

North Carolina Medicaid Special Bulletin



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Attention:
Local Management Entities (LMEs)
Providers of Mental Health, Substance Abuse, and
Intellectual/Developmental Disability Services

Behavioral Health and I/DD Updates

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Approval of Innovations 1915 (c) Waiver Amendment

The Centers for Medicare and Medicaid Services (CMS) has approved the amendment to the Innovations waiver with an effective date of October 1, 2011. This approval authorizes the State to expand the service area from the previously approved five counties to 65 counties, add waiver capacity, update service definitions, and update provider qualifications and performance measures. This approval allows for the implementation of Innovations for the following Local Management Entities-Managed Care Organizations (LME-MCO):

- Western Highlands Network LME-MCO effective January 3, 2012
- Eastern Carolina Behavioral Health (ECBH) LME-MCO effective April 1, 2012
- Smoky Mountain LME-MCO and Sandhills LME-MCO effective July 1, 2012

Extension of Current CAP-MR/DD Waiver and Process for Submitting Authorization Requests

The Centers for Medicare and Medicaid Services (CMS) has granted an extension until June 29, 2012 for the current 2008 Community Alternatives Program for Persons with Mental Retardation/Developmental Disabilities (CAP MR/DD) waiver.

The extension was granted to allow time for the N.C. Division of Medical Assistance (DMA) and the N.C. Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS) to continue to work with CMS on a transition plan for individuals who are living in facilities that do not meet the CMS-approved “home and community characteristics.” DMA will submit an additional request to CMS to extend the waiver to June 30, 2012 to allow for ease of transition. When the waiver is approved by CMS, DMA will publish the final service definitions, along with the effective start date of the waiver.

DMA appreciates the amount of time that recipients, families, case managers, and providers have spent working on developing transition plans. To that end, we have drafted the following guidelines in an attempt to minimize further disruption for recipients and their families when determining whether the case manager and recipient/family need to submit an updated revision (authorization request), including the Person Centered Plan (PCP) revision form with appropriate signatures, CAP Targeted Case Management (CTCM) form, and updated cost summary.

- If services were authorized to fit the new waiver requirements and the recipient/legally responsible person accepted the plan/services, then a revision (authorization request) does **not** need to be submitted. Specifically, if a request to change Home Supports services to Home and Community Supports and Personal Care has been approved, those services can be provided.
- If services currently authorized under the 2008 CAP MR/DD waiver are not in compliance with the newly proposed waiver requirements, then a revision (authorization request) does **not** need to be submitted at this time. **However, a revision for**

authorization of new services must be submitted by July 1, 2012, to have services meet the requirements under the new waiver.

- If an authorization request was approved to change services to meet the new waiver requirements, and the recipient/legally responsible person would rather continue with his or her current services under the 2008 CAP waiver, then the case manager needs to document this information in a case management note and update the PCP and cost summary for the recipient record. This updated PCP will serve as the authorization in the interim until July 1, 2012. The case manager does not submit this information to the Utilization Review (UR) Vendor. The plan that was to go into effect previously will now go into effect on July 1, 2012. If an authorization is requested at this time, a revision must be submitted to the UR Vendor.
- If a Continued Needs Review (CNR) with an effective date of April 1, 2012, has been approved or is currently being reviewed by a UR Vendor, and the recipient/legally responsible person would rather continue with his or her current services, then the case manager needs to update the PCP and cost summary to show three months of services under the current waiver and nine months of services in compliance with the requirements of the new waiver. This updated CNR must be submitted to the UR Vendor by July 1, 2012.
- The plan that has been updated by the case manager serves as the authorization of services. A case manager can send the updated CNR and CTCM form to the appropriate UR Vendor at any time and ask for an updated authorization letter.

Recommended Referral Forms for Use between Primary Care and Behavioral Health Providers

Community Care of North Carolina (CCNC) in partnership with Local Management Entity-Managed Care Organizations (LME-MCO), Primary Care Physicians (PCP), and Critical Access Behavioral Health Agencies (CABHA), has developed a set of three referral forms for use between primary care and behavioral health providers to facilitate easier consultation and communication.

Form #1 – Behavioral Health Request for Information – This form is for behavioral health providers who begin working with a new consumer, or have identified a potential medical need and wish to make contact with the PCP.

Form #2 – Referral to Behavioral Health Services Section I – This form is for PCPs to make a direct referral to a behavioral health provider for an assessment and/or services.

Form #3 – Behavioral Health Feedback to Primary Care Section II – This form is to be used in conjunction with the Form #2 (above). It is for behavioral health providers to complete and send back to the PCP after receiving a referral.

Providers are encouraged to obtain consent for release of information, as is necessary in the sharing of substance abuse information.

Processing of Therapeutic Foster Care Claims for N.C. Health Choice and EPSDT Recipients

Local Management Entities (LME) and Local Management Entities-Managed Care Organizations (LMEs-MCO) must continue to process Therapeutic Foster Care (TFC) claims for N.C. Health Choice (NCHC) recipients through the fee-for-service system, even after Waiver implementation has occurred in its area.

This process requires that LMEs maintain their current LME Medicaid number. LMEs will need to continue processes for reimbursing the TFC provider. In situations in which LMEs merge, the LME must designate one LME fee-for-service Medicaid number to serve this purpose. This arrangement will need to continue until NCHC TFC services are included in the capitated contract with the N.C. Division of Medical Assistance (DMA).

N.C. Health Choice Claims for Substance Abuse Intensive Outpatient (SAIOP)

Substance Abuse Intensive Outpatient (SAIOP, HCPC code H0015), was inadvertently omitted from the benefit plan for N.C. Health Choice. This procedure code has now been added to the HP Enterprise Systems claims system and providers may bill. Claims for this service will now process correctly.

Co-Pay Issues for N.C. Health Choice Claims

The N.C. Division of Medical Assistance (DMA) has identified problems resulting from the transition of claims processing from Blue Cross Blue Shield (BCBS) to HP Enterprise Services for N.C. Health Choice (NCHC) recipients. These problems are generating denied claims and are being addressed through data system changes.

The issue is the application of inappropriate co-pays for specific NCHC services.

The claims for services which have had a co-pay deducted in error will need to be voided and then resent when the system has been corrected to bypass the co-pay requirement. Please do not resend these claims until you have been notified that the system changes are complete.

The affected services are:

H2012 HA	Day Treatment—Child and Adolescent
T1023	Diagnostic/ Assessment
H2022	Intensive In-home Services
H2011	Mobile Crisis Management
H2033	Multisystemic Therapy
H0035	Partial Hospitalization
H0015	Substance Abuse Intensive Outpatient Service
H0014	Ambulatory Detoxification
H0020	Outpatient Opioid Treatment
H0032	Targeted Case Management - MH/SA
T1017 HE	Targeted Case Management - IDD
RC 911	PRTF
RE100	Inpatient Hospitalization
H0046	Level I Family Type
S5145	Level II Family Type - Therapeutic Family
H2020	Level II Group Home
H0019	Level III & IV Group Homes

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