



ALAMANCE-CASWELL
LOCAL MANAGEMENT ENTITY
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PROVIDER OPERATIONS MANUAL

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The manual designates applicability of specific information for Medicaid and State Funded providers. The absence of a designation indicates that the information/source is applicable to both Medicaid and State Funded providers.

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INTRODUCTION

This manual is a binding part of the Agreement or contract between the LME and providers of Medicaid and State Funded services. The intent of this manual is to reference detailed information and where possible require the same statewide procedures as part of any agreement or contract between an LME and a provider agency.

This manual includes only information pertinent to the performance of the Agreement or contract, whichever applies. The manual does not include information about DHHS endorsement procedures or licensure requirements that take place prior to any agreement with a Medicaid Provider.

Information or procedures that pertain specifically to Medicaid providers or to State Funded providers are identified. The absence of this designation indicates applicability to both types of providers. References to the LME policy and procedures mean that the local LME may insert their own information and that statewide applications do not apply at this time.

All state-funded services (Integrated Payment and Reporting System-IPRS) are provided within a closed network. The LME has selected a limited number of providers who are able to be paid for IPRS. The relationship between the LME and these providers is governed by a contract.

BRIEF OVERVIEW OF THE LME

The Alamance-Caswell LME is responsible for developing and monitoring a community of qualified providers who will deliver direct services to the target population.

The LME received approval of its **Local Business Plan** in 2007. The LME structure incorporates six major areas: Finance, Information Systems/Reimbursement, Quality Improvement/Provider Relations, Utilization Management/Crisis, Human Resources, Care Coordination (*See Section VII for LME Organizational Chart and Departmental Descriptions*).

Functions of the LME include but are not limited to:

- Assessing community needs for behavioral health services and supports
- Developing and monitoring the provider community
- Approving and authorizing contracts for services
- Promoting best practices, evidenced based practice, and consumer choice
- Ensuring that services are provided in sufficient amount, duration and scope to achieve meaningful outcomes for consumers
- Collaborating with community members to ensure community capacity to meet identified needs
- Protecting the rights of recipients of services in compliance with applicable rules and regulations
- Assuring cost-effective, well-coordinated services for each consumer
- Authorizing appropriate services
- Ensuring the meaningful input of consumers and stakeholders in service design and implementation
- Implementing and ensuring a continuous quality improvement philosophy and practice

SECTION I

Provider Relations

- Medicaid Provider - www.dhhs.state.nc.us/dma/mp/mpindex.htm
- State Funded Provider (GS 122C-151.4) AA/CP policies/procedures

TECHNICAL ASSISTANCE & TRAINING COLLABORATION

Reference section of State Funded Contract – Article II- 2.18 and Medicaid Funded MOA – Article I – 1.6.

- Medicaid Provider – DMA website www.dhhs.state.nc.us/dma/home.htm
 - State Funded Provider: Area Program Form

The LME shall provide timely and reasonable technical assistance regarding new State initiatives, or as the result of monitoring activities as related to the services covered in the Agreement, subject to the State's timeliness and availability of the information necessary to provide the technical assistance. Providers shall give reasonable notice to the LME for any and all requests for technical assistance. Training collaboration shall be done whenever possible with the LME or Providers in order to effectively and efficiently utilize the resources available.

Technical assistance is routinely offered, and is at times required, by the LME in conjunction with any quantitative/qualitative review findings; as a result of monitoring site visit(s) made by LME staff; and/or in conjunction with any plan of correction that may be required after any local, state or federal audit or license review. Technical assistance needs will be assessed by the LME and provided in a mutually satisfactory manner. If technical assistance is required, fees may be associated if there is an expense associated with that training (i.e lunch, supplies, etc...).

Provider agencies may request technical assistance and/or training in any area of service offered by the LME. These trainings may include but are not limited to: Human Rights, Medical Records, Service Documentation, Incident Reporting and Evidence Based Practices.

Requests for specific technical assistance should be directed to:

**Quality Assurance/Improvement Department
319 N. Graham-Hopedale Rd., Suite A
Burlington, NC 27217
(336) 513-4200**

PROBLEM RESOLUTION, DISPUTES & APPEALS

If problems arise between the Provider and the LME in the delivery of services, both parties shall attempt whenever possible to resolve these problems informally in a reasonable and timely manner. In the event that informal resolution is not appropriate or is unsuccessful, the process outlined in GS 122C-151.4 shall be followed. For further information contact the LME provider liaison.

LME DIRECTORY

MAIN NUMBER (336) 513-4200

Please note: This is not an exclusive list of all LME employees but, is intended to provide a list of key contacts within the LME to assist in directing calls from providers.

Contract/Agreement Questions	Jandy H. Andrews, Finance Officer Ext. 4419 jandrews@acmhdds.org
Provider Relations <ul style="list-style-type: none"> • Credentialing/Privileging • Endorsement • Monitoring 	Jean Gibson, Provider Liaison Ext. 4142 jgibson@acmhdds.org
Authorizations	Rhonda Long, UR/STR Admin. Ext. 4147 rlong@acmhdds.org
Billing/Invoices/Payment	Traci Henry, Accountant Ext. 4148 thenry@acmhdds.org
Medical Records	Kim Bandy, Medical Records Manager Ext. 4216 kbandy@acmhdds.org
Quality Improvement/Quality Assurance <ul style="list-style-type: none"> • QI Planning • Provider Monitoring • Community Liaison 	Jodi Meacham, QI/Provider Relations Manager Ext. 4123 jmeacham@acmhdds.org
Care Coordination	Ric Bruton, System of Care Coordinator Ext. 4224 rbruton@acmhdds.org
Quality Improvement/Quality Assurance <ul style="list-style-type: none"> • Incident Reporting • Provider Monitoring • Complaints 	Barbara Docimo, QI Specialist Ext. 4010 bdocimo@acmhdds.org
Provider Relations <ul style="list-style-type: none"> • NC TOPPS • STR Reports 	Trina Powell, Provider Relations Specialist Ext. 4158 tpowell@acmhdds.org
Quality Improvement/Quality Assurance <ul style="list-style-type: none"> • NC-SNAPS 	Joanne Melton, CAP Support Ext. 4109 jmelton@acmhdds.org
Provider Relations <ul style="list-style-type: none"> • Provider Training 	Carmen Morrow, Provider Relations Support Ext. 4108 cmorrow@acmhdds.org

NOTIFICATION OF CHANGE OF ADDRESS

Provider agencies are responsible for notifying the LME, the Division of Medicaid Assistance (DMA), and the Division of Mental Health, Developmental Disability, and Substance Abuse Services (DMH/DD/SAS) with any changes relevant to the physical and/or mailing address. If a change in the physical and/or mailing address of either governing body occurs, provider agencies will receive a formal notification.

Medicaid Providers must use the appropriate form located at the DMA website:
www.dhhs.state.nc.us/dma/form

State Funded Providers must use the appropriate form located at the DMA website:
www.dhhs.state.nc.us/mhddsas

Both Medicaid and State Funded providers shall complete the AC-LME Provider Directory Form (Attachment A) anytime there are changes to the physical and/or mailing address, as well as other information captured in the document.

Any party may, at any time, change its address for notification purposes by mailing a notice to the other Party at the address designated by that Party. The new address shall be effective on the date specified in such notice, or if no date is specified, on the tenth (10) day following the date such notice is received.

SECTION II

Comprehensive List of Requirements for the LME and Provider Agencies

The following graph serves as sufficient and necessary direction to Providers for accessing pertinent rules, regulations, standards, and other information referenced in Article I, Section 1.2 of the Agreement.

These documents change based on legislative action, change in federal and state policy, and state procedures. There is a mutual responsibility for Providers and the LME to each routinely check these items for updates on requirements. If a Provider is uncertain how a State or Federal change will be implemented, or if LME has concerns about how a change will be implemented, the LME shall make a good faith effort to get further information or resolution regarding implementation and share this with the Provider. However, the Provider shall not exclusively rely upon only the LME for information. If a Provider has problems obtaining or understanding the information referenced in this section, please contact the following department/individual at the LME:

QA/QI Department, Ext. 513- 4200

REQUIREMENT	SUGGESTED ACCESS	WEB SITE, IF AVAILABLE
APSM 30-1 (Rules for MH/DD/SA- Core rules for services and also includes State-covered services definitions) APSM 45-1 (Confidentiality) APSM 45-2 (Service Record Manual) APSM 45-2a (Service Records Resource Manual) APSM 95-2 (Client Rights) APSM 10-3 (Records Retention and Disposition Schedule) APSM 75-1 (Area Programs Budget ProManual) 45 CFR Par & 164 (HIPAA Standards for Privacy and Security of Health Information)	Contact: 3015 Mail Service Center Raleigh, NC 27699 (919) 715-1294	Contact Web Master for the NC Division of MH/DD/SA Services and NC Division of Medical Assistance www.dhhs.state.nc.us/mhddsas/manuals
CAP-MR/DD Manual –(CAP Providers and Core Competencies Training Requirements for MR/MI service providers)	Contact: 3015 Mail Service Center Raleigh, NC 27699 (919) 715-1294	http://www.dhhs.state.nc.us/mhddsas/developmentaldisabilities/operations/index.htm
Medicaid-Related Documents <ul style="list-style-type: none"> • Medicaid covered service definitions • Medicaid Service Guidelines • Medicaid Communications 	Contact: 3015 Mail Service Center Raleigh, NC 27699 (919) 715-1294	http://www.dhhs.state.nc.us/mhddsas/medicaid/index.htm
Residential Licensure Requirements	(919) 855-3750	http://facility-services.state.nc.us/provider.htm
Health Care Personnel Registry	(919) 733-8500 or (919) 715-0562	http://facility-services.state.nc.us/hcarpage.htm and www.ncnar.org
SB 163- Monitoring of Providers		http://www.dhhs.state.nc.us/mhddsas/sb163/index.htm

State Level		
<p style="text-align: center;">General Statutes</p> <p>122-C Mental Health, Substance Abuse, Developmental Disabilities Act of 1985</p> <p>Applicable sections include but are not limited to:</p> <ul style="list-style-type: none"> ▪ 122C-3 Definitions ▪ 122C-4 Use of phrase “client or his legally responsible person” ▪ 122C-51 Declaration of Policy on clients rights ▪ 122C-52 Right to confidentiality ▪ 122C-53-56 Exceptions... ▪ 122C-57 Right to treatment and consent to treatment ▪ 122C-58 Civil Rights and civil remedies ▪ 122C-59 Use of Corporal punishment ▪ 122C-60 Use of physical restraints or seclusion ▪ 122C-61 Treatment rights in 24-hour facilities ▪ 122C-62 Additional rights in 24-hour facilities ▪ 122C-63 Assurance for continuity of care for individuals with mental retardation ▪ 122C-64 Human Rights Committees ▪ 122C-65 Offenses relating to clients ▪ 122C-66 Protection from abuse and exploitation; reporting ▪ 122C-67 Other rules regarding abuse, exploitation, neglect, no prohibited ▪ 122C-(116,141,142,146) Local Government Entity ▪ 122C-151.3 and 151.4 Resolving Disputes with Contractors, etc... ▪ 90-21.4 Treatment of Minors ▪ 7A 517, 452-553 Abuse and neglect of Minors ▪ 108A 99-111 Abuse and Neglect of Disabled Adults ▪ 122C-151.3 and 151.4 Resolving Disputes with Contractors, etc... 		<p>All of the NC general statutes can be located on-line at the following site. Just type in the statute number you wish to review in the search box that is in this site.</p> <p style="text-align: center;">www.ncleg.net</p>
DHHS Disaster Preparedness, Response and Recovery Plan		www.ncdhhs.gov/mhddsas/disasterpreparedness/index.html
Monitoring of Providers		http://www.ncdhhs.gov/mhddsas/provider_monitor_tool/index.htm
Performance Agreement (03-04) between DMH and area programs-Attachment 12-prompt pay		www.dhhs.state.nc.us/mhddsas/performanceagreement
Contract between the Area Authority and the NC Division of MH/DD/SAS		http://www.dhhs.state.nc.us/mhddsas

Section III

Authorization Process

- Medicaid Provider –Please refer to www.dhhs.state.nc.us/dma/home.htm
- State Funded Providers shall adhere to the following procedures:

OVERVIEW

Determination of consumer eligibility and clinical necessity for proposed treatment requires the complete cooperation of participating providers with the review process. The LME is responsible for utilization management (UM), which includes preauthorization and concurrent review. Under the terms of the provider contract, all initial and continued adult and child mental health/substance abuse/developmental disabilities services require prior approval in order for a claim to be paid.

The only services that do *not* require preauthorization are emergency services. However, even in the case of emergency services, the LME should be notified of the emergency situation as soon as reasonably possible without compromising the consumer's treatment or safety. The LME will then be able to ensure that services rendered have the appropriate authorization entered into the electronic system so that claims are paid timely. The LME also needs to ensure that any necessary follow-up services are both arranged and authorized.

EMERGENCY SERVICES

The LME defines emergency services as those services necessary to screen and stabilize a consumer in cases where a prudent layperson, acting reasonably, would have believed an emergency existed.

Assistance with the delivery of emergent services is available 24 hours per day/7 days per week via the main telephone number for the LME. Crisis staff are available on-site at the LME during regular business hours (Monday-Friday, 8:00-5:00). Assistance is provided by local hospitals who provide on-site evaluations in their facilities or by the Mobile Crisis Team. Regardless of whether the situation occurs during or after business hours, the assistance is obtained via the LME's main telephone number.

ROUTINE SERVICES

Authorization for routine (non-urgent) services, both initial and concurrent, should be obtained via the LME by dialing the main telephone number during business hours and following the prompts for authorization requests.

Most authorization requests are received by facsimile; the review for appropriateness will occur during the review. However, the LME will continue to accept authorization requests via mail or telephonically for crisis situations. If there are questions regarding the appropriateness of the faxed or mailed request, a staff member from the LME may contact the provider by telephone to obtain the necessary information so that a determination can be made. Facsimile request for authorization is the LME preferred method.

Once the pertinent information is obtained and processed, an authorization number will be generated and sent to the provider via facsimile.

INITIAL AUTHORIZATION PROCEDURE

Generally, consumers initiate the referral process by contacting the LME to access the mental health system. Consumers are pre-screened and triaged by a LME staff member who refers the consumer to an appropriate provider based on their level of acuity. Consumers must be offered provider choice and an appointment according to the schedule below based on their triage level:

- Routine (or non-urgent) – Within 5 State business days (or 7-calendar days)
- Urgent – Within 48 hours
- Non Life-Threatening Emergent – Within 2 hours
- Life-Threatening Emergent – Immediately (usually 911 is called)

When the consumer is determined to be safe and to qualify for a “routine” appointment, LME UM staff will transfer the consumer to their provider of choice in order to schedule the initial appointment. If voice mail is obtained at the provider’s office, a message will be left asking that the provider please contact the consumer directly to schedule the routine appointment. Providers must offer the consumer an appointment within the routine standard of 5 (five) State business days from the time the consumer contacted the LME, not 5 days from the time the provider responds to the message and returns the call. If the consumer refuses an appointment that is offered within the 5-day standard, the provider should document that the consumer refused the appointment. It is essential that an appointment within the 5-day standard is offered. Given these standards are set forth by the Division; providers who do not have the capacity to meet this standard will not receive referrals until they are able to do so.

When the consumer’s need is determined to be “urgent” or “emergent”, the LME UM clinician will keep the consumer on the line while scheduling an appointment within the timeframes above. If the provider’s voice mail is obtained, the LME staff will contact a different provider until they are able to reach one who will be able to schedule the appointment as required (i.e. 48 hours for an “urgent” appointment and 2 hours for an “emergent” appointment). The LME clinician will not leave a voice mail when seeking appointments for a consumer who has been triaged as urgent or emergent. If a consumer does not present for their scheduled urgent/emergent appointment, providers are asked to notify the LME, as soon as possible, to ensure that any necessary follow-up telephone calls to the consumer are arranged.

An authorization number will be sent to the provider per facsimile on the day of the referral; whether routine, urgent, or emergent.

CONCURRENT AUTHORIZATION (CONTINUED) PROCEDURE

Following the comprehensive intake assessment, the primary practitioner, the consumer and other involved individuals as necessary, begin the person-centered planning (PCP) process. The PCP process must thoroughly consider and take full advantage of the consumer’s resources, such as natural, family and community supports (both formal and informal) in order to achieve the determined outcomes and goals for the consumer. Once the PCP is complete, the primary

practitioner should send the Treatment Request Form to the LME to obtain the necessary authorization(s) needed to carry out the Plan.

During the course of the UM review, LME UM staff will look for evidence that the consumer's own resources have been incorporated into the PCP and are being utilized to meet the identified goals.

DENIAL (NON-CERTIFICATION) PROCEDURE

Clinical Non-Certification (Medical Necessity Denial):

A determination by the LME that an admission, extension of stay, or other MH/DD/SA service has been reviewed and, based on the information provided, does not meet the clinical requirements for medical necessity, appropriateness, level of care, or effectiveness under the auspices of the applicable service definitions.

In the event that the LME UM clinician is unable to approve requested services because the clinical situation does not appear to meet medical necessity criteria, the case will be forwarded to a clinical peer reviewer or a physician advisor. The reviewer/advisor will contact the treating provider to discuss the case. During the conversation, the LME peer review/physician advisor may approve the case. If, however, the reviewer/advisor does not feel that the consumer meets criteria for the requested service, a medical necessity denial will be issued. It is important to note that alternative services will be offered and if agreed upon, a denial will not need to be issued. However, if an agreement cannot be reached between the treating provider and the clinical peer reviewer or physician advisor, a denial will be issued. The determination will be sent in writing and will include a description of appeals rights, as well as the mechanism for initiating an appeal.

Administrative Non-Certification:

A denial determination that is the result of a breach of a contractual agreement between the LME and a network provider is considered an Administrative Non-Certification denial. An administrative non-certification may also be issued when a consumer breaches the agreement with the North Carolina Division of MH/DD/SAS or the Division of Medical Assistance or pursues payment for services outside the parameters of the program, especially for state-funded consumers.

Administrative denials are issued by LME UM staff in the following situations:

- Ineligibility of consumer for covered services, such as when a consumer does not meet target population criteria (This scenario does not apply to Medicaid eligible consumers.)
- Proposed or provided services performed by a non-participating providers (providers not contracted with the LME)
- Proposed or provided services that are not part of the Service Definitions of the North Carolina Division of Mental Health, Developmental Disability, and Substance Abuse Services, and therefore are not covered by the LME
- Proposed or provided services exceeding the maximum number of units allowed by the DMA/DMH
- Failure of contracted providers to obtain prior authorization of services rendered
- Information requested by the UM reviewer to make a decision is not received within the designated time frame. The reviewer has five working days to respond to a request.

As in the case of clinical denials, written notification is sent to both the provider and the consumer; appeals rights are included. It is important to note that clinical peer reviewers or physician advisors are not consulted for contractual (administrative non-certifications). When the administrative non-certification is due to a breach of a contract on the part of the provider, the consumer is held harmless, i.e. the provider may not bill the consumer.

FAILURE TO FOLLOW THE AUTHORIZATION PROCESS WILL RESULT IN UNAUTHORIZED CARE AND NON-PAYMENT. THE CONSUMER AND THE LME SHALL BE HELD HARMLESS FROM ANY FINANCIAL RESPONSIBILITY FOR THE PARTICIPATING PROVIDER'S CHARGES AND UNAUTHORIZED CARE.

Section IV

Claims

- Medicaid Provider – please refer to www.dhhs.state.nc.us/dma/home.htm
- State Funded Provider: AA/CP policies/procedures

Area Authority/LME Fee Collection Policy and Minimum Fee/Sliding Scale Fee Schedule:

Providers who have been approved to do admissions to the LME have received materials and training pertaining to financial admissions and use of the LME sliding fee scale.

Claims Filing Requirements:

The provider is responsible for billing first and third party payments. The Provider is responsible for reporting to the LME such funding by providing copies of the Explanation of Benefits. Both parties agree to assist in the coordination of each Individual's health care benefits so as to avoid undue delay in the provision of service and to ensure that Federal and State-allocated funding shall be used only if and when other sources of first and third party payment have been exhausted. Both parties agree to make every effort to verify insurance and other third party benefit plan details during first contact, so that persons are directed to appropriate providers and to ensure compliance with North Carolina General Statute Chapter 122C. During an emergency, the Provider shall provide the necessary services and then complete the process to authorize and submit for payment.

Service Reporting and Submission of Invoices:

All Providers must use the forms referred to in Section VII of the Operations Manual for reporting of periodic, day/night services and attendance in residential services, unless specific exceptions is given by the Contracts Management Department. The attendance tracking form is required for reporting Room and Board, even if the Provider directly bills the treatment service to Medicaid. If you choose to do a computerized version of our form, it MUST be identical in lay out and content. These forms are required until otherwise notified.

- Periodic services must be reported twice monthly (mid-month and end of month)
- Residential (including room and board reports) and Day/Night must be reported once monthly

Periodic and Day/Night services reported should always reflect the actual minutes of service delivery up to the amounts ordered/authorized for the specific client.

Until further notice, all service reporting for the preceding month must be received no later than the 5th of the month following service delivery. If you experience an unusual problem in any given month and there will be an unexpected delay, you should call us and we will do our best to work with you on that situation.

Target Populations and Enrollment:

Consumer enrollment into the IPRS system is done through the LME's BUI system. This procedure is covered in the IPRS training that is provided. To be eligible for enrollment into an IPRS target population (or benefits plan), the consumer must meet both of the following criteria:

(1). The diagnostic criteria of the target population, meaning that consumer has a diagnosis that is listed under the diagnostic range of the target population consumer is being enrolled in:

AND

(2). The eligibility criteria of the target population, meaning that consumer meets the criteria as outlined under the eligibility criteria section of the target population consumer is being enrolled in current target populations along with the service array can be found at this website:

www.dhhs.state.nc.us/mhddsas/iprsmenu/index.htm.

The LME will notify the provider at the end of the year billing and submission deadlines as they are announced by DHHS.

The LME will accept electronic forms of the and also the HIPAA complaint 837. Faxes of the CMS-1500 forms are acceptable if your fax location meets HIPAA privacy and security regulations, but hard copies are preferred. DO NOT send BOTH a fax and a hard copy.

Invoices, including residential, whether a Medicaid billable service or not, must list the type of service(s) billed, the **LME** medical record number for the specific client (which is included with the approval/authorization), the number of units or days of service delivered per client, and the contract rate approved for each service.

If your organization does more than one type of service for a client, we prefer to have all the reporting for all services on the client for the calendar month before payment is processed, even though you may choose to send us separate invoices for each type of service. Invoices received for services for which you have not submitted the service reporting information in the manner described in this section will not be paid until we have received such. All invoices will be processed in accordance with Prompt Pay guidelines.

ORIGINAL invoices should be sent either via fax or mail (but not both) to the Contracts Management Department. The current contact information for The Contracts Management Department is as follows:

Contracts Management Department
Alamance-Caswell Local Management Entity
319 N. Graham-Hopedale Rd. Suite A
Burlington, NC 27217

Phone: 336-513-4200

Fax: 336-513-4449

Electronic Connectivity Requirements:

Procedures and requirements with regard to electronic billing and service reporting to the LME are under development and will be distributed as a manual update when complete.

Payment Schedules:

- Medicaid Provider – please refer to www.dhhs.state.nc.us/dma/home.htm
- State Funded Provider's must submit claims as noted in Services Reporting and Submission of Invoices above in order for the LME to ensure that the IPRS filing deadlines are met.

Claims received after 60 days of the delivery of the service will not be subject to the prompt pay provisions. The LME reserves the right to rescind unexhausted authorized units for any service in which a clean claim has not been received within 60 days of the date of service, resulting in non-payment of those claims. This will allow the LME to better utilize limited dollars for the procurement of MH/DD/SA services. The LME will notify Providers in written form of the deadline for reporting May and June services as this deadline will be less than 60 days due to end of fiscal year IPRS shortened submission deadlines.

Claims Adjudication:

Clean claims will be paid within Prompt Pay guidelines if received within 60 days of service delivery. A clean claim must meet all of the following criteria:

1. The specific service(s) that constitute the claim has/have been authorized prior to the date of service.
2. The service(s) has/have been provided and properly documented according to DHHS guidelines.
3. The service(s) must be reimbursable as defined in the contract between the LME and the Provider and this manual.
4. The service(s) is/are reported to the LME without errors, all required data elements associated with the specific claim are present and in standardized format.
5. The claim(s) has/have been received by the LME within sixty (60) days of service delivery for DMH payment through IPRS (in order for the LME to file the claim within the DMA filing requirements) and by DMA deadlines for Medicaid.
6. Medical record documentation supports medical necessity and service description criteria.

Claims Payment Disagreements:

In the event of a disagreement regarding any payment for services for a specific client(s), Provider should contact the Contracts Management Department, ext. 4215, within 72 hours of receipt of the written notice of reimbursement that varies from invoices submitted. If unable to be resolved at this level, Contracts Management Department staff will set-up a review meeting to further resolve the disagreement within the following 5 working days. The meeting will include the LME staff deemed by the LME to be needed in attendance at the review, but at a minimum will include the LME Finance Director, or designee, and whichever Provider staff are reasonably needed in attendance to help resolve the disagreement.

Prompt Pay:

See Prompt Pay Provision (Fiscal Management 3-Attachment 16).

New Admissions for those with Enhance Benefits/Services:

It is necessary to complete the following items to be submitted to the LME within 5 days.

- LME Consumer Admission and Discharge Form
- Target Population Assignment
- Financial Documents (Original sent to LME)
 - Financial Statement
 - Financial Agreement

All data will be sent to the LME Medical Records Department in no less than 5 working days from time of intake.

LME Record Numbers:

The LME will assign a record number to the individual during the telephone screening contact. The identified record number will be used to identify individuals and to be reported on all LME forms and documentation sent to the State.

- If a Medicaid consumer who has not gone through the LME screening process comes to a provider, the provider must complete the registration fields in *the LME Consumer Admission and Discharge Form* and submit them electronically to the LME within 5 days of initiating service. This “*registration*” will provide the LME with the data that is needed for the submission to the Client Data Warehouse (CDW) as required by the Division of MH/DD/SAS and the LME can assign a Medical Record number to the consumer.

Updates:

Consumer information and status must be updated when new data is collected or when existing data is modified. Changes must be sent to the LME within 5 days of provider becoming aware of update. Items that must be updated include:

- LME Consumer Admission and Discharge Form (**for Basic Benefits**)- **indicate diagnosis changes**
- **Target Pops- indicate changes**
- **Financial Status- complete the financial forms from the Intake Packet**

Discharges:

The provider must complete the following forms when a decision has been made to discharge the consumer from a program. The forms must be submitted to the LME and maintained in the Provider Service Record along with a discharge summary for the specific service, as applicable.

The following are the forms that are to be completed and items submitted to the Medical Records Department:

- LME Consumer Admission and Discharge Form **w/Discharge indicated on the top or appropriate location.**
- **Discharge NC-SNAPP/NC TOPP**

Information may be faxed or mailed to the contact below. Please paperclip/staple documents and clearly identify type of packet (Intake, Discharge, or Update).

Procedures for Performing a Financial Intake:

- Following the format of the Financial Form, general information must be obtained from the client. The form should be filled out in its entirety. Once the form is completed it is to be signed and dated by both the client and the interviewer. The top copy is routed to Reimbursement; the interviewer keeps the yellow and pink copies. The client also should completely understand and sign a financial agreement. A copy of this agreement needs to be attached to the financial copy that is sent to reimbursement and it is also customary to supply a copy to the client.
- Everyone is set to sliding fee scale based on the number of people in the household and the annual income of the household. This is referred to as the client's ability to pay. A sliding fee schedule has been provided in this packet. The client must have valid proof of income for everyone in the household that is working. Valid proof includes a current W-2, a current check stub or a letter written on company letterhead signed by a representative of the company stating pay rate, monthly pay and/or annual salary. If there is overtime pay on the check stub it is not customary to include that as part of the annual income, unless the client specifically states that he receives that much or more in overtime every payday. If a client does not have proof of income or refuses to give such then the client's ability to pay is set at 100% until such proof can be received.

(Note: Unless given a W-2, you have to manually calculate the annual income based on the pay stub. You do that by taking the gross amount of pay and multiplying by the number of paydays in a year. If the client is paid every two weeks, then there are 26 paydays in a year, if they are paid weekly, then there are 52 paydays in a year and if they are paid monthly, then there are 12 paydays in a year).

- Once the income and sliding scale have been established, then any insurance information needs to be obtained. Whether the client has private insurance, Medicaid, Medicare or all three a copy of the card(s) need to be attached to the copy that is sent to reimbursement.

Section V

Provider Documentation and Submission Requirements

- Medicaid Provider - www.dhhs.state.nc.us/dma/provenroll.htm
- State Funded Provider: See below

Documentation Submission Requirements at a minimum are as follows:

Admission/Intake/Discharge Process:

Providers authorized by the LME to complete admissions to the Area Authority must complete and submit forms as indicated on the Admission/Intake/Discharge Process document referred to in Section VII. When a decision has been made to discharge a consumer from a program, discharge documentation must also be submitted as indicated on the Admission/Intake/Discharge process document referred to in Section VII.

Psychotherapy and Behavioral Counseling Services when the Area Authority concurrently provides Psychiatric Services-all populations and funding:

In addition to the Provider's service plan and plan updates noted above for all services, a detailed summary of the client's therapy/counseling treatment since the prior physician visit shall be submitted to the Area Authority no later than 1 week prior to a scheduled psychiatric visit with the Area Authority's physician. Copies of actual therapy/counseling notes and rating scales shall be submitted upon request and/or in situations in which the client is being seen by Area Authority staff for urgent or emergent needs. The therapist/counselor or their designated supervisor shall be available, by phone or in person, at any time needed during a routine scheduled visit, or urgent or emergent unscheduled visit, to respond to physician questions as needed. (See Section VII to view the list of forms needed to complete this process).

New Admissions for those with Enhanced benefits/Services:

It is necessary to complete the following items to be submitted to the LME within 5 days.

- PCP Admission Form
- Target Population Assignment
- Financial Documents (Original sent to LME)
 - Financial Statement
 - Financial Agreement

All data will be sent to the LME Medical Records Department in no less than 5 working days from time of intake.

Section VI

Quality Improvement and Performance Monitoring

See Glossary of Terms for definitions of QA/QI/QM used in this section.

Entrance into the Quality Provider Community (QPC):

The Alamance Caswell Local Management Entity adheres to the *Policy and Procedures for the Endorsement of Providers of Medicaid Reimbursable MHDDSA Services* set forth by the North Carolina Department of Health and Human Services. Any willing and qualified provider who chooses to provide MHDDSA Services may become members of the Alamance- Caswell provider community by successfully completing the official endorsement process.

The endorsement process provides the AC LME with the required information to admit a provider into the provider community. All applicants for enhanced services must complete the designated application and submit all required supporting documentation. All providers who successfully complete the endorsement process receive an MOA with the AC LME and then directly enroll with the Division of Medical Assistance (DMA) to bill Medicaid direct for services provided to Medicaid recipients.

All providers who serve consumers who do not have Medicaid, but fall within the IPRS target population, will receive notification of a predetermined amount of IPRS funds at the beginning of AC LME's fiscal year or at the initiation of the provider's contract. These providers must meet the legal requirements to have a contract with the AC LME in order to bill for the services rendered. The community of providers that serves IPRS funded consumers is a closed network. Entrance into the closed network only occurs if there is an identified need for a specific service or provider as determined by the AC LME's Credentialing Committee.

All providers of the Qualified Provider Community are responsible for notifying the AC LME of any changes that may affect their endorsement status, including, but not limited to, change of address of the service site or corporate office site, change of contact information licensing sanctions, or adverse consumer occurrences.

Withdrawal of Endorsement

Withdrawal of endorsement may be initiated when:

- There is evidence of substantial failure on the Provider's part to comply with current rules, including 10 NCAC 26C. 0502; or
- The Provider has not satisfactorily addressed, within a reasonable time period, issues that endanger the health, safety or welfare of the individuals receiving services; or
- The Provider has been convicted of a crime specified in G.S. 122C-80; or
- The Provider has not made available or accessible all sources of information necessary to complete the monitoring processes set out in G.S. 122-C- 112.1; or
- The Provider has not submitted the required documentation; or
- The Provider has altered documents to avoid sanctions; or

- The Provider has not submitted, revised or implemented a plan of correction within the specified timeframes; or
- The Provider has not removed the cause of a summary suspension of DHSR licensure within the specified time frame.”

In cases of substantial failure to comply with current rules as noted above the Provider’s corporate verification may be withdrawn and all LME’s/County Programs will be notified by DMH. The Provider will be notified of the intent to withdraw endorsement via the standard “Notification of Endorsement Action” letter. The notice/letter will be signed by the Area Director and copied to the DMH and LME’s/County Programs statewide. The DMH will issue a recommendation to the DMA to disembroil the Provider. The DMH will copy the letter to the DHSR if it is a licensable service.

If the Provider’s corporate verification has been withdrawn there will be a waiting period of six (6) months before the Provider can request corporate verification from any LME/County Program. If a site/service endorsement is withdrawn, there will be six (6) month waiting period before the Provider can reapply for site/service endorsement with the LME/County Program that withdrew the endorsement. The active date of Medicaid payment will stop when the DMA pulls the Provider number.

Provider Monitoring:

Local Provider monitoring is conducted by the Alamance-Caswell LME as required by North Carolina Administrative Code 27G.0602 and is conducted for the following providers of publicly funded services:

- Category A: Indicates 24-hour residential facilities, day treatment, and out patient services except for hospitals (facilities licensed pursuant to General Statute 122C article 2).
- Category B: General Statute 122 C, Article 2, community based providers that do not require a state license.

Contract Providers are monitored at a minimum of annually, and any provider can be monitored more frequently if there is a concern or in response to a complaint.

The results of the monitoring reviews may be shared with other LME’s, the Division of MH/DD/SAS, or DHSR. In addition, we maintain a duty to report suspected or alleged abuse, neglect or exploitation to the respective Department of Social Services.

The Monitoring Visit

Two staff from the LME Quality Improvement Department will come on-site to review your program. A walk through of the facility will be completed to review various health and safety issues, to assure that records are stored in a manner that protects confidentiality and to verify licensure (if your facility is licensed). Consumers and direct care staff may also be interviewed.

It is important that your Qualified Professional be present during the monitoring visit to answer questions and provide additional information that may be needed.

During a local monitoring, providers will be asked to have at minimum the following information available:

- Two client files:
 - If medications are administered, at least one of the files reviewed should be of a consumer to whom you administer medications
 - If restrictive interventions are used, at least one of the files reviewed should be of a consumer for whom a restrictive intervention has been utilized
- Two Personnel files
 - One direct care employee
 - One clinical supervisor (qualified professional)
- Policy and Procedure Manual
- Quality Management Plan
 - Include minutes of meetings for the past six months
- Human Rights
 - Include minutes of meeting for the past six months
- Incident Reports
 - For the past six months
- Restrictive Interventions Logs
 - For the past six months
- Evidence of consumer self-governance
 - Minutes of house meetings for the past six months

Communicating the Results of the Monitoring Visit

At the end of the monitoring visit, the members of the LME’s monitoring team shall engage in a brief, “verbal” review of the findings. A detailed written report will be sent to the provider within ten working days.

In most instances you will be given fifteen working days to respond in writing to the findings of the review. You will be given sixty days from the date that you receive the monitoring report to correct the non-compliances. You will be asked to submit evidence that the items have been corrected. The plan of correction may be verified for implementation at your next monitoring review.

Not responding, or not correcting items cited in the report within the time frame specified in the letter may result in a report being made to your licensing agency by the LME.

Service Record:

The service record maintained and owned by the Provider will be considered the “original” record for the consumer, unless otherwise specifically agreed upon in writing with the LME.

Upon closure or transfer/sale of an agency, the complete original should be closed and a discharge summary completed. The provider is responsible for the storage and maintenance of

the closed record and releases upon request. Alamance-Caswell LME has the right to request documentation for audit purposes and the information shall be submitted as requested.

This is a summary of key components. This does NOT include all requirements. Providers should refer to Division of MHDDSA manual(s) available on the DMHDDSA website noted in Section II above as well as below.

All contracted services must be documented in accordance with *North Carolina Division of Medical Assistance (DMA)* and the *Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMHDDAS)*. These are outlined in the *NC Service Records Manual*, APSM.45-2 and 45-2A. The requirements are not limited to:

- The appropriate individual must order all Medicaid covered services.
- An order of service must be documented in the Provider's Service Record and completed prior to the delivery of services.
- A person-centered plan must be in the Service Record that is goal specific, measurable, with time specific and clear interventions and has documentation that the individual was involved in the development of the service goals.
- Each event must be documented, dated and authenticated.
- State mandated forms should be used for documentation of all services provided on behalf of the LME.
- The Provider must submit records for review by the LME upon request within the time frame requested.

Service Record Documentation:

1. Records are to be kept in accordance with the *Service Records and Service Records Resource Manual*. APSM 45-2; 45-2a. Providers are encouraged to print and keep a copy of the *Service Records Manual* (APSM 45-2), *Service Records Resource Manual (APSM 45-2a)* and the *Retention Manual for consumer records (APSM 10-1)* on site. (All of these can be found and printed from the website maintained by the state at www.dhhs.state.nc.us/mhddsas/manuals/index.htm).
2. Comprehensive service plans are to be used for consumers receiving enhanced benefits following person-centered planning guidelines. Relative to goals on the service plan and service authorized, each Provider is expected to develop consumer specific measurable interventions. The goals will be incorporated into the consumer's person-centered plan. The Provider's service-specific interventions should be reviewed by the treatment team in a treatment team meeting and should be reviewed at the initial development upon review and on an as needed basis.
3. Consumer specific oversight and monitoring is to be provided by the responsible party, progress is to be tracked on the goals. The goals and detailed interventions must be reflective of the individual's specific strengths, needs and desires.
<http://www.dhhs.state.nc.us/mhddsas/announce/commbulletins/commbulletin034pcpguidelines.pdf>
4. Consumer (or guardian/legally responsible person) signature must be obtained the date in which the PCP was written/reviewed/revised. An individualized PCP will begin upon admission and will be updated/revised to reflect additions/changes in the consumer's

condition. At a minimum, the PCP will be reviewed by the responsible professional based upon the target date assigned to each goal, whenever the consumer's needs change, service provider changes or upon request of the consumer or guardian.

5. Progress notes must address a goal on the PCP, the intervention provided and the effectiveness (progress made or lack thereof) of the intervention. Refer to documentation requirements and suggestions in the Medicaid guidelines. If progress has not been made within a 3-month period or within 2 cycles of the goal being implemented, the goal is to be reviewed to ensure its appropriateness.

Suggestions for Provider Service Record Review:

The LME highly suggests that your agency develop and implement a Service Record Review process. The following are areas to consider as you are developing your process:

Service Record Review Procedural Suggestions:

- Have both quantitative and qualitative component to the review.
 - *Quantitative: Is the item there or not?*
 - *Qualitative: What is the quality of the item being reviewed?*
- It is Best Practice for a QP to conduct the review for qualitative.
- The review needs to be a peer review and not a self-audit.
- Plans of correction (POC) should be completed on any area found out of compliance for both quantitative and qualitative issues.
- A second level of review should be conducted at a management level to ensure that POC's have been implemented, errors are corrected, and trends tracked.
- Staff involved in the reviews will need to be trained on using the review tool to ensure understanding and consistency.
- Results of the reviews should be submitted to your internal QI Committee to review and note trends. Any trends noted should be addressed.

Human Rights Reporting:

The State requires that your agency submit quarterly reports to the LME for client rights activities. The activities include:

1. **Completed documentation regarding abuse, neglect, or exploitation sent to QI Department (over and above Incident Reporting) and supporting documentation which should include:**
 - **HCPR (24 hour and 5 day reports for residential providers)**
 - **Completed investigation; and**
 - **Any other contacts with oversight agencies (DHSR, DSS, etc.) or law enforcement.**
2. **Log of restrictive intervention activities; and**
3. **Human Rights Minutes must reflect the review/approval of all requirements:**
 - **Review of incidents involving:**
 - *Allegations/substantiation of abuse, neglect, and/or exploitation*

- *Injury of unknown source*
- *Fraud against an individual or facility*
- *Diversion of drugs from an individual or facility*
- *Rights violations*
- *Deaths*
- *Client-to-client involvement that results in an incident report that frequently occurs*
- **Review of incidents related to medication errors/refusals;**
- **Behavior Plans reviewed and approved or recommendations given;**
- **Review of new Policies/Procedures/Rule related to Human Rights;**
- **Human Rights training provided during the quarter; and**
- **Provider Complaints**

The reports and minutes indicated above are to be submitted to the QI Department by 10th day of the month following the end of the quarter. In the event that Alamance-Caswell clients are not served in your facility, please indicate with written or e-mail notification. (*View Quarterly QI Activities Memo that has a section to complete to indicate that services were not provided to a consumer in the catchment area*).

Report may be sent via a hard copy to the above address or emailed to rbruton@acmhdds.org. Should you have any questions, please call (336) 513-4200 ext. 4224. Your promptness in submitting the report is greatly appreciated.

For additional information from the State concerning Client Rights, please visit the following website:

www.dhhs.state.nc.us/mhddsas/manuals/forms/dhhs-incident11-18-04

Incident Reporting

All incidents pertaining to LME clients shall be reported to the LME and NC DHHS as required in APSM 95-2(Client rights) and APSM 30-1 (Quality Assurance/Improvement), and 10A NCAC 27G.0600. NOTE: there's also a form (DHHS Incident and Death Form) and manual for incident report at: <http://www.dhhs.state.nc.us/mhddsas/manuals/index.htm>. Please fax to the attention of Barbara Docimo at 336-513-4422.

Requirements for Incident Response and Reporting

- **Level I Incidents:** Must respond to and document internally.
- **Level II Incidents:** Provider must respond to **and** report within 72 hours to the LME.
- **Level III Incidents:** Provider must respond to **and** report within 72 hours to the LME, DMH/DD/SA Quality Management Team **and**, if licensed under G.S. 122-C to the DFS Mental Health Licensure and Certification Section.

Statewide standardized forms must be used. These forms are located at:

<http://www.dhhs.state.nc.us/mhddsas/manuals/forms/dhhsincidentdeathreport-formqm02rev2-22-06.dot>

For more detailed information on Incident Reporting, please read the State Manual located:
<http://www.dhhs.state.nc.us/mhddsas/manuals/forms/dhhs-incident11-18-04manual-total.pdf>

Quarterly Reporting of Level I Incidents

Providers are to summarize Level I incidents and report to the LME for each quarter in the fiscal year for those individuals in the catchment area. Please reference the Provider Quarterly Incident Report Memo which is located at the following web-site:
<http://www.dhhs.state.nc.us/mhddsas/manuals/forms/providerqtrreport-formqmQM11rev1-06.doc>. Please fax Quarterly Incident Reports to the attention of Barbara Docimo at 336-513-4422.

Due Dates for the Quarterly Level I Incident Report

First Quarter: July, August, September is due **October 10**
Second Quarter: October, November and December is due **January 10**
Third Quarter: January, February and March is due **April 10**
Fourth Quarter: April, May and June is due **July 10**

Use the updated statewide-standardized form located at the following site:
<http://www.dhhs.state.nc.us/mhddsas/manuals/forms/level1criticalincidentsqtrlyreport1-05form-qm11.dot>

Person-Centered Planning: Communication Bulletin #34, Revised Person Centered Plan and Revised Instruction Manual (Announcement 3/4/9)

The Person-Centered Planning Guidelines can be located at the following web site:

http://www.ncdhhs.gov/mhddsas/statspublications/manualsforms/pcp/pcp_2008_instruction_manual.pdf

Staff must also be trained in the appropriate manner according to the Service Definitions. For additional information, please visit the following web site:

<http://www.dhhs.state.nc.us/mhddsas/servicedefinitions/servicedefinitions2-22-06update.pdf>

Crisis Planning:

North Carolina requires a CRISIS PLAN for consumers to promote recovery and to lessen the trauma of emergency events. Calls to 911 Emergency Response should not be the only intervention included in the Crisis Plan. The treatment team is the best resource for developing Crisis Plans.

Every Provider must complete a Crisis Plan on each consumer who receives enhanced services, including phone numbers and other provider contact information. This is especially important for those consumers who have had multiple hospitalizations, jail or court involvement, or extensive use of Crisis Emergency Services. This plan is not only helpful to the caregiver on how to de-escalate the consumer, but also to know what triggers will send the consumer into crisis and what helps the consumer regain control. This information can be invaluable to those that are attempting to care for the consumer while in crisis.

Providers shall maintain a goal of preventing crisis; however, when crisis situations are unavoidable, the provider shall ensure continuity of care. Consumers shall have access to their “first responder” emergency intervention twenty-four hours a day, seven days a week, from the primary clinician/designee who is responsible for ensuring consumer safety and referral to a more restrictive level of care as necessary. Providers who are not the primary clinician must communicate consumer crises that are outside current patterns of behavior to the primary clinician in a timely manner.

Clinical Outcome Measures:

It is the standard practice that the LME collect and analyze data being generated by both the LME and service providers to identify statistical trends and design improvements in the quality and delivery of services. This is completed by on-site monitoring, service record reviews, provider reporting and State required outcome tools.

The collecting of outcome data is the responsibility of the Provider. The LME has the oversight responsibility of monitoring, assessing and ensuring the quality of treatment and services. The following tools are approved tools for the collecting of outcome data:

- a. The **NC TOPPS** is currently administered to all consumers six years of age and older, who have an MI or SA diagnosis and qualifying services: The initial form will be administered at admission and updated forms will be completed at three-months, six months, nine-months, twelve months and every six months thereafter and then at discharge.
- b. The **NC-SNAP** assessment is to be done on all consumers receiving DD services when they first enter the system, and annually thereafter. However, if there is a *significant* change in supports, an update needs to be completed and submitted. If a consumer stops receiving services for any reason, or moves to another LME - then the provider needs to complete the Summary Report & Supplemental Information page (or "cover page") only with the Change to DD Support Status reason checked and submit it to the NC-SNAP database manager within 30 days. The provider does not have to do a discharge assessment.

It is vital that the LME obtain direct feedback, regarding the degree to which services are meeting the needs and expectations of consumers and their families. All providers are required to collect consumer satisfaction data on an annual basis as a State requirement (using the State tool and notification made by the LME). It is requested that the provider administer their own internal satisfaction surveys on an annual basis and report the information to both their internal Quality Improvement Department and also the LME.

These activities emphasize the importance of communication, teamwork, and collaboration in the delivery of quality services in the community. The LME’s community of providers is responsible for participating in LME quality improvement activities as indicated in the LME Quarterly QI Activities Memo. Submitting an annual QI Plan in addition to the minimum quarterly QI Committee Minutes is required.

Assurance of Confidentiality (10A NCAC 26B.0108)

1. The Area or State Facility Director shall make known to all employees, students, volunteers and all other individuals with access to confidential information the provisions

of the rules in this Subchapter and G.S. 122C-52 through 122C-56. The facility shall develop written policies and procedures in accordance with the rules of this Subchapter and applicable statutes and provide training to all individuals with access to confidential information.

2. Such individuals shall indicate an understanding of the requirements governing confidentiality by signing a statement of understanding and compliance. Employees shall sign such statement shall contain the following information:
 - A. Date and signature of the individual and title;
 - B. Name of area or state facility;
 - C. Statement of understanding;
 - D. Agreement to hold information confidential; and
 - E. Acknowledgement of civil penalties and disciplinary action for improper release or disclosure.

Send QI Department Data to:

Fax: QI Department 336-513-4422

or

Mail: Jodi Meacham

319 N Graham Hopedale Rd. Suite A
Burlington, NC 27217
336-513-4200, ext.4123

E-mail: jmeacham@acmhdds.org

**Summary of
QI Provider Reports and Required Documentation**

<u>Report/Documentation</u>	<u>Frequency</u>	<u>Due Date</u>
Individual consumer's level II and III incident reports	Per occurrence	Within 72 hours after incident
QI Meeting Minutes	Quarterly	10th day after quarter ends
Quarterly Incident Report	Quarterly	10th day after quarter ends
HR Meeting Minutes	Quarterly	10th day after quarter ends
QI Projects	Annually	July 15th
QI Annual Plan	Annually	July 15th
HR Annual Plan	Annually	July 15th
UM Information	Upon Request	QI Dept. contacts specific providers when information is needed
NC TOPPS (Mental Health and Substance Abuse Primary Diagnosis)	Initially, 3 months, 6 months, 12 months and every 6 months thereafter	Based on admission date
NC-SNAP (DD Primary Diagnosis)	Initially, and annually thereafter (*update needed if there is a significant change in the needs profile)	Based on admission date
DFS License	As renewed	As renewed
Oversight Agency Monitoring Reports (DSS,DFS,LME)	As they occur	As they occur

Section VII

System of Care

The Alamance-Caswell LME is committed to the development and implementation of a comprehensive home and community-based System of Care (SOC) as the vehicle to achieve improved outcomes for children and families in Alamance and Caswell counties. The LME supports the utilization of System of Care principles and practice by the Provider community, as the foundation for service development and delivery for children with complex needs and their families. Provider agencies participating in the Alamance-Caswell provider community must be willing to work cooperatively on behalf of children and families whom they serve, and be active participants in the System of Care in respective communities in the catchments area.

Providers are expected to plan and deliver services to children with complex needs and their families consistent with SOC values and principles and to adhere to all SOC elements including:

- 1) Utilization of Child and Family Teams as the vehicle for person-centered planning. Providers are also to ensure that staff responsible for service planning with children receiving enhanced benefit services and their families receive appropriate training in System of Care principles and Child and Family Team facilitation.
- 2) Full participation in Care Review, as established in respective communities.
- 3) Collaboration with others through the work of the Community Collaborative.
- 4) Ensure that families receiving MH/DD/SA services have access to the *NC System of Care Handbook for Children, Youth, and Families* available on the Division's website at <http://www.dhhs.state.nc.us/mhddsas/childandfamily/pdf/soc-familyhandbook1-06.pdf>.

Elements of System of Care included in the Alamance, Caswell, and Rockingham communities include:

- **Child and Family Teams:** These are individualized teams consisting of the individual/family, their providers, and informal supports that work together to develop and implement individualized family-centered service/support plans.
- **Community Collaboratives:** Community Collaboratives consist of a broad range of agencies, public and private providers, family advocates and others that support families, assess needs in the community, and establish effective relationships to improve local services.
- **Care Review:** A subcommittee of the Community Collaborative, this is a representative body from partnering agencies charged with ensuring that children/youth with complex needs, and their families, receive quality community-based services and supports matched with their strengths and needs, and are served in the least restrictive community setting possible.

- **Two-County Executive Committee:** This committee includes representatives from the two Community Collaboratives and provides oversight and review of the activities of the collaboratives as well as leadership for collaborative planning and decision-making.
- **Children's Executive Oversight Committee:** Present in Alamance County. This committee includes directors of major child-serving community agencies and reviews activities of mandated child-serving committees in addition to providing leadership and direction for services/supports in Alamance County.

System of Care is a nationally recognized Best Practice framework that organizes public and private community services and resources into a comprehensive and interconnected network to assure that individuals and families with complex needs have access to the services and supports they need to be successful at home, in school, and in the community. A System of Care is beneficial to families, agencies and communities because it enriches the array of community-based resources, reduces duplication of efforts, reduces unnecessary separation of children from their families, effectively unifies the efforts of those who assist individuals and families, and actively supports the development of healthy and productive families.

System of Care Values and Principles

Core Values

1. The system of care should be child centered and family focused, with the needs of the child and family dictating the types and mix of services provided.
2. The system of care should be community based, with the locus of services as well as management and decision-making responsibility resting at the community level.
3. The system of care should be culturally competent, with agencies, programs, and services that are responsive to the cultural, racial, and ethnic differences of the populations they serve.

Guiding Principles

1. Children with or at risk for serious emotional disturbances should have access to a comprehensive array of services that address the child's physical, emotional, social, and educational needs.
2. Children with or at risk for serious emotional disturbances should receive individualized services in accordance with the unique needs and potentials of each child and guided by an individualized service plan.
3. Children with or at risk for serious emotional disturbances should receive services within the least restrictive, most normative environment that is clinically appropriate.
4. The families and surrogate families of children with or at risk for serious emotional disturbances should be full participants in all aspects of the planning and delivery of services.

5. Children with or at risk for serious emotional disturbances should receive services that are integrated, with linkages between child-servicing agencies and programs and mechanisms for planning, developing, and coordinating services.
6. Children with or at risk for serious emotional disturbances should be provided with case management or similar mechanisms to ensure that multiple services are delivered in a coordinated and therapeutic manner and that they can move through the system of services in accordance with their changing needs.
7. Early identification and intervention for children with or at risk for serious emotional disturbances should be promoted by the system of care in order to enhance the likelihood of positive outcomes.
8. Children with or at risk for serious emotional disturbances should be ensured smooth transitions to the adult service system as they reach maturity.
9. The rights of children with or at risk for serious emotional disturbances should be protected, and effective advocacy efforts for children and youth with emotional disturbances should be promoted.
10. Children with or at risk for serious emotional disturbances should receive services without regard to race, religion, national origin, sex, physical disability, or other characteristics, and services should be sensitive and responsive to cultural differences and special needs.

Information on the System of Care in Alamance and Caswell Counties, including protocols and procedures for Child and Family Teams and Care Review, can be found on the LME's website at www.acmhdds.org and in the Child and Family Team Handbook at:

http://www.acmhdds.org/documents/system_of_care/information/handbooks/alamance_county_child_family_team_handbook.pdf.

For questions, comments, or concerns related to System of Care please contact:

Ric Bruton
System of Care Coordinator
319 N. Graham Hopedale Road
Burlington, NC 27217
Phone: (336) 513-4200, ext. 4224
rbruton@acmhdds.org

Section VIII

State Funded Providers-LME Specific Policies/Forms/Local Governance Requirements

The description of forms listed below can be accessed through the LME:

1. Organizational Chart and Departmental Descriptions
2. Tracking/Services reporting forms for all services
3. Outpatient Treatment Reports for authorizations
4. Notification of Change of Address
5. Prompt Pay Provision excerpt from Division/LME Performance Agreement
6. Admission/Intake/Discharge Process
7. Client Identification Face Sheet and Key
8. Financial paperwork

Section IX

Glossary of Terms

Definitions included in this section are primarily for clarification of terms used in the body of this Agreement, its attachments and manual. However many of these definitions are also used in existing state and LME documents and are included here to be helpful but are not to be considered comprehensive. Where similar definitions apply to multiple terms, the terms are grouped. Broad categories are defined with specific elements detailed as a part of the entire definition.

ACCESS – An array of treatments, services and supports is available; consumers know how and where to obtain them; and there are no system barriers or obstacles to getting what they need, when they are needed.

ACCREDITATION – Certification by an external entity that an organization has met a set of standards.

ACT-Assertive Community Treatment

ADULT- A person 18 years of age or older, unless the term is given a different definition by statute, rule, or policies.

ADMINISTRATIVE SERVICES- Services other than the direct provision of MH/DD/SA services (including case management) to eligible or enrolled persons, necessary to manage the MH/DD/SA system, including but not limited to: provider relations and contracting, provider billing accounting, information technology services, processing and investigating grievances and appeals, legal services (including any legal representative of the Contractor at Administrative hearings concerning the Contractor's decisions and actions), planning, program development, program evaluation, personnel management, staff development and training, provider auditing and monitoring, utilization review and quality management.

ADVOCACY – Activities in support of, or on behalf of, people with mental illness, developmental disabilities or addiction disorders including protection of rights, legal and other service assistance, and system or policy changes.

AMERICAN SOCIETY OF ADDICTION MEDICINE (ASAM) - An international organization of physicians dedicated to improving the treatment of people with substance use disorders by educating physicians and medical students, promoting research and prevention, and informing the medical community and the public about issues related to substance use. In 1991, ASAM published a set of patient placement criteria that have been widely used and analyzed in the alcohol, tobacco and other drug field.

AOC - Administrative Office of the Courts.

APPEAL- means a formal request for review of a decision made by the Contractor or a subcontracted provider related to eligibility for covered services or the appropriateness of treatment services provided.

APPEALS PANEL - The State MH/DD/SA appeals panel established under NC. G.S.

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ASSESSMENT – A comprehensive examination and evaluation of a person's needs for psychiatric, developmental disability or substance abuse treatment, services and/or supports according to applicable requirements.

AUTHORIZATION - The process by which Utilization Management agrees to a medically necessary specific service or plan of care based upon best practice. The granted request of a provider is assigned a number for tracking and linked to the subsequent claim that will be made for reimbursement. *PRE-AUTHORIZATION/PRIOR*

AUTHORIZATION is the process of approving use of certain resources in advance rather than after the service has been requested. Approval for admission to hospitals in an emergent situation is one example. *RE-AUTHORIZATION* is the process of submitting a request for services for a consumer who has already received authorized services. The request shall specify the scope, amount and duration of service requested and shall indicate the consumer's progress toward outcomes, the use of natural and community supports, and how the requested services will support the outcome the individual is seeking. *RETROSPECTIVE AUTHORIZATION* is authorization to provide services after the services have been delivered.

BASIC SERVICES – Mental Health, Developmental Disability or Substance Abuse services that are available to North Carolina residents who need them whether or not they meet criteria for target or priority populations.

BENEFIT PACKAGE OR PLAN – An array of treatments, services and/or supports intended to meet the needs of target or priority populations. *BENEFIT LIMITATIONS* are any provision, other than an exclusion, which restricts coverage, regardless of medical necessity. *Covered Benefits* medically necessary services that are specifically provided for under the provisions of Evidence of Coverage. A covered benefit shall always be medically necessary,

but not every medically necessary service is a covered benefit. For example, some elements of custodial or maintenance care, which are excluded from coverage, may be medically necessary, but are not covered. **BEST PRACTICE (S)** – Interventions, treatments, services or actions that have been shown by substantial research or professional consensus to generate the best outcomes or results. The terms, *EVIDENCE-BASED*, or *RESEARCH-BASED* may also be used.

BLOCK GRANT – Funds received from the federal government (or others), in a lump sum, for services specified in an application plan that meet the intent of the block grant purpose. Also referred to as *CATEGORICAL FUNDING*.

CARE COORDINATION – The methods utilized to notify other providers of significant events in the course of care and to enable multiple providers to give integrated care to an individual. Professionals with a broad knowledge of the resources, services and programs supported by the public MH/DD/SA system and the community at-large advocate for access and link individuals to entitlements and services. It is an administrative Service Management Function performed by the Contractor for individuals not enrolled or not meeting target population definitions.

CARF - Council on Accreditation of Rehabilitation Facilities

CATCHMENT AREA - The geographic part of the State served by a specific Contractor. The *GEOGRAPHIC AREA* can be a specific county or defined grouping of counties that are available for contract award. The Contractor is responsible to provide covered services to eligible residents of their area.

CENTERS FOR MEDICAID AND MEDICARE SERVICES (CMS) - The federal agency responsible for overseeing the Medicaid and Medicare programs. Formerly, it was known as the Health Care Financing Administration, (HCFA).

CERTIFICATION – A Statement of approval granted by a certifying agency confirming that the program/service/agency has met the standards set by the certifying agency. The Contractor or the NC Council may be the certifying agency for subcontracted Providers.

CFAC – Each LME has a Consumer Family Advisory Committee, which is comprised of consumers and family members representing all disability groups. CFACs meet on a regular basis in their communities to support and communicate their concerns and provide advice and comment on all state and local plans.

CHILD-An eligible person who is under the age of 18, unless the term is given a different definition by statute, rule or policy.

CHILD AND FAMILY TEAM (CFT)- A child and family team is a group of people, chosen with the family, that meets with a child and family to set goals and plan services. The CFT is built around the family to make sure the family's strengths are promoted and their needs are met

CLAIMS MANAGEMENT – The process of receiving, reviewing, adjudicating, *INVESTIGATING*, paying, and otherwise processing service claims submitted by network and facility providers. *CLAIM* – An itemized statement of services, performed by a provider network member or facility, which is submitted for payment. *CLEAN CLAIM*- means a claim that successfully passes all adjudication edits. **CLIENT** - An individual who is admitted to or receiving public services. “Client” includes the client’s personal representative or designee and the terms *CONSUMER*, *RECIPIENT* and *PATIENT* are often used interchangeably.

CLIENT OUTCOMES INVENTORY (COI) – DMH/DD/SAS measurement system for assessing treatment/services outcomes of mental health and substance abuse service consumers.

CLIENT DATA WAREHOUSE - The DHHS’s source of information to monitor program, clinical and demographic information on the clients served. The data are also used to respond to Departmental, Legislative and Federal reporting requirements.

CLINICAL PRACTICE GUIDELINES – Utilization and Quality Management mechanisms designed to aid providers in making decisions about the most appropriate course of treatment for a specific clinical case. The guidelines or *TREATMENT PROTOCOLS* are summaries of best practice research and consensus. They include professional standards for providing care based on diagnostically related groups. NC has adopted protocols for MH and DD. NC uses ASAM Guidelines for substance abuse.

COA -Council on Accreditation

CO-MORBID CONDITION- CO-OCCURRING DISORDERS, DUAL DIAGNOSIS –Terms that reflect the presence of two or more disorders at the same time (e.g. substance abuse and mental illness; developmental disability and mental illness; substance abuse and physical health conditions, etc and require specialized approaches).

COMPLAINT – A report of dissatisfaction with some aspect of the public MH/DD/SA system. The term *DISPUTE* is used to indicate a specific complaint about a service or a provider that requires attention and joint resolution.

CONFLICT OF INTEREST – A situation where self interest could negatively impact the best interests of the person being served or the system.

CONSENSUS - Majority opinion regarding a group decision. It is not the same as total agreement.

CONSUMER- An individual who is admitted to or receiving public services. “Consumer” includes the consumer’s personal representative or designee and the terms *CLIENT*, *RECIPIENT* and *PATIENT* are often used interchangeably.

CONSUMER/FAMILY ADVISORY COMMITTEE – A Board appointed group of persons receiving services, families of persons receiving services, advocates and other stakeholders that participate in meaningful decision making relative to the local program. The group shall meet at least monthly in a public forum to review data, practices, policies and plans of the Contractor and make recommendations to the Board from the consumer/family perspective.

CONTRACT- A legal agreement between a payer and a subscribing group or individual which specifies rates, performance covenants, the relationship among the parties, schedule of benefits and other pertinent conditions. The contract usually is time limited. A contract is defined as a document that governs the behavior of a willing buyer and a willing provider. In this case the Contract is the 2004 Performance Agreement between the Department and the LME.

CONTRACTOR - An organization or entity agreeing by signature to provide the goods and services in conformance with the stated contract requirements, NC statute and rules and federal law and regulations.

CONTRACT YEAR-A period from July 1 of a calendar year through and including June 30 of the following year.

COPAYMENT- The portion of the cost of services, which the enrolled person pays directly to the Contractor or the subcontracted providers at the time-covered services are rendered.

CORE SERVICES – *BASIC SERVICES* such as screening, assessment, crisis or emergency services available to any person who needs them whether or not they are a member of a target or priority population. The term also includes universal services such as education, consultation and prevention activities intended to increase knowledge about mental illness, addiction disorders, or developmental disabilities, reduce stigma associated with them and/or prevent avoidable disorders.

CORPORATE COMPLIANCE – The systematic local governance plan for detection of fraud and abuse as defined in the Balanced Budget Act.

CREDENTIALING – The process of approving providers for membership in a network to provide services to consumers. This term can also refer to a peer competency-based credential such as a license for professionals.

CRISIS – Response to internal or external stressors and stressful life events that may seriously interfere with/or compromise a person’s ability to manage. A crisis may be emotional, physical, or situational in nature. The crisis is the perception of and response to the situation, not the situation itself. *CRISIS RESPONSE* is the immediate action to assess for acute MH/DD/SA service needs, to assist with acute symptom reduction, and to ensure that the person in crisis safely transitions to appropriate services. These services are available 24 hours per day, 365 days per year. These services may be referred to as *EMERGENCY* services as well. NC requires a *CRISIS PLAN* for consumers to promote recovery and to lessen the trauma of emergency events.

CULTURAL COMPETENCE/PROFICIENCY –A process that promotes the development of skills, beliefs, attitudes, habits, behaviors and policies which enable individuals and groups to interact appropriately, showing that we accept and value others even when we may disagree with them.

CUSTOMER – Customers may be *ULTIMATE CUSTOMERS* who are the intended and actual recipients of the services provided by the public system, *INTERNAL CUSTOMERS* are those individuals internal to the system who rely on each other to provide the service to the ultimate customer; and *EXTERNAL CUSTOMERS* are those groups and individuals outside the system that have a take in the outcomes and products produced by the system.

DD - Developmental Disability

DEFAULT – The breach of conditions agreed to in the Contract and/or failure to perform based upon defined terms and conditions the scope of work specified in the Contract.

DE-INSTITUTIONALIZATION – Release of consumers from institutions for care, treatment and supports in local communities. De-institutionalization became national policy with the Community Mental Health Centers Act of 1963. The 1997 Supreme Court decision in *OLMSTEAD V. LC* has given new momentum to the development of community based services for individuals who have remained in State Hospitals and Mental Retardation Centers because community services were not available. This movement is often referenced as movement to least restrictive care or to lower levels of care where safety and community integration are balanced and supported through the community system of services.

DEPARTMENT OF HEALTH AND HUMAN SERVICES, (DHHS) – North Carolina agency that oversees State Government Human Services programs and activities.

DEVELOPMENTAL DISABILITY - A severe, chronic disability of a person which: a) is attributable to a mental or physical impairment or combination of mental and physical impairments; b) is manifested before the person attains age 22, unless the disability is caused by a traumatic head injury and is manifested after age 22; c) is likely to continue indefinitely and, d) results in substantial functional limitations in three or more of the following areas of major life activity: self-care, receptive and expressive language, capacity for independent living, learning, mobility, self-direction and economic self sufficiency; and e) reflects the person’s need for a combination and sequence of special interdisciplinary, or generic care, treatment, or other services which are of a lifelong or extended duration

and are individually planned and coordinated; or f) when applied to children from birth through four years of age, may be evidenced as a developmental delay.

DHHS- Department of Health and Human Services.

DIAGNOSTIC AND STATISTICAL MANUAL (DSM IV) – A book, published by the American Psychiatric Association, of special codes that identify and describe MH/DD/SA disorders.

DISASTER – A disaster is any natural or human-caused event, which threatens or causes injuries, fatalities, widespread destruction, distress, and economic loss. Disasters result in situations that call for a coordinated, multi-agency response. A disaster calls for a response and resources that usually exceed local capabilities.

DIVERSION – Choosing lower cost and/or less restrictive services and/or supports. For example, choosing a community program instead of sending a person to a State Hospital. The term is also used when preventing arrest or imprisonment by providing services that restore functioning and avoid detention. In North Carolina diversion programs are in place in response to SB859 that prohibits admission of persons with mental retardation to public psychiatric hospitals.

DIVISION OF MENTAL HEALTH, DEVELOPMENTAL DISABILITIES AND SUBSTANCE ABUSE SERVICES (DMH/DD/SAS) - A Division of the State of North Carolina, Department of Health and Human Services responsible for administering and overseeing public mental health, developmental disabilities and substance abuse programs and services.

DJJDP - Department Of Juvenile Justice and Delinquency Prevention.

DOMAINS - Major areas of concern to the NC Public MH/DD/SA system and its mission, goals, and strategies for which indicators and measures are developed to examine outcomes of service in the lives of people served.

DPI -Department of Public Instruction

DSS - Department of Social Services

EARLY PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT SERVICES

(EPSDT) – Early and Periodic Screening, Diagnosis and Treatment is a Medicaid program for Title XIX individuals under the age of 21. This mandatory preventive child health program for Title XIX children requires that any medically necessary health care service identified in a screening be provided to an EPSDT recipient. The MH/DD/SA component of the EPSDT diagnostic and treatment services for Title XIX members under age 21 years are covered by this contract.

EDUCATION – Activities designed to increase awareness or knowledge about any and all aspects of mental health, mental illness, developmental disability or substance abuse to individuals and/or groups. Education and training are also activities or programs delivered to staff to ensure that service providers are competent to provide services identified as best practices.

ELIGIBILITY – Determination of the service and/or benefit package an individual may be entitled to or determination of a class membership that allows entry to certain services and supports. The determination that individuals meet prescribed criteria for a particular program, set of services or benefits.

EARLY INTERVENTION - The provision of psychological help to victims/survivors within the first month after a critical incident, traumatic event, emergency, or disaster aimed at reducing the severity or duration or event-related distress. For mental health service providers, this may involve psychological first aid, needs assessment, consultation, fostering resilience and natural supports, and triage, as well as psychological and medical treatment.

EMERGENCY- Means a situation in which an individual is experiencing a serious mental illness or a developmental disability, or a child is experiencing a serious emotional disturbance, and one of the following apply: The individual can reasonably be expected within the near future to physically injure himself, herself, or another individual, either intentionally or unintentionally. The individual is unable to provide himself or herself food, clothing, or shelter, or to attend to basic physical activities such as eating, toileting, bathing, grooming, dressing or ambulating, and this inability may lead in the near future to harm to the individual or to another individual. The individual's judgment is so impaired that he or she is unable to understand the need for treatment and, in the opinion of the mental health professional, his or her continued behavior as a result of the mental illness, developmental disability, or emotional disturbance can reasonably be expected in the near future to result in physical harm to the individual or to another individual.

ENROLLED – Individuals are admitted for service and have been provided at least one service and assigned a unique identifying number.

FAIR HEARING RIGHTS – Advance and Adequate Notice - The Contractor notice in accordance with DHHS policy and procedure using prescribed forms when denying, reducing, suspending or terminating covered services that require prior authorization. The Contractor shall comply with all notice, appeal and continuation of benefits requirements specified by State and Federal law and regulations.

FEE FOR SERVICE – A method of payment for health care. A payer pays the Contractor or a service provider for each reimbursable treatment, upon submission of a valid claim, and according to agreed upon business rules. The *FEE SCHEDULE* is a list of reimbursable services and the rate paid for each service provided.

FEMA - Federal Emergency Management Agency

FORENSIC – Term used to describe a person with mental illness, developmental disability or substance abuse who is involved in the criminal justice system. This includes persons found Not Guilty by Reason of Insanity (NGRI), those who are Incompetent to Stand Trial, or who are in jails or prisons or referred to the mental health system by criminal courts for evaluation and treatment.

FORMULARY – A list of drugs that are considered preferred therapy for a given condition and cost effective and are to be used by providers in prescribing medications. **FUNCTIONAL OUTCOMES** - The extent to which individuals receiving services and supports reach their goals. These outcomes generate from *DOMAINS* as defined earlier related to desirable life developments that all people wish to achieve, such as safe and affordable housing, employment or a means of support, meaningful relationships, participation in the life of the community, etc.

GAPCD - Governor’s Advisory Council for Persons with Disabilities

GENERAL FUND – State funds used by the General Assembly for public programs and initiatives.

GEOGRAPHIC ACCESSIBILITY – A measure of access to services, generally determined by drive/travel time or number and type of providers in a service area. The Contract standard is 30 minutes/30 miles.

GRIEVANCES – A formal complaint by a service recipient that shall be resolved in a specified manner detailed in this Contract.

HEALTH CHOICE – The health insurance program for children in North Carolina that provides comprehensive health insurance coverage to uninsured low-income children. Financing comes from a mix of federal, State, and other non-appropriated funds.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) –Public Law 104-191, 1996 to improve the Medicare program under title XVIII of the Social Security Act, the Medicaid program under title XIX of the Social Security Act, and the efficiency and effectiveness of the health care system, by encouraging the development of a health information system through the establishment of standards and requirements for the electronic transmission of certain health information. The Act provides for improved portability of health benefits and enables better defense against abuse and fraud, reduces administrative costs by standardizing format of specific healthcare information to facilitate electronic claims, directly addresses confidentiality and security of patient information - electronic and paper-based, and mandates “best effort” compliance.

HIPAA - Health Insurance Portability and Accountability Act

HUD - Housing and Urban Development

HUMAN RIGHTS COMMITTEE – The body established by statute for hearing grievances and appeals related to rights violations guaranteed by law and under this contract.

INCURRED BUT NOT REPORTED (IBNR)- means liability for services rendered for which claims have not been received. Refers to claims that reflect services already delivered, but, for whatever reason, have not yet been reimbursed. Failure to account for these potential claims could lead to inaccurate financial estimates.

INTEGRATED PAYMENT AND REPORTING SYSTEM (IPRS) - An electronic, web-based system for reporting services and making payments that will eventually replace the Willie M., Thomas S., and Pioneer systems of claims processing. The IPRS system will be built on the existing Medicaid Management Information System (MMIS) currently processing Medicaid claims for the Division of Medical Assistance, (DMA). The goal of the IPRS project is to replace the existing UCR systems with one integrated system for processing and reporting all MH/DD/SAS and Medicaid claims.

IPRS-Integrated Payment Reporting System

JOINT COMMISSION ON ACCREDITATION OF HEALTHCARE ORGANIZATIONS (JCAHO) – Agency that reviews the care provided by hospitals and determines whether accreditation is warranted.

LBP - Local Business Plan

LEAST RESTRICTIVE CARE – The service that can be provided in the most normative setting while insuring the safety and well being of the individual.

LENGTH OF STAY (LOS) – The amount of time that a person remains in a service program, including hospitals, expressed in days.

LEVEL OF CARE (LOC)- A structured system for evaluating acuity and *INTENSITY OF NEED* against the amount, duration and scope of service required by a consumer. For substance abuse programs, As used in the ASAM criteria for substance abuse, this term refers to four broad areas of treatment placement, ranging from inpatient to outpatient.

LICENSURE – A State or Federal Regulatory System for service providers to protect the public health and welfare. Licensure of healthcare professionals and hospitals are examples.

LME - Local Management Entity

LOCAL BUSINESS PLAN – In the reformed MH/DD/SA system, a comprehensive plan required of local management entities for mental health, developmental disabilities and substance abuse services in a certain geographical area.

LOCAL MANAGING ENTITY (LME) - The local administrative agency that plans, develops, implements and monitors services within a specified geographic area according to the terms of this Contract including the development of a full range of services and/or supports for both insured and uninsured individuals.

LOCAL QUALITY MANAGEMENT COMMITTEE – A cross system group of stakeholders including the LME, providers, consumers, and family members that reviews data and trends to make recommendations for continuous improvement in the system of care and supports.

MANAGEMENT REPORTS – Collections of data that are benchmarked to enable the agency to compare performance against standards and to seek continuous improvement. The reports should be comprehensive incorporating timeliness, utilization and penetration rates, customer satisfaction, functional outcomes and compliance with various standards and terms inherent in this Contract.

MEDICAID – A jointly funded Federal and State program that provides medical expense coverage to low-income individuals, certain elderly people and people with disabilities. The Federal Government requires that the State/Local Government match the Federal Government funds. In North Carolina, this is approximately 60% federal/40% State/Local match. People qualifying for Medicaid are “entitled” to supports and services based upon a State Medicaid Plan that is approved by the Federal Government. That Plan describes the services and benefits the individual is entitled to receive and the conditions of service provision.

MEDICAL DIRECTOR – A Board Certified Psychiatrist responsible for establishing and overseeing medical policy throughout the system under the terms of this Contract.

MEDICAL NECESSITY - Criteria established to ensure that treatment is essential and appropriate for the condition or disorder for which the treatment is provided. The criteria reference the scope, amount and duration of service appropriate for levels of acuity and rehabilitative care.

MEDICARE – A Federal Government Hospital and medical expense insurance plan primarily for elderly people and people with long-term disabilities.

MEMBER HANDBOOK – A document developed and disseminated by the Contractor according to parameters established in this Contract to inform potential eligibles, eligibles, and enrolled persons of their rights, responsibilities and treatment coverages.

MEMORANDUM OF AGREEMENT (MOA) or MEMORANDUM OF UNDERSTANDING (MOU) – A written document, signed by two or more parties, containing policies and/or procedures for managing issues that impact more than one agency or program.

MH - Mental Health

MMIS - Medicaid Management Information System.

MST - Multi-Systemic Therapy

NATIONAL COMMITTEE FOR QUALITY ASSURANCE (NCQA)-A non-profit organization created to improve patient care quality and health plan performance in partnership with system management plans, purchasers, consumers, and the public sector.

NATIONAL PRACTITIONER DATA BANK (NPDB) – A database maintained by the Federal Government that contains information on physicians and other medical practitioners against whom medical malpractice claims have been settled or other disciplinary actions that have been taken.

NATURAL AND COMMUNITY SUPPORTS – Places, things, and (particularly), people who are part of our interdependent community lives and whose relationships are reciprocal in nature.

NCQA - National Council for Quality Assurance

NEEDS ASSESSMENT - A process by which an individual or system (e.g., an organization or community) examines existing resources to determine what new resources are needed or how to re-allocate resources to achieve a desired goal.

NORTH CAROLINA SUPPORT NEEDS ASSESSMENT PROFILE (NC-SNAP) – Assessment instrument used to determine the care or supports needed by a person with developmental disabilities.

OPERATIONAL AND FINANCIAL REVIEW- Review of the Contractor conducted by DMH/DD/SAS to assess compliance with contract requirements.

OUTREACH - Programs and activities to identify and encourage enrollment of individuals in need of MH/DD/SA services and/or to encourage people who have left service prematurely to return.

PATIENT PLACEMENT CRITERIA (PPC) - Standards of, or guidelines for, alcohol, tobacco and other drug (ATOD) abuse treatment that describes specific conditions under which patients should be admitted to a particular level of care (admission criteria), under which they should continue to remain in that level of care (continued stay criteria), and under which they should be discharged or transferred to another level (discharge / transfer criteria). PPC generally describe the settings, staff, and services appropriate to each level of care and establish guidelines based on ATOD diagnosis and other specific areas of patient assessment.

PCP - Person Centered Plan

PCPM – Per Citizen Per Month. The basis on which the Contractor is paid for administrative functions under the terms of some contracts.

PEER REVIEW – The analysis of clinical care by a group of clinician’s professional colleagues. The provider’s care is generally compared to applicable standards of care, and the group’s analysis is used as a learning tool for the members of the group. **PENETRATION** – The extent to which the system serves those individuals expected to have a specific medical condition, in this case persons with developmental disabilities, persons with mental illnesses and persons with substance abuse disorders. **PERFORMANCE INDICATORS** - Measurable evidence of the results of activities related to particular areas of concern as indicated in this Contract. The measures are quantitative indicators of the quality of care provided that consumers, payers, regulators and others could use to compare the care or provider to other care or providers.

PERFORMANCE STANDARDS- Benchmarks an agency or provider is expected to meet. The standards define regulatory expectations in meeting them, the agency or provider may meet a required level for “certification” or “accreditation”.

PERSON-CENTERED PLANNING - A process focused on learning about an individual’s whole life, not just issues related to the person’s disability. The process involves assembling a group of supporters selected by the consumer who are committed to supporting the person in pursuit of desired outcomes. Planning includes discovering strengths and barriers, establishing time-limited and identifying and gaining access to supports from a variety of community resources prior to utilizing the community MH/DD/SA system to assist the person in pursuit of the life he/she wants. Person-centered planning results in a written plan that is agreed to by the consumer and that defines both the natural and community supports and services being requested from the public system to achieve the consumer’s desired outcomes. The plan is used as the basis for requesting an authorization for services.

PHYSICAL DEPENDENCE - A condition in which the brain cells have adapted as a result of repeated exposure to a drug and consequently, require the drug in order to function. If the drug is suddenly made unavailable, the cells become hyperactive. The hyperactive cells produce the signs and symptoms of drug withdrawal.

PLAN OF CORRECTION – A written response to findings of an audit or review that specify corrective action, time frames and persons responsible for achieving the desired outcomes.

PP - Primary Provider

PREVALENCE – The estimated degree of incidence of a condition in a given population.

PREVENTION – Activities aimed at teaching and empowering individuals and systems to meet the challenges of life events and transitions by creating and reinforcing healthy behaviors and lifestyles and by reducing risks contributing to mental illness, developmental disabilities and substance abuse. Universal Prevention programs reach the general population; Selective Prevention Programs target groups at risk for mental illness, developmental disabilities and substance abuse; Indicated Prevention Programs are designed for people who are already experiencing mental illness or addiction disorders.

PSR - Psychosocial Rehabilitation

PRIMARY CARE- (a) Basic or general health care usually rendered by general practitioners, family practitioners, internists, obstetricians and pediatricians—often referred to as primary care practitioners. (b) Professional and related services administered by an internist, family practitioner, obstetrician-gynecologist or pediatrician in an ambulatory setting, with referral to secondary care specialists, as necessary.

PRIMARY SOURCE VERIFICATION – A process through which an organization validates credentialing information from the organization that originally issued the credential to the practitioner.

PRINCIPLE DIAGNOSIS-The medical condition that is ultimately determined to have caused the consumer to seek care. The principal diagnosis is used to assign every consumer to a diagnosis-related group. This diagnosis may differ from the admitting diagnosis.

PRIORITY POPULATIONS – Groups of people within target populations who are considered most in need of the services available within the system.

PRIVILEGING – Process for determining, usually through training and supervision that an individual provider has the necessary skills and knowledge to offer designated services and can provide them without supervision.

PROMPT SERVICES - Services provided when needed. For target or priority populations, routine appointments within 14 days, initial hospital discharge visits within 3 days, urgent visits within 2 days, emergent visits immediately and no later than 24 hours **qualify as prompt.**

PROVIDER – In this Contract, a person or an agency that provides MH/DD/SA services, treatment, and supports under a subcontract to the LME.

OPERATIONS MANUAL – A document attached to a subcontract for the purpose of explaining how to work with the local system, the requirements for service delivery, authorization, claims submission, etc.

PROVIDER PROFILING – The process of compiling data on individual provider patterns of practice and comparing those data with expected patterns based on national or local statistical norms. The data may include medication prescribed, hospital length of stay, size of caseload, and other services. Some data may be compiled for use by consumers in choosing preferred providers based on performance indicators.

PUBLIC MENTAL HEALTH, DEVELOPMENTAL DISABILITIES AND SUBSTANCE

ABUSE SERVICES SYSTEM – The network of managing entities, service providers, government agencies, institutions, advocacy organizations, and commissions and boards responsible for the provision of publicly funded services to consumers.

QIC - Quality Improvement Committee

QPN - Qualified Provider Network

QUALIFIED PROVIDER NETWORK – The group of subcontractors subcontracted by a Contractor to provide supports and services to persons for whom the Contractor authorizes care.

QUALITY MANAGEMENT (QM)- The framework for assessing and improving services and supports, operations, and financial performance. Processes include: **QUALITY ASSURANCE** and **QUALITY IMPROVEMENT**. **QUALITY IMPROVEMENT (QI)** is a

process to assure that services, administrative processes, and staff are constantly improving and learning new and better ways to provide services and conduct business. As distinct from QA, the purpose of QI, also referred to as continuous quality improvement (CQI), is to continuously improve the process and outcome (quality) of treatments, services, and supports provided to consumers and administrative functions. **QUALITY ASSURANCE (QA)** involves periodic monitoring of compliance with standards.

RECOVERING STAFF - Counselors with and without educational degrees working in the substance abuse treatment fields who are in recovery.

RECOVERY – A personal process of overcoming the negative impact of a disability despite its continued presence. Like the victim of a serious accident who undergoes extensive physical therapy to minimize the impact of damaging injuries, people with active addictions as well as serious, disabling mental illnesses and developmental disabilities can also make substantial recovery through symptom management, psychosocial rehabilitation, other services and supports, and encouragement to take increasing responsibility for self.

REFERRAL - Establishing a link between a person and another service or support by providing authorized documentation of the person's need and recommendation for treatment, services, and supports. It includes follow-up in a timely manner consistent with best practice guidelines.

REGISTER – The process of gathering initial data and entering an individual into the service system.

RESPONSIBLE CLINICIAN - An assigned professional deemed competent and credentialed by the Contractor to serve as a fixed point of accountability for the consumer's PCP, monitoring and outreach.

REVENUES – Money earned through reimbursements paid for covered services or other local sources, grants, etc.

SA - Substance Abuse

SAPT - Substance Abuse Prevention and Treatment

STATE-means the State of North Carolina.

STATE PLAN- Annual (each fiscal year) updated comprehensive MH/DD/SAS systems reform plan derived from the systems reform statute and titled "Blueprint for Change".

STATE PLAN (MEDICAID)- The written agreements between the State of NC and CMS which describe how the NC DMH/DD/SAS programs meet all CMS requirements for participation in the Medicaid program and the Children's Health Insurance Program.

SCREENING/TRIAGE – An abbreviated assessment or series of questions intended to determine whether the person needs a referral to a provider for services based on eligibility criteria and acuity level. A screening may be done face-to-face or by telephone, by a clinician or paraprofessional who has been specially trained to conduct screenings. Screening is a core or basic service available to anyone who needs it whether or not they meet criteria for target or priority populations.

SEAMLESS - Treatment system without gaps or breaks in service, such that persons being served transition smoothly and with ease from one treatment component to another.

SELF-DETERMINATION – The right to and process of making decisions about one's own life.

SENTINEL EVENT – CRITICAL INCIDENT, UNUSUAL INCIDENT, ETC. A sentinel event may include any type of incident that is clinically undesirable and avoidable. Sentinel events signal episodes of reduced quality of care. Many organizations monitor medication errors, review of deaths, accidents, evacuation drill responses, rights violations, medical emergencies, use of restraint or seclusion, behavior management etc. The purpose of sentinel event monitoring is to discover root causes and implement a continuous improvement process to prevent further events.

SEVERELY EMOTIONALLY DISTURBED (SED) – A designation for people less than 18 years of age who, because of their diagnosis, the length of their disability and their level of functioning, are at the greatest risk for needing services. **SEVERELY MENTALLY ILL (SMI)** – Refers to adults with a mental illness or disorder that is described in the Diagnostic and Statistical Manual of Mental Disorders, 4th Edition, that impairs or impedes functioning in one or more major areas of

living and is unlikely to improve without treatment, services and/or supports. People with serious mental illness are a target or priority population for the public mental health system for adults.

SERIOUSLY AND PERSISTENTLY MENTALLY ILL (SPMI) – Refers to people with a mental illness or disorder so severe and chronic that it prevents or erodes development of functional capacities in primary aspects of

daily life such as personal hygiene and self care, decision-making, interpersonal relationships, social transactions, learning and recreational activities.

SERVICE MANAGEMENT – An administrative function that includes Utilization Management and Care Coordination under this Contract. The service is carried out by experienced professionals with broad knowledge of the services and programs supported by the public system, managing a set of services by advocating for access and linking the person to the services. At the system level, this means activities such as implementing and monitoring a set of standards for access to services, supports, treatment; making sure that people receive the appropriate level and intensity of services; management of State Facilities’ bed days, making sure that networks create consumer choice in service providers.

SPECIALIST REVIEW – A consultation or second opinion rendered by a member of the UM staff when an authorization request falls outside the defined criteria for service selection, amount or duration.

STANDARD OF CARE – A diagnostic and/or treatment consensus that a clinician should follow when providing care based upon the discipline’s peer group organization, such as the APA or NASW.

STATE MENTAL HEALTH AUTHORITY – The single State agency designated by each State’s governor to be responsible for the administration of publicly funded mental health programs in the State. In North Carolina that agency is the Department of Health and Human Services.

STATE MENTAL HEALTH, DEVELOPMENTAL DISABILITIES AND SUBSTANCE

ABUSE SERVICES PLAN – Plan for Mental Health, Developmental Disabilities and Substance Abuse Services in North Carolina. This Statewide plan forms the basis and framework for MH/DD/SA services provided across the State. **STATE OR LOCAL CONSUMER ADVOCATE** - The individual carrying out the duties of the State Local Consumer Advocacy Program Office. **SUBSTANCE ABUSE** – The DSM IV defines substance abuse as occurring if the person 1) uses drugs in a dangerous, self defeating, self destructive way and 2) has difficulty controlling his use even though it is sporadic, and 3) has impaired social and/or occupational functioning all within a one year period.

THE SUBSTANCE ABUSE AND MENTAL HEALTH ADMINISTRATION OF THE FEDERAL

GOVERNMENT (SAMHSA) - SAMHSA is an agency of the U.S. Department of Health and Human Service. It is the Federal umbrella agency of the Center for Substance Abuse Treatment, Center for Substance Abuse Prevention, and the Center for Mental Health Services.

SUBSTANCE ABUSE PREVENTION AND TREATMENT BLOCK GRANT (SAPTBG) -A Federal program to provide funds to States to enable them to provide substance abuse services.

SUBSTANCE DEPENDENCE - DSM IV defines substance dependence as requiring the presence of tolerance, withdrawal, and/or continuous, compulsive use over a 1year period.

SUBCONTRACT-Any contract between the Contractor (Contractor) and a third party for the performance of all or a specified part of this Contract. The *SUBCONTRACTOR* means any third party engaged by the Contractor, in a manner conforming to the contract requirements for the provision of all or a specified part of covered services under this Contract.

SYNAR AMENDMENT – Section 1926 of the Public Health Service, is administered through the Substance Abuse Prevention and Treatment (SAPT) Block Grant and requires States to conduct specific activities to reduce youth access to tobacco products. The Secretary of the US Department of Health and Human Services is required by statute to withhold SAPT Block Grant funds (40% penalty) from States that fail to comply with the SYNAR Amendment.

SYSTEM OF CARE (SOC)-A framework and structural approach to arranging the delivery and coordination of services for children and adolescents that employs evidence based thinking and arranges a comprehensive array of mental health and other services into a collaborative network to meet their multiple needs. Key principles of SOC are: interagency collaboration, individualized strengths-based care, cultural competence, community-based services and supports, child and family partnership, and accountability to results.

TARGET POPULATIONS –Groups of people with disabilities with attributes considered most in need of the services available within the system; populations as identified in federal block grant language. *NON-TARGET POPULATION* are those individuals with less severe disorders that can be adequately and most cost effectively treated by the private sector, primary physicians or by using generic community resources.

TRANSITION – The time in which an individual is moving from one life/development stage to another. Examples are the change from childhood to adolescence, adolescence to adulthood and adulthood to older adult.

UM - Utilization Management

UNIFORM PORTAL ACCESS - The standardized process and procedures used to ensure consumer access to, and exit from, public services in accordance with the State Plan.

UTILIZATION MANAGEMENT (UM)- is a process to regulate the provision of services in relation to the capacity of the system and needs of consumers. This process should guard against under-utilization as well as over-utilization of services to assure that the frequency and type of services fit the needs of consumers. The administration of services or supplies, which meet the following tests: they are appropriate and necessary for the

symptoms, diagnosis, or treatment of the medical condition; they are provided for the diagnosis or direct care and treatment of the medical condition; they meet the standards of good medical practice within the medical community in the service area; they are not primarily for the convenience of the plan member or a plan provider; and they are the most appropriate level or supply of service, which can safely be provided. This function is carried out by professionals qualified in disciplines related to the care being authorized and requires their use of tools such as service definitions, level of care criteria, etc.

UTILIZATION-The use of services. Utilization is commonly examined in terms of patterns or rates of use of a single service or type of service. Use is expressed in rates per unit of population at risk for a given period such as the number of admissions to the hospital per 1,000 persons per year, or the number of services provided per 1,000 persons by a system of care annually.

UTILIZATION REVIEW (UR)- An analysis of services, through systematic case review, with the goal of reviewing the extent to which necessary care was provided and unnecessary care was avoided. The examination of documents and records to assure that services that were authorized were in fact provided in the right amount, duration and scope, within the time frames allotted; and that consumers benefited from the service. The review also examines whether the actual request for authorization was valid in its assessment of the consumer and the intensity of need. There are a variety of types of reviews that may occur concurrent with the care being provided, retrospectively or in some cases prospectively if there are questions about the authorization requested.

Section X Resource List

NC Division of Mental Health, Developmental Disabilities and Substance Abuse Services:
<http://www.dhhs.state.nc.us/mhddsas/>

Division of Medical Assistance: <http://www.dhhs.state.nc.us/dma/bulletin.htm>.

NC Council of Community Programs: <http://www.nc-council.org/>

NC Community Support Providers Council: <http://www.ncproviderscouncil.org/about.htm>

NC General Assembly: <http://www.ncga.state.nc.us/homePage.pl>

Value Options: <http://www.valueoptions.com/>

Alamance-Caswell-Rockingham LME: <http://www.acmhdds.org/>

NC Integrated Payment Reporting System (IPRS): <http://www.dhhs.state.nc.us/mhddsas/iprsmenu/index.htm>

The Division of Health Services Regulation: <http://www.ncdhhs.gov/dhsr/>