



North Carolina Department of Health and Human Services

Beverly Eaves Perdue, Governor

Lanier M. Cansler, Secretary

Division of Mental Health, Developmental Disabilities and Substance Abuse Services

3001 Mail Service Center
Raleigh, North Carolina 27699-3001
Tel 919-733-7011 • Fax 919-508-0951
Leza Wainwright, Director

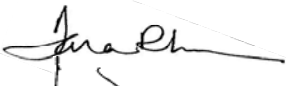

Division of Medical Assistance

2501 Mail Service Center
Raleigh, North Carolina 27699-2501
Tel 919-855-4100 • Fax 919-733-6608
Tara R. Larson Acting Director

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MEMORANDUM

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

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| SUBJECT: | Implementation Update #52 Community Support Services Tiered Rates Day Treatment Rate Change Provider # Changes to Completed Authorizations Procedures for Change of Ownership Reporting Withdrawal, Revocation or Suspension Alternative Definitions & Performance Measures | Clinical Policy 8A Update NC-TOPPS at a Glance Dashboard Accreditation Update Complete CAP-MR/DD Requests CAP-MR/DD Update |
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Community Support Services – Tiered Rates

The General Assembly enacted Session Law 2008-107 Section 10.15A(a)(b), which changes the payment methodology of Community Support services from a blended rate to a tiered rate based upon the individual qualifications of the staff providing the service. DMA submitted a State Plan Amendment (SPA) to the Center for Medicare and Medicaid Services (CMS) for approval to implement these changes. **The SPA has been approved effective with date of service January 1, 2009.**

For dates of service December 1, 2007, through December 31, 2008, providers were required to append secondary modifiers U3 or U4 to the CPT procedure code H0036 to identify units of service provided by the Qualified Professional (QP) and Non-Qualified Professional (non-QP) staff persons. Effective with date of service January 1, 2009, these two secondary modifiers have been replaced by eight new secondary modifiers (refer to the tables below).

Community Intervention Services (CIS) providers billing for Community Support services are required to apply these new secondary modifiers on claim submissions for procedure code H0036 in addition to the required primary modifier:

- H0036 HA – Community Support Child
- H0036 HB – Community Support Adult
- H0036 HQ – Community Support Group

The rates associated with the four levels of staff credentials have been approved by the DHHS Rate Review Committee and CMS. Please note that these final rates represent a change from the proposed rates that were posted on the DMA website.

H0036 HA - Community Support Child

| Staff Level | Code | First Modifier | Second Modifier | Unit Rate |
|-------------------------------------|-------|----------------|-----------------|-----------|
| Qualified Professional - Licensed | H0036 | HA | HP | \$22.04 |
| Qualified Professional – Unlicensed | H0036 | HA | HO | \$18.25 |
| Associate Professional | H0036 | HA | HN | \$10.29 |
| Paraprofessional | H0036 | HA | UB | \$5.92 |

H0036 HB - Community Support Adult

| Staff Level | Code | First Modifier | Second Modifier | Unit Rate |
|-------------------------------------|-------|----------------|-----------------|-----------|
| Qualified Professional - Licensed | H0036 | HB | HP | \$22.04 |
| Qualified Professional – Unlicensed | H0036 | HB | HO | \$18.25 |
| Associate Professional | H0036 | HB | HN | \$10.29 |
| Paraprofessional | H0036 | HB | UB | \$5.92 |

For H0036 HQ – Community Support Group, a separate set of modifiers will be necessary.

| Staff Level | Code | First Modifier | Second Modifier | Unit Rate |
|-------------------------------------|-------|----------------|-----------------|-----------|
| Qualified Professional - Licensed | H0036 | HQ | U8 | \$ 7.09 |
| Qualified Professional – Unlicensed | H0036 | HQ | U7 | \$ 5.87 |
| Associate Professional | H0036 | HQ | U6 | \$ 3.31 |
| Paraprofessional | H0036 | HQ | U5 | \$ 1.90 |

Authorizations for all Community Support services will continue at the aggregate level with payment at the detail level. **Systematic adjustments will not be made to previously processed claims submitted with the secondary modifiers U3 or U4 for dates of service on or after January 1, 2009. Providers must resubmit the paid claim details as a new claim. Please refer to the June 2007 general Medicaid Bulletin (<http://www.ncdhhs.gov/dma/bulletin/0607bulletin.htm>) for details on submitting replacement claims.** It is recommended that providers separate all claim details for Community Support services for dates of service before or after January 1, 2009, to ensure efficiency in payment.

Each claim for Community Support services will require the use of the two modifiers to be processed for payment. Primary modifiers HA, HB, or HQ must be placed in the first modifier position on the corresponding claim detail line. Secondary modifiers must be placed in the second modifier position on the corresponding claim detail line. **Payment of the claim is driven by the second modifier. Errors in entering the correct second modifier could result in recoupment upon audit of medical records.**

CMS-1500 Claim Examples:

These examples are for illustration purposes only. Actual codes billed should reflect who rendered the services.

| 24. A. SERVICE | DATE(S) OF SERVICE | | | | | | B. PLACE OF SERVICE | C. EMG | D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) | | | E. DIAGNOSIS POINTER | F. \$CHARGES | G. DAYS OR UNITS |
|----------------|--------------------|----|----|-------|----|----|---------------------|--------|--|----------|---|----------------------|--------------|------------------|
| | From MM | DD | YY | To MM | DD | YY | | | CPT/HC PCS | MODIFIER | | | | |
| | 01 | 12 | 09 | 01 | 12 | 09 | 11 | H0036 | HA | HO | 1 | 73.00 | 4 | |
| | 01 | 12 | 09 | 01 | 12 | 09 | 11 | H0036 | HA | UB | 1 | 47.36 | 8 | |
| | 01 | 12 | 09 | 01 | 12 | 09 | 11 | H0036 | HA | HN | 1 | 41.16 | 4 | |
| | 01 | 12 | 09 | 01 | 12 | 09 | 11 | H0036 | HQ | U7 | 1 | 23.48 | 4 | |

Below are guidelines to assist providers in accuracy of claim submission:

- Providers should bill only one line each for primary and secondary modifier combination per date of service per client. If more than one staff person with same level of credentials provides services on the same date, these staff units should be rolled into one detail line.
- It is expected that any combination of staff and associated modifiers may be billed on the same date of service.
- The determination of staff qualifications is dictated by the staff credentials providing the service; not the actual intervention.
- No rounding of time is allowed for billable services; only round down when time does not reach a complete 15 minutes per individual staff rendering the service.
- The maximum of 32 units per week per adult client (H0036 HB) is applied to the combined total of all modifiers and units of service.

Day Treatment Rate Change

Medicaid providers enrolled to offer the services of Child and Adolescent Day Treatment, please note the rate change:

| Service Code | Old Rate | New Rate |
|---------------------|-----------------|-----------------|
| H2012 HA | \$31.25/hour | \$34.75/hour |

These rates are effective as of January 1, 2009. Please refer to the Division of Medical Assistance website at: <http://www.ncdhhs.gov/dma/fee/> for additional updates which will be posted as changes are made.

Provider Number Changes to Completed Authorizations

In April, 2008, via Implementation Update #42, it was communicated that ValueOptions would no longer make changes to provider numbers on authorizations already in place. Since that time there have continued to be a high volume of requests to have this done, typically related to an agency merger/acquisition or to correct a previous submission error. In response, DMA has worked with ValueOptions to develop a way to accommodate these requests. A provider may choose this new option, outlined below, or continue the standard process of submitting an updated Inpatient Treatment Report (ITR) for medical necessity review to request a new authorization.

If a provider wishes to have ValueOptions make changes to the provider number on an authorization without having to submit a new authorization request, ValueOptions will charge the provider \$9.70 for each authorization changed. This fee will cover the cost of ValueOptions making these changes, since changing a provider number on an authorization requires voiding the old authorization, building a new authorization with the new provider number, attaching relevant inquiries and reviews into the inquiry, documenting the basis of the activity, and creating and mailing an authorization letter to the provider that corresponds to the new authorization.

In order to request such changes, providers must complete the Provider Change Request Form located at www.valueoptions.com/providers/Network/North_Carolina_Medicaid.htm and mail a hard copy of the completed Provider Change Request Form along with a check payable to ValueOptions Inc. for the appropriate amount to ValueOptions Provider Relations, P.O. Box 13907, Research Triangle Park, NC 27709-3907. The requested changes will be completed within ten business days after receipt of the check and completed form (extraordinary volumes may require longer). Providers may e-mail any questions about this new service to ValueOptions Customer Service at PSDCustomerService@valueoptions.com. All requests are subject to review and approval by DMA.

DMA Procedures for Processing Change of Ownership

The Division of Medical Assistance's Provider Services Unit must process a new Provider Enrollment Packet and execute a new Medicaid Participation Agreement to document a change of ownership.

A change of ownership is constituted by any of the following actions:

- An exchange of monies or an asset purchase, both of which result in the assignment of a new tax identification number.
- A stock purchase, which may not result in the assignment of a new tax identification number.
- A change in a shareholder's/partner's percentage of interest in ownership.
- A transfer of title and property to another party.
- A merger of the provider corporation into another corporation or the consolidation of two or more corporations resulting in the creation of a new corporation.

When a change of ownership occurs, DMA must terminate the previous owner(s) Medicaid provider number effective with the date of the change of ownership. The previous owner is required to submit a Medicaid Provider Change Form to DMA

verifying the change of ownership and requesting termination of their Medicaid participation. DMA cannot proceed with enrollment of the new owner without this notification from the previous owner.

The new owner must submit to DMA a copy of the stock transfer document or bill of sale to document the change of ownership. The new owner must obtain an endorsement from the appropriate Local Management Entity (LME) when a change of ownership occurs; the previous owner's endorsement is not transferable. The new owner's enrollment effective date for endorsed services may not precede the date of the change of ownership or the date of endorsement.

As detailed in the DMA Participation Agreement, the previous owner's Medicaid provider number and the Medicaid Participation Agreement itself are not transferable. In addition, prior approval numbers are issued to the provider who submits the request. If a recipient changes providers or a change of ownership occurs before the approved services are rendered, the new provider must submit a prior approval request in order to continue service provision. However, the new provider may submit supporting documentation from the previous provider or they may use the new process outlined earlier in this Implementation Update under the section entitled, *Provider Number Changes to Completed Authorizations*.

Additional documentation specific to the type of provider is also required. Refer to DMA's website at <http://www.ncdhhs.gov/dma/provider/changematrix.htm> for a detailed list of requirements.

Reporting Withdrawal, Revocation or Suspension of a License, Accreditation, Endorsement and/or Certification

Any provider or facility whose license, accreditation, endorsement and/or certification is withdrawn, revoked or suspended is not eligible for participation in the North Carolina Medicaid program. Providers whose license, accreditation, endorsement and/or certification is withdrawn, revoked or suspended should notify DMA immediately.

Reactivation in the Medicaid program may occur when the license, accreditation, endorsement and/or certification is reinstated by the respective authority. Reactivation must be requested in writing by the provider or the facility and the submission of a new enrollment packet may be required. A copy of the reactivated license, accreditation, endorsement and/or certification must accompany the request for reactivation. Reactivation is effective no earlier than the date on the reinstated license, accreditation, endorsement and/or certification.

Alternative IPRS Service Definitions Included in System Performance Measures

The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS) has received questions about whether alternative Integrated Payment and Reporting System (IPRS) service definitions will be acceptable in calculating the current critical performance measures, particularly the measure of aftercare for persons discharged from state facilities. In recognition of the importance of attending to basic needs as well as clinical needs, the DMH/DD/SAS will include in those calculations all alternative service definitions designed to link a person to community services. DMH/DD/SAS will also explore future measures to track when persons receive *clinical* services after discharge since outreach, engagement, and coordination activities alone are not sufficient to help individuals achieve recovery or to prevent the need for inpatient readmissions.

Clinical Policy 8A Update

Clinical coverage policy 8A is in the final stages of review and it is anticipated that it will be reposted to the DMA and DMH websites in early January 2009.

NC-TOPPS Outcomes at a Glance Dashboard

We are pleased to announce the newly posted "*Outcomes at a Glance*" online dashboard. The outcomes dashboard allows the public to view and print graphs showing current State and Local Management Entity (LME) information on meaningful outcomes for substance abuse and mental health consumers. Some of these important measures include, but are not limited to, alcohol and drug use, employment, homelessness and mental health symptoms. The online dashboard is updated on a monthly basis. You can access the dashboard by going to the NC-TOPPS homepage at: <http://www.ncdhhs.gov/mhddsas/nc-topps/> and clicking on the icon "*Outcomes at a Glance*."

Input and feedback from stakeholders has been very helpful in the development of this dashboard. We appreciate this collaborative effort and continue to seek your suggestions for improving our consumer outcomes system. If you have questions regarding the dashboard, please send them via electronic mail to: ContactDMHQuality@ncmail.net.

Accreditation Update

Accreditation of Targeted Case Management Services

DMA is in the final process of resubmitting a State Plan Amendment (SPA) to the Centers for Medicare and Medicaid Services (CMS) for Targeted Case Management (TCM). Included in that SPA are requirements that TCM providers directly enroll with DMA and that they achieve national accreditation. When that SPA is approved and implemented, in

accordance with G. S. 122C-81, directly enrolled providers of Targeted Case Management services will be required to become nationally accredited within one year of their effective date of enrollment in the Medicaid program.

Accreditation of CAP-MR/DD Waiver Services

If a provider of CAP-MR/DD services has obtained national accreditation before the effective date of the new waiver, November 1, 2008, DMH/DD/SAS has determined that the provider does not have to obtain additional CAP-MR/DD service specific accreditation for the individual services offered by the provider until the next regular accreditation review by the accreditation agency. This means that the provider already accredited by one of the accreditation agencies approved by the Department of Health and Human Services does not need to obtain accreditation within one year of implementation of the new waiver. Providers shall inform their national accrediting organization when new services are added for a determination from the accrediting body about how the new service will be handled based on the scope of the provider's current accreditation.

A few modifications were made to the requirements for some of the services that pre-dated the new waiver. These modifications are the addition of staff qualifications and training requirements including: a GED or high school diploma, First Aid/CPR training/certification and training regarding the core competencies. Accrediting organizations may require that the provider submit an attestation of conformance to the standards against which they were accredited based on the additional requirements of the service definition as part of their annual attestation.

If an organization already has national accreditation as a mental health provider and the national accrediting body does not have standards to accredit CAP-MR/DD waiver services, the DMH/DD/SAS will work with the national accrediting bodies to determine the best solution to minimize the expense on the provider to obtain a new accreditation as long as a solution can be worked out which does not compromise the integrity of the national organization's standards for accreditation.

If a provider organization is not yet accredited, the provider should choose the accrediting organization whose service standards best match the services the provider offers, and achieve national accreditation within the one year statutory requirement. The DMH/DD/SAS works with each accrediting organization in determining those standards which best align with our service definitions.

Complete CAP-MR/DD Requests

Submission of a complete CAP-MR/DD request allows prompt, efficient processing and best serves consumers and providers. A recent ValueOptions work study showed that incomplete CAP-MR/DD requests take twice as long to process than complete requests. Twenty-six percent of the CAP-MR/DD requests completed in November 2008 were incomplete and required outbound calls by ValueOptions to the case manager. The top ten reasons why CAP-MR/DD requests are pending due to lack of information:

1. Current PCP, NC-SNAP, or psychological evaluation are missing.
2. MR2/SNAP/POC is not consistent regarding behaviors.
3. Cost summary not inclusive of all services or requested units differ from plan.
4. Crisis plan absent or insufficient.
5. Goals not habilitative, not measurable or no justification for enhanced services.
6. Formal behavior plan absent with SNAP of three or more for behavioral supports.
7. Incorrect dates, especially for initial plans, and unclear date of prior approval versus Murdoch signature.
8. Missing LME letter when guardian is providing services.
9. Less than two bids submitted for a home modifications/augmentative communication device/vehicle adaptation.
10. Request does not clearly state the number of additional units being requested.

CAP-MR/DD Update

Uniform Person Centered Plan Format Implementation Schedule Change

In an effort to support the system to have adequate time to secure information and to gain mastery in the use of the uniform Person Centered Planning (PCP) format, the implementation of the new PCP format for CAP-MR/DD has been changed from January 1, 2009 to March 1, 2009. This affects the requirement to implement the use of the Risk Identification Tool (Risk Assessment), which is also being changed to March 1, 2009 to be consistent with the uniform Person Centered Plan format.

Risk Identification Tool (Risk Assessment)

All PCPs submitted by March 1, 2009 must include a completed Risk Assessment. The Risk Assessment/Risk Identification Tool is NOT a substitute for a Crisis Plan or a Behavior Plan. The completion of the Risk Identification Tool (Risk Assessment) provides information to be included in the PCP to support the needs of the participant related to potential risks.

CAP Monitoring Procedure for Implementation of New and Modified Services

The December Implementation Update provided guidance regarding the LME monitoring activity requirements for providers of the new and modified CAP-MR/DD services: *LME Monitoring Procedure of Current Medicaid Enrolled Providers of CAP-MR/DD Services Compliance to Staff Qualifications and Staff Training/Competencies Requirements* and *LME Monitoring Procedure of Current Medicaid Enrolled Providers of CAP-MR/DD Services Who Intend to Provide Home Supports Effective 11-08*. As a result of questions the following is intended to provide additional clarification. The guidance document indicates the LME monitoring review is to be completed by the LME located in the catchment area where the provider's corporate/business verification office is located. In the case where the provider's corporate office/business verification location does NOT provide CAP-MR/DD services the ***provider is responsible*** for determining an alternate service location that does provide the CAP-MR/DD services. The ***provider is responsible*** for notifying (using the signed Attestation Letter) the appropriate LME, based on the location of the alternate service location that does provide the CAP-MR/DD services, to complete the monitoring review.

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

cc: Secretary Lanier Cansler
Allen Feezor
Dan Stewart
DMH/DD/SAS Executive Leadership Team
DMA Deputy and Assistant Directors
Sharnese Ransome
Kaye Holder
Wayne Williams
Shawn Parker
Denise Harb