to CMS

We are pleased to announce the DMH/DD/SAS and the DMA submitted the two new waiver applications (Supports Waiver and Comprehensive Waiver) to the Centers for Medicaid and Medicare (CMS) as scheduled on August 1, 2008. We are grateful to each of you who participated in the development of the two new waivers. The waivers will be implemented on November 1, 2008, ***pending CMS approval***. The Divisions are now involved in the multiple tasks associated with implementation of the two new waivers. We are committed to working with individuals, families, LMEs and service providers to ensure a seamless transition to the new waivers and extend our appreciation in advance for your patience during this transition period.

Below is a brief summary of shared components of the submitted Supports and Comprehensive Waiver:

- Many of the existing service definitions (contained in the current Comprehensive Waiver) have been revised to ensure components meet best practice standards for services and supports for individuals with intellectual and developmental disabilities. No services were removed. In addition, new services have been developed to provide additional options and more refined services and supports.
- The Supports Waiver and the Comprehensive Waiver provide community based services and supports for persons with developmental disabilities, mental retardation, and autism, who meet ICF-MR level of care criteria to remain living at home and in the community as an alternative to institutionalization.
- Objectives of the Supports Waiver and the Comprehensive Waiver include:
    1. Enhancing the focus on person-centered planning and the alignment of services and supports with Person Centered Plans.
    2. Reforming day supports, supported employment, and long term vocational supports to ensure that participants are progressing towards their employment goals, and have meaningful daily activities.
    3. Reforming residential service to facilitate smaller community congregate living situations.
    4. Facilitate living and working in the most integrated setting.
    5. Improving outcome-based quality assurance systems.
- Each individual will have a **Person Centered Plan** (PCP) developed with the individual and family. The PCP will detail the individual's strengths and needs, ensure health and safety issues are addressed, and indicate the services and supports required. Services and supports will be provided in the most integrated setting utilizing natural supports that enhance the individual's quality of life as defined by the individual. The person centered planning process will utilize the uniform PCP format.
- **National Accreditation** will be required of providers of waiver services within one year of implementation of the waivers or enrollment with DMA**.**
- **Case Management** will be provided through the State Medicaid Plan and will not affect the participant's individual budget.
- Assessments of each individual will include a uniform **Risk Assessment Tool**. This process will support the person centered planning process by standardizing the process by which planning teams clearly identify areas of

service and support needs related to the identified risks experienced by the individual and ensure development of those supports in the individual's Person Centered Plan**.**

- Each LME will implement a uniform **Prioritization Tool** to assist in determining the utilization of waiver slots. On a quarterly basis DMH/DD/SAS will conduct a review of the status of the allocated capacity to determine if there are unused slots in any particular LME; those which are unused within 30 days thereafter will be targeted for reallocation by DMH/DD/SAS to other LMEs. If within each waiver year, an LME is noted to have two out of four quarters with slots unused, the LME will submit a Plan of Correction to DMH/DD/SAS, within 60 days of the last review to define their process to expedite the use of waiver slots.
- Each waiver contains quality improvement strategies to address: Waiver Administration and Operation, Qualified Providers, Health and Safety, Level of Care, Service Plans, and Financial Accountability.

Supports Waiver Overview
The Supports Waiver is intended for individuals who live in their own home or reside with their family with some support; and individuals who live in licensed residential facilities. Self-direction is an option in this waiver for individuals living in their own home or with their family. The Supports Waiver contains an annual cost limit of $17,500. The maximum number of unduplicated participants who are served in each year that the waiver is in effect is 2000 year one, 3000 year two and 4000 year three. Slots are reserved for individuals transitioning from the Piedmont Innovations Waiver, and for emergency situations.

- Services provided within the Supports Waiver include: Personal Care, Home and Community Supports, Respite, Crisis Services, Behavior Consultation (NEW), Adult Day Health, Day Supports, Transitional Work Services (NEW), Long Term Vocational Supports (NEW), Supported Employment, Individual Caregiver Training and Education, Personal Emergency Response System, Specialized Consultative Services, Specialized Equipment and Supplies, Transportation, Vehicle Adaptations, Home Modifications, and Augmentative Communication.
- Self-direction of services/supports is an option in this waiver during the second year of the waiver. This includes the assistance of a Support Broker and Financial Management Service. The Supports Broker and Financial Management Service will be provided as an administrative function and will not affect the participant's individual budget.

Comprehensive Waiver Overview
The Comprehensive Waiver is intended for individuals who reside in their own home, reside with their family, or receive residential services in community congregate settings in the community. The Comprehensive Waiver contains an annual cost limit of $135,000.

The maximum number of unduplicated participants who are served in each year that the waiver is in effect is 9,250 year one, 9,500 year two and 9,750 year three. Slots are reserved for individuals transitioning from the Piedmont Innovations Waiver, Money Follows the Person Demonstration Project, CAP-C, Developmental Centers and emergency situations.

- Services provided within the Comprehensive Waiver include: Personal Care, Home and Community Supports, Respite, Home Supports (NEW), Residential Supports, Crisis Services, Behavior Consultation (NEW), Adult Day Health, Day Supports, Transitional Work Services (NEW), Long Term Vocational Supports (NEW), Crisis Respite (NEW), Supported Employment, Individual Caregiver Training and Education, Personal Emergency Response System, Specialized Consultative Services, Specialized Equipment and Supplies, Transportation, Vehicle Adaptations, Home Modifications, and Augmentative Communication.

Unless noted otherwise, please email any questions related to this Implementation Update to ContactDMH@ncmail.net.

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