North Carolina
Medicaid Special Bulletin

An Information Service of the Division of Medical Assistance
Please visit our Web site at www.ncdhhs.gov/dma

JULY **2006**

Attention:
All Mental Health/Substance Abuse Providers

Authorization and Utilization Review for Behavioral Health Services

Introduction

The Division of Medical Assistance (DMA) is the N.C. Department of Health and Human Resources (DHHS) agency that manages the Medicaid program in the State of North Carolina. The federal government, through the Centers for Medicare and Medicaid Services (CMS), requires that all agencies serving a Medicaid population and receiving Medicaid funds must have a utilization control program in place to monitor each recipient's/applicant's need for services. The purpose of the program is to ensure that services are appropriate to each individual's symptoms and that services are neither overutilized nor underutilized.

ValueOptions (VO) has been selected to provide utilization review activities for mental health, developmental disability (designated services), and substance abuse services provided to Medicaid recipients. VO will also work collaboratively with DMA and the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS) to support the transition of review functions from the Local Management Entities (LMEs) to VO.

VO will authorize all mental health and substance abuse services for **all** Medicaid recipients throughout the state **except** for those Medicaid recipients who reside in the Piedmont catchment area (Cabarrus, Davidson, Rowan, Stanly, and Union counties).

Until further notice, Durham will continue to authorize Medicaid services as they were doing prior to June 1, 2006. This means that inpatient hospital, EPSDT, PRTF, residential after 120 or 30 days, and outpatient will continue to be authorized or reauthorized by VO. This is the same process used prior to the June 1st statewide utilization review procedures.

Contacting ValueOptions

The phone number for VO is 888-510-1150 and the fax number is 919-941-0433. Providers can access VO's Web site at http://www.valueoptions.com (click on "For Providers," then "Network Specific Info," and then the North Carolina Medicaid link.)

Clinical Coverage Policies

Refer to the clinical coverage policies for behavioral health services on DMA's Web site at http://www.ncdhhs.gov/dma/mp/mpindex.htm for additional information on service requirements, limitations to services, and billing guidelines.

Services Requiring Prior Authorization

Inpatient Psychiatric Hospital Services

All admissions must be approved. This includes admissions on the same day as a previous discharge from either the same hospital or a different hospital. (This also includes situations where a patient never left the hospital, but the hospital record shows a discharge and readmission.)

Inpatient Services for Adults and Children Applying for Medicaid during a Psychiatric Hospital Stay

Hospitals admitting a patient who is neither Medicaid-eligible on or before admission nor pending eligibility, but **who applies for Medicaid during a psychiatric hospitalization**, must submit the entire medical record to VO within 30 days of discharge. VO will perform a post-discharge review to determine prior approval for medically necessary days of acute care. A phone call to VO is not necessary for patients **who apply for Medicaid during or after the stay**. Hospitals must obtain a Medicaid identification (MID) number for the patient and send it to VO along with the medical record.

In addition to the MID number, if the patient is a child or adolescent admitted to a psychiatric hospital, a Certification of Need (CON) form must also be sent to VO. Due to difficulties in being able to meet the CMS (formerly the Health Care Financing Administration) requirements for performing a CON on or before the Medicaid application date, and realizing that hospitals may have problems receiving notification of a patient's application for Medicaid, DMA suggests that a CON be completed and immediately submitted to VO for **every** child or adolescent admission to a psychiatric hospital, regardless of Medicaid status on admission. VO will place the CON in a holding file if the form indicates the patient has yet to apply for Medicaid. If a patient applies for Medicaid **on or after the discharge date**, the hospital must still send the entire medical record to VO for review with the CON (if applicable) and the MID number.

Once eligibility has been verified, VO will determine whether the days were medically necessary. VO will send a notification letter to the hospital stating approval or denial of acute care days. Any approval will include a prior approval number.

If eligibility verification reflects that the Medicaid application occurred **on or before admission** rather than during the stay as reported, the hospital stay will not be reviewed. For any patient already eligible or pending eligibility on admission, the hospital must still request **telephone prior approval** from VO within two working days of admission and continue with the concurrent review process.

Submitting Records for Inpatients (Adults and Children) Applying for Medicaid during or after a Psychiatric Hospital Stay

Hospitals admitting a patient who is neither Medicaid-eligible on or before admission nor pending eligibility, but **who applies for Medicaid during a psychiatric hospitalization**, must send in the entire medical record to VO for psychiatric review within 30 days of discharge. If a patient **applies for Medicaid after hospital discharge**, the complete medical record must be sent to VO within four months of the patient's Medicaid application date. It is the facility's responsibility to make sure the record is mailed within this timeframe. VO will perform a post-discharge review to determine prior approval for medically necessary days of acute care if the record arrives at their place of business on time. A medical record received after the deadline will not be reviewed.

Inpatient Hospital Admissions

Federal regulations require a CON form to be completed for admissions of Medicaid recipients under the age of 21 to a psychiatric hospital. (Refer to 42 CFR 441.152 and 441.153 for detailed requirements.) It is vital that this CON meet all the federal requirements and that a copy of the completed form be maintained in the patient's medical record for inspection during any federal or state audit that might occur. The state-approved CON form is required only for psychiatric hospitals. Federal regulations require that the team providing the CON must include, at a minimum, a board-eligible or board-certified psychiatrist and one of the following:

- a psychiatric social worker;
- a registered nurse with specialized training or one year's experience in treating mentally ill individuals;
- an occupational therapist who is licensed and has specialized training or one year of experience in treating mentally ill individuals;
- a psychologist who has a master's degree in clinical psychology or who has been certified by the state or by the state psychological association.

For additional information on the composition of the team, refer to 42 CFR 441.156.

Under federal regulations, the procedures to be followed for the CON vary depending on the status of the patient's Medicaid eligibility at the time of admission, as shown below. The hospital is responsible for determining the patient's Medicaid status at the time of admission. If the proper procedures for admission approval (established below) are not followed, Medicaid payment will be denied.

Child Medicaid Recipient, Elective Admission

For a patient who is under the age of 21 and a Medicaid recipient at the time of admission to the hospital, and who is admitted on an elective basis, the **hospital** must do the following:

- contact VO at 1-888-510-1150 for admission approval on or before the date of admission. For psychiatric hospitals, federal regulations require that the CON form must be completed by an independent team (VO) on or before the date of admission. Medicaid payment for psychiatric hospitals cannot begin prior to the date the CON is completed. Medicaid payment for the psychiatric units of the general hospitals cannot begin prior to the date that VO completes the preadmission approval; and
- supply VO with the recipient's MID number. Medicaid's claims payment system cannot accept an admission approval until the MID is entered in the prior approval segment by VO.

VO will determine whether the admission can be approved. For an **approved admission,** VO will do the following:

- complete the CON if the admission is to a psychiatric hospital and forward a copy of the CON to the hospital to be maintained in the patient's medical record for federal or state audit. Approval for Medicaid payment cannot begin prior to the date the CON is completed;
- verbally issue the prior approval and follow with a written notice of the admission approval; and
- send the approval information to Medicaid's fiscal agent.

The CON is valid for 15 days. Failure to admit the patient within this timeframe will necessitate a new CON to be completed by VO.

For a **denied admission,** VO will notify the patient or patient's guardian, the hospital, and the patient's county department of social services (DSS) (if DSS is the legal guardian) by certified mail, return receipt requested, with instructions for appeal.

Child Medicaid Recipient, Emergency Admission

For a patient who is under the age of 21 and a Medicaid recipient at the time of admission to the hospital, and who is admitted on an emergency basis, the **hospital** must do the following:

- call VO at 1-888-510-1150 for admission approval within two working days of the admission. Delay in contacting VO beyond the two days will result in denial of admission approval from the date of admission to the date the hospital contacts VO to initiate admission approval; and
- supply VO with the recipient's MID number. Medicaid's claims payment system cannot accept an admission approval until the MID is entered in the prior approval segment by VO.

In addition, **if the facility is a psychiatric hospital,** it must send VO the original completed state-approved CON form signed and dated by the appropriate interdisciplinary team members. A faxed copy may be sent to VO but is not considered valid until the original CON is received by VO. The hospital should maintain a copy of the completed and signed CON in the recipient's record for state or federal audit purposes.

VO will determine if the admission meets the criteria for emergency admission, defined as the "sudden onset of a psychiatric condition manifesting itself by acute symptoms of such severity that the absence of immediate medical attention could reasonably be expected to result in serious dysfunction of any bodily organ/part or death of the individual or harm to another person by the individual."

- If the admission does not meet the criteria for emergency, VO must treat the admission as an elective admission (and follow the guidelines listed above).
- If the admission meets the criteria for emergency, VO can continue the admission approval process as outlined below.

For psychiatric hospitals, VO will review the state-approved CON form submitted by the hospital to ensure that the signatures of both of the interdisciplinary team members are individually dated within 14 days of the admission. *Admission approval cannot be given until VO has received a valid CON.*

- If both of the signatures are within 14 days of admission, VO can enter the "start date" for admission approval as the admission date, if:
  - the admission is otherwise approvable, and
  - the hospital contacted VO within two working days of admission. If the hospital did not contact VO within two working days, VO will enter the "start date" for admission approval no earlier than the date the hospital contacted VO to initiate the admission review or the last appropriately signed and dated signature on the CON.
- If either of the signatures is beyond the 14 days from admission, the earliest "start date" for admission approval that VO can enter is the latest date that the CON was signed by either team member, if:
  - the hospital contacted VO within two working days after admission, and
  - the admission is otherwise approvable.

Example:

Date of admission	March 3, 2005
Date hospital called VO	March 4, 2005
First CON signature date	March 13, 2005
Second CON signature date	March 20, 2005
Earliest "start date" for admission approval	March 20, 2005, if otherwise approvable

For all emergency admissions of child Medicaid recipients,

- If VO determines that they can approve the admission, VO will:
  - verbally issue approval to the hospital and follow with a written notice of the admission approval, and
  - submit admission approval information to Medicaid's fiscal agent.
- If VO is unable to approve the admission, they will notify the patient or patient's guardian, the hospital, and the patient's county DSS (if DSS is the legal guardian) by certified mail, return receipt requested, with instructions for appeal.

Child with Pending Medicaid Eligibility, Regardless of Elective/Emergency Status

For patients under the age of 21 with pending Medicaid eligibility at the time of admission, the **hospital** must

- contact VO at 1-888-510-1150 for admission approval as soon as the hospital becomes aware of the Medicaid application; and
- provide VO with the applicant's MID number. (This number is assigned at the time that the application is taken.) VO cannot complete an admission approval and submit the approval to Medicaid's fiscal agent without the MID number.

In addition, **if the facility is a psychiatric hospital,** it must send VO the completed state-approved CON form signed by the appropriate interdisciplinary team members. The interdisciplinary team members must certify that the three criteria were met for the date that the hospital is seeking to have Medicaid coverage begin. A faxed copy may be sent to VO but is not considered valid until the original CON is received by VO. The hospital should maintain a copy of the completed and signed CON in the patient's record for federal or state audit.

VO will determine whether admission approval can be given and will verify the dates of application and approval for Medicaid eligibility through DMA.

- If the patient was a **Medicaid recipient at the time of admission,** VO must use the appropriate process for admission approval of recipients listed above.
- If the patient was **not a Medicaid recipient at the time of admission,** VO can enter a "start date" for admission approval as early as the date the hospital is seeking to have Medicaid coverage begin, if otherwise approvable.

If VO determines that they can approve the admission, VO will:

- verbally issue approval to the hospital and follow with a written notice of the admission approval, and
- submit admission approval information to Medicaid's fiscal agent.

If VO is unable to approve the admission, VO will notify the patient or patient's guardian, the hospital, and the patient's county DSS by certified mail, return receipt requested, with instructions for appeal.

General Information Regarding Admission Approvals for Psychiatric Care

Admission approval by VO is not a guarantee of Medicaid eligibility. It is only a confirmation of medical necessity for inpatient services. The hospital must separately verify the patient's period of eligibility for Medicaid.

When submitting the request for admission approval, the hospital must provide VO with, at a minimum, the following information. It is vital that the person contacting VO has all of this information available at the time of the initial contact:

- the recipient's MID number. (These are issued and available even on pending applications.);
- the recipient's name, date of birth, county of residence, and sex;
- the name of the hospital, the provider number, and (planned) date of admission;
- the DSM-III-R diagnosis (diagnoses) applicable for the patient at the time of admission. For requests for retroactive admission approval as allowed above, these must be applicable for the date the hospital is requesting Medicaid payment to begin;
- a description of the initial treatment plan relating to the admitting symptoms;
- precipitating event/current symptoms requiring inpatient treatment;
- medication history;
- prior hospitalization; and
- prior alternative treatment.

When the initial call to VO does not result in a decision regarding admission approval, if the hospital or physician becomes aware of new or other non-reported information, the hospital or physician should provide the information to VO at any time up to the date of denial by VO. Faxed copies can be used; this may avert the need for a peer-to-peer review.

Federal regulations do not require that general hospitals have a CON form as defined in 42 CFR 441.152 and 441.153.

Services Authorized Under Criterion V

A request for Criterion V services may be made by a hospital following a non-certification by VO when there is a clear absence of appropriate community-based services available if discharge were to occur. Working with the hospital, the community support services qualified professional (CSS QP) needs to facilitate discharge to an appropriate service from the first day of Criterion V services. Requests for authorization must be submitted using the Criterion V authorization request packet from VO's Web site. The Outpatient Review (ORF2) form or the Inpatient Treatment Report (ITR) form is not used for these services; the authorization request packet for Criterion V services must be utilized when requesting prior authorization. This packet can be found on the VO Web site.

Psychiatric Residential Treatment Facility Services

All admissions to psychiatric residential treatment facilities (PRTFs) are considered elective.

Certification of Need Process for Inpatient PRTF Admissions

Federal regulations require that a CON form be completed for admissions of Medicaid recipients under the age of 21 to an inpatient setting. (Refer to 42 CFR 441.152 and 441.153 for detailed requirements.) It is vital that this CON meet all the federal requirements and that a copy of the completed form be maintained in the patient's medical record for inspection during any federal or state audit that might occur. The state-approved CON form is required only for psychiatric inpatient settings. Federal regulations require that the team providing the CON must include, at a minimum, a board-eligible or board-certified psychiatrist and one of the following:

- a psychiatric social worker;
- a registered nurse with specialized training or one year's experience in treating mentally ill individuals;
- an occupational therapist who is licensed and has specialized training or one year of experience in treating mentally ill individuals;
- a psychologist who has a master's degree in clinical psychology or who has been certified by the state or by the state psychological association.

For additional information on the composition of the team, refer to 42 CFR 441.156.

Under federal regulations, the procedures to be followed for the CON vary depending on the status of the patient's Medicaid eligibility at the time of admission. The PRTF is responsible for determining the patient's Medicaid status at the time of admission. If the proper procedures for admission approval are not followed, denial of Medicaid payment will be made as indicated below.

For these elective admissions, for patients under the age of 21 who are Medicaid recipients at the time of admission, the PRTF must:

- contact VO at 1-888-510-1150 for admission approval on or before the date of admission. For all psychiatric inpatient settings, federal regulations require that the CON form must be completed by an independent team as described above on or before the date of admission. The CSS QP is responsible for seeing that this is done and submitted to VO with a copy to the PRTF. Medicaid payment for PRTFs cannot begin prior to the date the CON is completed; and
- supply VO with the recipient's MID number. Medicaid's claims payment system cannot accept an admission approval until the MID is entered in the prior approval segment by VO.

If VO determines that they can approve the admission, VO will:

- verbally notify the CSS QP and the PRTF that the admission has been approved;
- follow with a written notice of the admission approval; and
- send the approval information to Medicaid's fiscal agent.

The CON is valid for 15 days. Failure to admit the patient within this timeframe will necessitate the submission of a new CON.

If VO is unable to approve the admission, they will notify the patient or patient's guardian, the PRTF, and the patient's county department of social services (DSS) (if DSS is the legal guardian) by certified mail, return receipt requested, with instructions for appeal.

Residential Services

Beginning with date of service June 1, 2006, VO will provide all new initial authorizations and concurrent reviews for Levels I through IV Residential Services, **including** all 1-, 2-, or 3-bed facilities and facilities with 4 beds or more. Transition will occur for existing LME authorizations for Level II and III services for facilities with 1 to 3 beds and for therapeutic foster families by July 15, 2006. Level II and III residential services that have been authorized for 120 days and Level IV services that have been authorized for 30 days prior to June 1, 2006, will transition to VO at the end of the 120- or 30-day timeframe.

Out-of-State Services

Placement of any child in an out-of-state facility must be approved prior to the admission. Requests for services provided by out-of-state facilities must come from the CSS QP or the LME after all available in-state resources have been researched. Requests for authorization must be submitted using the out-of-state authorization request packet from VO's Web site. The ORF2 form or the ITR form is not used for these services; the out-of-state authorization request packet must be utilized when requesting prior authorization. This packet can be found on the VO Web site. The out-of-state facility must meet North Carolina standards and must be approved by the DMH/DD/SAS.

The out-of-state facility must enroll with Medicaid to provide the service.

Evaluation/Assessments/Individual Outpatient Psychotherapy/Outpatient Family Therapy/Group Therapy

These services are reviewed at the existing trigger points (after 8 visits per calendar year for adults and after 26 visits for children under age 21). For adults, group services count as ½ visit. Any combination of individual and group visits may be provided as long as the 8-visit limit is not exceeded. Additional visits require prior authorization.

Effective with date of service July 15, 2006, **services will be authorized to the attending provider number**, not to the group number, and will be authorized to specific modifiers.

Referral Requirements for Outpatient Services for Recipients under the Age of 21

For outpatient services for recipients under age 21:

- The benefit package includes 26 outpatient visits per calendar year when referred by the Carolina ACCESS (CA) primary care physician (PCP), a Medicaid-enrolled psychiatrist, or the LME. Visits beyond the 26-visit limit require the mental health provider to obtain an order for the services and to submit a copy of the order with the request for prior authorization from VO.
- The mental health provider's services cannot be paid unless the referring provider's number is listed on the claim. This number is to be obtained prior to the child's first visit. To facilitate the referral process, referrals may be made by telephone, by fax, or in writing. Mental health providers are expected to communicate the plan of care and anticipated length of treatment to the referring provider, following the guidelines for patient confidentiality, as a means to ensure continuity of care.

Outpatient Services for Recipients under the Age of 21

The benefit package includes 26 outpatient visits per calendar year.

- Prior authorization may be requested after the 20th "unmanaged" psychiatric visit. The prior authorization request form must include the dates of service on which the provider requesting prior authorization has rendered treatment.
- Prior authorization must be obtained prior to the 27th visit.

Outpatient Services for Recipients Aged 21 and Over

For recipients aged 21 and over, referrals are not required. They may self-refer.

- Medicaid recipients aged 21 and over receiving outpatient mental health services require prior authorization after the 8th visit.
- Visits coded with a group code (for example, family therapy or group therapy) during the 8 unmanaged visits count as ½ visit.
- The total number of visits must not exceed 8 visits. This can be reached by combining individual and group visits, such as 4 individual visits and 8 group visits, 16 group visits with no individual visits, or any combination of the above.

The 24-office-visit limitation per year for psychiatric procedure codes – with the exception of 90862 (pharmacologic management) – does not apply because it has been replaced by the requirement for prior authorization after the 8th visit for mental health services subject to independent utilization review. Approval is based on medical necessity.

Note: If an E/M office code is billed by a psychiatrist for a recipient aged 21 or older, the visit will count as one of the recipient's 24 office visits. The 24-visit limit applies to all ambulatory medical visits, including mental health visits, that are billed with an E/M code. Procedure code 90862 (pharmacologic management) is included in this 24-visit count because it is not subject to prior authorization.

Co-payments are required for recipients aged 21 and older for all outpatient services.

Enhanced Mental Health and Substance Abuse Services

The following services are included in the package of enhanced mental health services covered by the N.C. Medicaid program. VO will provide the initial authorization for service and concurrent reviews for these services:

- Substance Abuse Intensive Outpatient Services (SAIOP)
- Assertive Community Treatment Team (ACTT)
- Community Supports (adult, child, and team) (CSS)
- Psychosocial Rehabilitation (PSR)
- Day Treatment
- Partial Hospitalization (PH)
- Opioid Treatment (methadone clinics)
- Professional Treatment Services in Facility-Based Crisis Programs
  Note: Review is required after the first 16 hours in the program.
- Targeted Case Management for mental retardation/developmental disability (MR/DD) (initial and concurrent review) (TCM)
- Non-hospital Medical Detoxification (adults)
- Non-medical Community Residential Treatment (review) (adults)
- Medically Monitored Community Residential Treatment (adults)
- Ambulatory Detox
- Mobile Crisis
  Note: Review is required after the first 8 hours.
- Intensive In-home Service (IIH)
- Multisystemic Therapy (MST)
- Substance Abuse Comprehensive Outpatient Treatment (SACOT)
- Medically Supervised or ADATC Detoxification/Crisis Stabilization
  Note: Review is required after the first 8 hours of admission

Refer to the May 2006 Special Bulletin, Enhanced Mental Health Services, for information on service requirements, limitations, and billing guidelines. A copy of the service definitions is available on the DMA/DD/SAS Web site (http://www.ncdhhs.gov/mhddsas).

Other Reviews

Retroactive reviews will be performed only when the recipient has retroactive eligibility. The recipient's medical records must be sent to VO by the provider immediately upon notification that the recipient has Medicaid eligibility.

Post-payment "look behind" reviews will be performed to evaluate the services provided to Medicaid recipients and to ensure that documentation conveyed during concurrent reviews is substantiated by documentation in the medical record. VO will request records for review on a monthly basis.

VO will also provide quality assurance monitoring (including Piedmont CAP/MR-DD services). Information will be requested by VO for these reviews on a monthly basis. There will not be a duplicate medical records request by VO for monitoring purposes of any kind.

Transition Phase

Beginning June 1, 2006, VO will open its telephone (888-510-1150) and fax lines (919-941-0433) to receive current authorizations from the area program/LMEs on ORF 2/SA and ITR forms. These will be transitioned to authorizations by VO effective with dates of service **July 15, 2006,** for children and **August 15, 2006,** for adults.

VO will begin processing **new** authorization requests from all providers beginning with dates of service **June 1, 2006,** for children and **July 1, 2006,** for adults. These requests should be submitted on an ORF2or ITR form.

Early and Periodic Screening, Diagnostic, and Treatment

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that provides recipients under the age of 21 with medically necessary health care to correct or ameliorate a defect, physical or mental illness, or a condition identified through a screening examination. While there is no requirement that the service, product, or procedure be included in the State Medicaid Plan, it must be listed in the federal law at 42 U.S.C. §1396d(a). Service limitations on scope, amount, or frequency described in this coverage policy do not apply if the product, service, or procedure is medically necessary.

EPSDT reviews will be conducted for requests for services beyond the scope of the implied limitation of a service for recipients under the age of 21. Requests are sent to the DMA's Assistant Director for Clinical Policy and Programs and forwarded to VO as appropriate.

The DMA has posted policy instructions pertaining to EPSDT online at http://www.ncdhhs.gov/dma/prov.htm.

Refer to the clinical coverage policies for behavioral health services on DMA's Web site at http://www.ncdhhs.gov/dma/mp/mpindex.htm for additional information on service requirements, limitations to service, and billing guidelines.

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