Transforming Lives

Trillium HEALTH RESOURCES

Network Communication Bulletin #047

To: **All Providers**

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Date: **August 12, 2019**

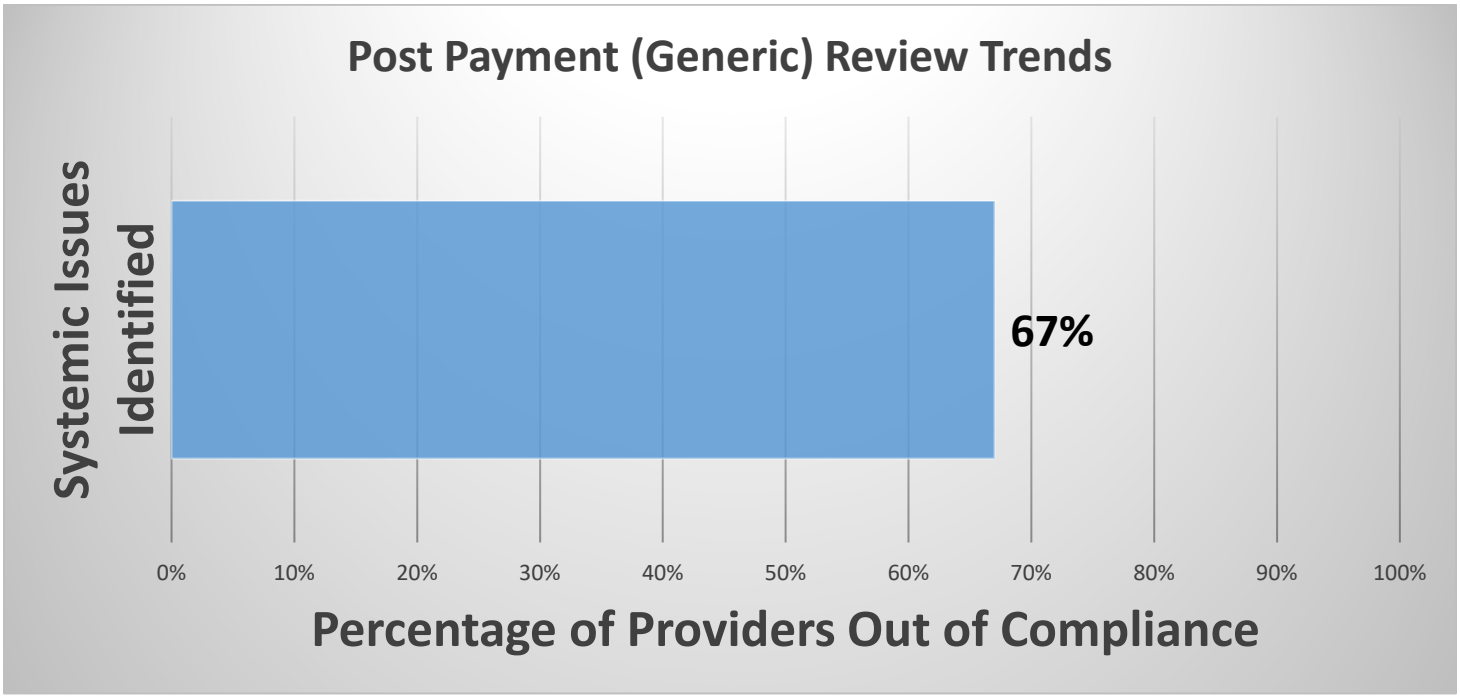
Subject: Victory Junction Information, Provider Monitoring Trends April-June 2019, JCB #335 State Funded Peer Supports Services Definition Update, JCB #334 LOCUS/CALOCUS Update, Third Party Insurance Plans "Add" Feature in Provider Direct, August 2019 Medicaid Bulletin Updates, Medicaid Transformation Resource for Providers

PROVIDER MONITORING TRENDS APRIL-JUNE 2019

Below is a summary of the trends identified in Provider Monitoring for reviews using the *Post-Payment Generic tool* during the April - June 2019 quarter, along with relevant guidance and recommendations:

- Post-Payment Generic tool- Question 17, Staff Qualifications- 67% of providers were out of compliance in this area. NCAC 27G .0104, 27G .0202, 27E .0107 and Clinical Coverage Policies/Service Definitions all govern staff qualification requirements and should be referenced to ensure staff are qualified to deliver the particular service provided. The deficiencies included lack of evidence that staff had received Client Specific training on the member's treatment plan/PCP (dx, goals, interventions, crisis plan, etc.) and/or specialized training, if necessary, to meet the member's needs.

There is no required format for this training, but it must documented in some way, e.g. training/review checklist, supervision note, staff signature on the plan/PCP, etc. and must be done prior to service delivery as well as anytime needs change or the plan/PCP is updated. Also, some provider staff were found not to have received training in **Alternatives to Restrictive Interventions** prior to service. NCAC 27E .0107 requires that anyone interacting with members receive this training prior to providing services and at least annually thereafter. Another common area of concern is related to **service definition-specific training** (e.g. related to IIH, CST, ACT, PSR, etc.). Providers should refer to Clinical Coverage Policies and Service Definitions for specific trainings required for their service (in addition to those required by NCAC) and their required timeframes (e.g. within 30, 60 or 90 days of hire, etc.)



STATE-FUNDED PEER SUPPORT SERVICES

Effective August 1, 2019 the State-funded Peer Support Services (PSS) service definition went live and the following billing codes will be used for State-funded PSS:

PSS- individual	PSS- group
H-0038	H-0038HQ

DMHDDSAS recognizes that some individuals currently receiving State-funded PSS could have existing authorizations in place that extend through the implementation of the new service definition. These authorizations may have to be re-issued to reflect the change in billing code for the service. Per the new service definition, a Comprehensive Clinical Assessment (CCA) or assessment that contains the same clinical information as a CCA, a Person-Centered Plan (PCP), and service order for medical necessity are required for any authorizations effective August 1, 2019, and thereafter.

LME-MCOs have the authority to determine if it is clinically appropriate to waive the CCA and PCP requirements on extended or re-issued authorizations to allow PSS providers to continue to access unused units on existing authorizations.

This exception would only be considered for authorizations dated prior to August 1, 2019. Alternatively, LME-MCOs can determine that new authorizations and new documentation are to be submitted by PSS providers for authorizations dated prior to August 1, 2019, using unmanaged units as defined in the new service definition. PSS providers will be expected to submit the required documentation for any service authorizations effective August 1, 2019, or later. PSS providers should contact their LME-MCO to determine what documentation they will require to re-issue existing authorizations for PSS services.

LOCUS/CALOCUS UPATE

The purpose of this bulletin is to clarify for LME/MCOs and providers the current status of use of the Level of Care Utilization System (LOCUS) and Level of Care Utilization System for children and adolescents (CALOCUS).

At this time, LOCUS and CALOCUS remain the assessment tools identified by DHB and DMH/DD/SAS for use in connection with medical necessity reviews for mental health services. LME/MCOs and providers should take note of the copyright restrictions imposed by the company which owns LOCUS and CALOCUS. Per these restrictions, paper or unmodified, read-only pdf versions of these instruments may be used at no charge.

However, the Department of Health and Human Services has been informed by the company which claims to own all electronic rights to LOCUS and CALOCUS, that other use of these instruments, including but not limited to, creation of modified or editable electronic versions or incorporation of the tools into electronic health record systems, is subject to licensure and user fees established by the company. Any questions regarding the copyright restrictions should be directed to the company which owns these tools, contact information available at: http://www.dbhn.com/index.cfm/contact-us/.

DHHS is continuing its ongoing evaluation of behavioral health assessment tools currently available for adults and children & adolescents to determine which of these instrument(s) may best meet the needs of LME/MCOs, providers, and the members they serve going forward.

THIRD PARTY INSURANCE PLANS "ADD" FEATURE IN PROVIDER DIRECT

Effective September 27, 2019, the ability to edit a member's third party insurance will be restricted via the Third Party Insurance "Add" Button.

Third party insurance information may continue to be added as it is done today in Provider Direct. However, as of September 27, 2019, the option to select and update a third party insurance record that is currently in Provider Direct will no longer be allowed. After September 27, 2019, any changes that need to be made to existing third party insurance in Provider Direct will need to be made by entering a Client Update.

If there is a discrepancy in what is submitted compared to the information in NCTracks, you may be asked to submit a Health Insurance Referral Form (HIRF) to NCTracks requesting the change to be made in their system. Once the change is made in NCTracks, the change will be approved and reflected in Provider Direct.

If you have any questions regarding this or on how to submit Client Updates, please contact Trillium's Eligibility and Enrollment Staff.

August 2019 Medicaid Bulletin Updates

Clinical Coverage Policy Update

The following new or amended clinical coverage policies are available on NC Medicaid's website at: https://medicaid.ncdhhs.gov/providers/clinical-coverage-policies.

- 9, Outpatient Pharmacy Program – July 15, 2019
- 8F, 8F, Research-Based Behavioral Health Treatment (RB-BHT) For Autism Spectrum Disorder (ASD – Aug. 1, 2019)

These policies supersede previously published policies and procedures.

Proposed new or amended Medicaid and NC Health Choice clinical coverage policies are posted for comment throughout the month. Visit Proposed Medicaid and NC Health Choice Policies for current posted policies and instructions to submit a comment.

Medicaid Claims Documentation

In accordance with 2 CFR part 200, subpart F, the North Carolina Office of the State Auditor (OSA) annually conducts the State Single Audit and accordingly selects a sample of NC Medicaid claims to determine if claims paid by the state were properly supported. During the recent SFY 2018 Single Audit, OSA reviewed claims documentation to ensure payments were made for Medicaid-covered services and to ensure claims followed proper coding and billing rules. Some claims documentation submitted were determined to be inadequate to support payment for services billed and were deemed an error.

Insufficient documentation errors identified in the SFY18 Single Audit included:

- Documentation does not support billed codes/modifiers/claim details
- Licensing/training/credentialing requirements not met
- Required components of service not completed -- provided documentation does not support services appropriate for beneficiary needs
- No documentation of intent to order services and procedures – incomplete or missing signed order or progress note describing intent for services to be provided
- Services not authorized/approved in accordance with program requirements

Providers can reduce the likelihood of future documentation errors by:

- Reviewing the monthly Medicaid Bulletin to stay abreast of changes that may impact billing, licensing, training and credentialing requirements
- Using the NCTracks provider portal to access web-based tutorials, classes and training materials to educate themselves and their billing personnel on all aspects of claims submission
- Implementing an internal quality assurance program which includes performing secondary reviews of claims for proper documentation prior to submission as well as performing periodic self-audits on submitted claims

Contact medicaid.sa@dhhs.nc.gov with any questions.

Provider Enrollment for Presumptive Eligibility Transitioning to NCTracks

Effective July 28, 2019, the presumptive eligibility provider enrollment process will be transitioned from NC Medicaid to NCTracks. NCTracks will assume the enrollment process for providers of presumptive eligibility for pregnant women and hospital providers of presumptive eligibility for Medicaid programs.

The requirements are not changing; however, the processes are slightly different for hospital-only providers and other medical/Medicaid providers. Separate presumptive eligibility provider agreements will be available on the NCTracks Provider Enrollment page under *Quick Links* (on the right side of the page) as of Monday, July 29, 2019, following implementation of the transition.

Requesting Presumptive Eligibility

Eligible providers must complete the appropriate presumptive eligibility provider application available on the NCTracks Provider Enrollment page under *Quick Links*, and send it to PresumptiveEligibility@gdit.com. NCTracks will send a welcome letter acknowledging receipt of the request. If any information is missing or inaccurate, NCTracks will send a return email to the provider indicating what information on the agreement is incorrect, and the provider will be asked to submit a corrected agreement.

Once all information is received, reviewed and deemed correct, NCTracks will upload the signed agreement along with any supplemental documents submitted into the provider's record. The DHB beneficiary services department will contact the provider to schedule the required training. Beneficiary services will conduct the training and notify NCTracks when the training has been successfully completed. NCTracks will then send an approval letter to the provider that includes the provider's name, NPI and effective date of enrollment. The effective date of enrollment in the presumptive eligibility program is the initial date the provider successfully completed the required training.

Disaster Relief Enrollment Application Streamlined

Effective July 28, 2019, an expedited disaster relief provider enrollment application process will be available during times of disaster such as a State of Emergency. This abbreviated enrollment application will collect limited information to enroll a provider for a limited time (120 days) and will be available to in-state, out-of-state (OOS), and border providers that are not yet enrolled in NC Medicaid, including individual providers and organizations.

For the disaster relief provider enrollment application only, federal application requirements may be waived (training, site visit, federal/state fees, background checks, and fingerprinting).

The enrollment application process will be expedited. NCTracks will verify the provider's enrollment status with Medicare or the provider's home state Medicaid agency to ensure the provider is in good standing. NCTracks will deny the disaster relief provider enrollment application if the provider is not in good standing.

More information will be provided during a disaster which deems the disaster relief provider enrollment application necessary for relief efforts.

Introducing NC's Transition to Medicaid Managed Care: The Crossover Communication Series

The transitional period surrounding the launch of Medicaid Managed Care is referenced as crossover.

DHHS will initiate crossover-specific activities in August 2019 and will continue these activities through April 2020.

These activities are designed to safeguard continuity of care for beneficiaries. These activities include:

1. Crossover-specific communication and education to providers, beneficiaries and other stakeholders.
2. Time-limited data transfer to ensure Prepaid Health Plans (PHPs) have claims history, prior authorization data and other information necessary to effectively support enrolled beneficiaries.
3. Implementing additional safeguards for high need beneficiaries.
4. Crossover-specific monitoring of the beneficiary and provider transition experience.

Upcoming Opportunities to Learn About Crossover-Related Activities and Processes Webinar	Date	Summary
Supporting the LTSS Community Through the Transition to Managed Care	Thursday, August 15, 2019 from 1-2 p.m.	This will continue the Long-Term Services and Supports (LTSS) webinar series launched in July 2019 and will focus on crossover-related activity specific to LTSS providers.
NC's Transition to Managed Care: The Crossover Series	Thursday, Sept. 5, 2019 from 1-2 p.m.	This session will provide general crossover guidance, with a focus on identifying beneficiary managed care detail and guidance on submitting prior authorization requests during the crossover period.
NC's Transition to Managed Care: The Crossover Series	Thursday, Sept. 19, 2019 from 1-2 p.m.	This session will be a continuation of the session on Sept. 5, 2019, providing a brief review of topics previously covered and additional guidance for supporting beneficiaries through the transition to Medicaid Managed Care.

MEDICAID TRANSFORMATION RESOURCE FOR PROVIDERS

The Department of Health and Human Services (DHHS) recently launched an online "Provider Playbook" as part of its commitment to ensure providers have resources to help their Medicaid beneficiaries transition smoothly to Medicaid Managed Care. This new Provider Playbook is a collection of information and tools specifically tailored to providers.

The first resources include:

- Fact Sheet #1. Medicaid Transformation: Overview. This fact sheet describes what will change for Medicaid beneficiaries, what provider can expect with Medicaid Managed Care, and how they can partner with the Department to support beneficiaries during the transition.
- Fact Sheet #2. Medicaid Transformation: Beneficiary Enrollment & Timelines. This fact sheet covers how health plans are either selected or assigned to beneficiaries, and when enrollment opportunities occur.
- Overview of the Beneficiary Enrollment Experience in NC Medicaid Managed Care for Medicaid Providers. This document gives providers a more detailed look at what beneficiaries will experience over the next few months as they transition to Medicaid Managed Care. In addition to providing details on topics in the Fact Sheets, it includes information on recertification, appeals and grievances, Behavioral Health I/DD Tailored Plans and transition of care.

New resources will be added to the Provider Playbook as they become available. For technical issues identified during open enrollment, please email MedicaidSWAT@dhhs.nc.gov or call 919-527-7460.

Any questions about this Communication Bulletin may be sent to the following email:

NetworkManagement@TrilliumNC.org. These questions will be answered in a Q&A format and published on Trillium's website.

Trillium offers trainings for providers and also shares about educational events across the region. To learn more, visit our Upcoming Events page. Trillium occasionally announces open enrollment and RFPs for new and existing providers. Visit the RFP | RFA | RFI | Opportunities page for listings.