# Operations Manual

CenterPoint Human Services

CARF 2009 - 2011

**Local Management Entity**
**"LME"**

**Operations Manual**
**Effective February 17, 2011**

# Table of Contents

# CenterPoint Human Services

# OPERATIONS MANUAL

## Introduction

The CenterPoint Human Services (CenterPoint) Operations Manual (Manual) is a binding part of the "Contract" and/or "Memorandum of Agreement" between CenterPoint and a provider of Medicaid, State, and/or County funded services. The Manual provides links to on-line resources, including required forms, and sets out the responsibilities of providers in delivering services. Meeting the expectations in the Manual is integral to building a strong partnership with CenterPoint as Providers share and support the Vision, Mission and Values of CenterPoint.

This manual does not include information about all DHHS policies and procedures, such as endorsement procedures that take place prior to any agreement with a Medicaid Provider. Rather, it includes only information pertinent to the performance of the Contract and/or Memorandum of Agreement, whichever applies.

**Vision**

We are a model for North Carolina of people in partnership empowering those we serve (with mental health, developmental disabilities, substance abuse challenges) to achieve the lives they choose.

**Mission**

Through collaborative partnerships we develop, manage and coordinate services to support those with mental health, developmental disabilities, and substance abuse needs.

**Values**

We live out our mission with

- credibility,
- integrity,
- accountability,
- compassion,
- accessibility,
- respect,
- quality, and
- stewardship.

# Where To Go For Questions

CenterPoint utilizes its website, www.cphs.org, the weekly electronic newsletter, "*The Friday Email"* and electronic "*Provider Alerts"* to disseminate breaking news, policy changes from the Division of Mental Health/Developmental Disabilities /Substance Abuse Services (Division), Division of Medical Assistance (DMA) or other relevant sources. To be added to the distribution list for these updates contact Michael Cottingham (mcottingham@cphs.org). To increase your agency's ability to comply with ever-evolving mandates, policy updates and short timelines, it is your responsibility as a provider to review the Division, DMA and CenterPoint websites on a regular basis.

| QUESTION / SUBJECT | CONTACT PERSON |
|---|---|
| **CenterPoint Main Office Number**<br>• **ACCESS to Services 24/7** | **336-714-9100**<br>**1-888-581-9988** |
| **Clinical and Physician Questions** | **Dr. Chad Stephens, MD, Medical Director (Effective 4/1/11)**<br>**336-714-9196**<br>**cstephens@cphs.org** |
| **Marketing & Public Relations Officer** | **Michael Cottingham**<br>**336-714-9132**<br>**mcottingham@cphs.org** |
| **Billing & Collections Manager** | **Kathy Tuttle**<br>**336-714-9336**<br>**ktuttle@cphs.org** |
| **Community Operations Manager**<br>• **System of Care**<br>• **Housing**<br>• **Community Outreach** | **Jeff Eads**<br>**336-714-9154**<br>**jeads@cphs.org** |
| **Provider Operations Manager** | **Denise Mannon**<br>**336-714-9114**<br>**dmannon@cphs.org** |
| **Provider Development Specialist**<br>• **General Inquiries**<br>• **Contract Changes/Requests**<br>• **NC-TOPPS** | **John Coble**<br>**336-714-9117**<br>**jcoble@cphs.org** |
| **Lead Provider Relations Specialist**<br>• **Monitoring**<br>• **Endorsement / MOA** | **Denise Price**<br>**336-714-9148**<br>**dprice@cphs.org** |

| | |
|---|---|
| **Quality Systems Manager**<br>• **Requests for Proposal / Grants**<br>• **Service Development**<br>• **Resource Development** | **~~Ellen Nicola~~**<br>**~~336-714-9157~~**<br>**~~enicola@cphs.org~~** |
| **Quality Assurance Specialist**<br>• **Medical Records**<br>• **Release of Information** | **Eleathia Wilkins**<br>**ewilkins@cphs.org**<br>**336-714-9175**<br>**Fax – 336-714-9111** |
| **Assistant Area Director - Operations** | **Ronda Outlaw**<br>**336-714-9115**<br>**routlaw@cphs.org** |
| **Director of Service Management**<br>• **Utilization Management**<br>• **ACCESS / Screening, Triage, Referral**<br>• **Guardianship** | **Burch Johnson**<br>**336-714-9138**<br>**bjohnson@cphs.org** |
| **Care Coordination Manager** | **Peter Rives**<br>**336-714-9173**<br>**prives@cphs.org** |
| **Consumer Affairs Specialist /Customer Service**<br>• **Consumer Complaints**<br>• **Client Rights** | **Tracy Warner**<br>**Consumer Complaints**<br>**Toll free 866-804-4323**<br>**336-714-9386**<br>**twarner@cphs.org** |
| **Assistant Area Director**<br>**Finance and Human Resources** | **Kevin Beauchamp**<br>**336-714-9130**<br>**kbeauchamp@cphs.org** |
| **Contracts Manager**<br>• **Contracts/Memoranda of Agreement**<br>• **Insurance** | **Lori Setchell**<br>**336-714-9325**<br>**lsetchell@cphs.org**<br>**Fax- 336-714-9367** |
| **Medicaid Billing Questions** | **http://www.dhhs.state.nc.us/dma/basicmed/index.htm** |

# Section I
# Provider and Community Operations

## A. Problem Resolution~~/Disputes~~ and Appeals

If problems arise between the Provider and CenterPoint ~~in the delivery of services~~, both shall attempt to resolve these problems informally in a reasonable and timely manner. In the event that informal resolution is not successful, the procedures outlined in N.C.G.S. § 122C-151.4 and 2009 S.L. 526 § 2(c) shall be followed. Depending on the nature of the dispute, there are three options for resolution:

**I. Disputes Regarding the Inclusion or Delivery of Services Pursuant to Contract or MOA.**
If the dispute regards denial or withdrawal of endorsement, rates paid pursuant to the contract, or other terms and requirements in the Contract or MOA the following process shall apply:

**1. Who may appeal?**

Parties with standing to file an appeal must meet at least one of the following requirements:

a. An organization that has an existing contractual agreement with the CenterPoint; or

b. An organization that had a contractual agreement with the CenterPoint within six months of the date of the appeal or during the prior fiscal year.

Client-related grievances, disputes, and/or disagreements over client specific issues are covered under the CenterPoint's "Client Grievance Process" and are not subject to the appeals procedure outlined below.

**2. Grounds for an Appeal**

Appeals may be made on the following grounds: (1) that CenterPoint is not acting or has not acted within applicable State law or rules in denying the Provider's application for endorsement, withdrawing a Provider's existing endorsement, or imposing a particular requirement on the Provider on fulfillment of the Contract or Memorandum of Agreement; (2) that a requirement of the Contract or Memorandum of Agreement substantially compromises the ability of the Provider to fulfill the contract; or (3) that CenterPoint has acted arbitrarily and capriciously in reducing funding for the type of services provided or formerly provided by the Provider..

**3. Procedure for filing an Appeal**

If problems arise in the delivery of services between the provider and the LME, the parties are encouraged to resolve the problems in a reasonable and timely manner.

a. **Local Reconsideration Process**

The request for local reconsideration shall be made in writing and sent by certified mail to the CEO/Area Director of CenterPoint within fifteen (15) business days from the receipt of the notification of the decision/action being appealed. The decision of CenterPoint shall be considered final if a local reconsideration request is not received within fifteen (15) business days after the provider receives the notification.

The request shall contain a brief statement of the facts upon which CenterPoint's decision is challenged. CenterPoint will respond to the provider's request for reconsideration within fifteen (15) business days of CenterPoint's receipt of the provider's request in writing sent by certified mail. This concludes the local reconsideration and appeal for the provider.

b. **Further Appeal**

In the event that the matter is not resolved through local reconsideration, a denial or withdrawal of endorsement may be appealed as follows.

(i) **Endorsement Actions Involving Community Support, Child and/or Adult Community Support Services.** To appeal, you must file a Community Support Provider Petition with the chief hearings clerk of DHHS within thirty (30) calendar days of the date the the Notice of Endorsement Action or the final agency reconsideration was mailed, whichever is later. You may obtain a copy of the form petition by calling the DHHS Hearing Office at 919-647-8200 and instructions for filing are contained on the form petition. The rights and relevant procedures on appeal are set forth in SL 2009 526 §2.(c) and any subsequent updates.

(ii) **Endorsement Actions Involving Any Other Services.** If the appeal is of an endorsement action that pertains to any services other than Child and/or Adult Community Support, you may file an appeal to the State MH/DD/SAS Appeals Panel by forwarding the final decision of CenterPoint, along with all supplementary and supporting documentation considered during the local appeals process, to the Division Director of the NC Division of MH/ DD/SAS within 15 calendar days of the date of the local reconsideration decision being rendered. *See* 10A NCAC 27G. 0810-.0812, and N.C.G.S. §122C-151.4.

## II. Disputes Regarding Provider Professional Competence Determinations

If the complaint or dispute is related to a provider's professional competence or conduct that could relate to a change in provider status, such as a plan of correction or other administrative action, the following Procedure shall be followed. (Please note that this does not apply to endorsement withdrawal, or funding)

| CenterPoint Human Services<br>DEPARTMENT PROCEDURE | |
|---|---|
| **Department Procedure Name:** | Quality Management Department: Provider Professional Competence Disputes |
| **Department Procedure Number:** | DP- 3.01U |
| **Approval Signature:** | |
| **Approval Signature Date:** | |
| **Effective Date:** | When signed |
| **Next Review Date:** | January 2012 |
| **Original Approval Date:** | January 2011 |
| **Last Review w/no Revision Date:** | New |
| **Last Review w/Revision Date:** | New |
| **Related Policy Name(s):** | PO- 3.01 LME Management of Service Delivery |
| **Related LME Procedure Name(s):** | N/A |
| **Related Dept Procedure Name(s):** | N/A |
| **Related URAC Standard(s):** | Complies with URAC Health Network Management V.6.0, standards 13-17 |
| **Related Lines of Business:** | All |

***Rationale/Purpose***

CenterPoint Human Services (CenterPoint) implements various mechanisms consistent with its written agreements including, but not limited to provider contracts and memoranda of agreement, ("Contracted Provider[s]") to address alleged contractual violations by Contracted Providers. At times, these actions taken by CenterPoint will lead to provider disputes with CenterPoint. Because CenterPoint respects providers' rights, a formal process to address significant contracted provider disputes in a fair, respectful, impartial and timely manner has been developed.

Provider professional competence disputes relate to those disputes regarding a provider's professional competence or conduct that could result in a change in provider status; an administrative dispute resolution mechanism is available for all other types of disputes. Examples of professional competence disputes include, but are not limited to, disputes regarding:

- Ethics,
- Clinical boundaries,
- Dual relationships,
- Professional competence to perform contracted services.

***Content***

The provider professional competence dispute resolution process ("PC dispute resolution process") is available to any Contracted Provider who wishes to initiate it. However not all provider grievances are subject to the PC dispute resolutions process. For example, the PC dispute resolution process is not available when provider participation is suspended, terminated or reduced in accordance with the written agreements.
The Provider Affairs Specialist is responsible for receipt and processing of disputes and sending written notification of the PC dispute resolution to the provider via registered mail (See attachment B).

Quality Management Department hires, trains and maintains a sufficient number of Provider Affairs Specialists to ensure timely responses to providers. All events related to disputes are documented in the database, including but not limited to documentation of panel proceedings and correspondence.

The provider dispute resolution process depends on the type of dispute. A dispute may involve:

1) The provider's professional competence or conduct that could result in a change in provider status within the provider network (panel disputes).

2) Administrative issues, such as timely filing of claims, network accessibility issues and failure to submit requested medical reports. *(See relevant Procedure.)*

To initiate the dispute resolution process when a provider's status in the network is at risk, a provider may:

- Telephone the CenterPoint Provider Affairs Specialist. If the caller does not reach a person directly, he/she may leave a message, and a staff person will return the call within one business day.
- Present in person to CenterPoint to talk with the Provider Affairs Specialist during normal business hours. (An appointment is recommended but not required.)
- Send a letter, email, or facsimile to the CenterPoint Provider Affairs Specialist stating they would like to file a dispute against an action taken by CenterPoint.

The Provider Affairs Specialist requests the provider submit a "Provider Dispute Form" (See attachment A). This document includes:

- Provider demographic information
- Summary of dispute/problem
- Provider's position on the issue(s)
- Actions the provider believes necessary to resolve the dispute/problem.
- Request for supporting documentation as the provider determines necessary/relevant

Panel Review Process

1) A first-level panel consisting of at least three qualified individuals, of whom at least one is a clinical peer, reviews the dispute.

2) A clinical peer is a participating provider who is not otherwise involved in network management, including participation on other committees.

3) Disputes that are found in favor of the provider end at this level.

4) If however, the provider is not satisfied with the resolution, he/she may request a second-level panel review via written request set by certified/registered mail.

5) A second-level panel consisting of at least three qualified individuals, one of which is a clinical peer that was not involved in the first-level panel, reviews the dispute.

The Provider Affairs Specialist provides each panel member with information including a summary of the dispute/problem; identification of panel members, including indication of which member of the committee is the clinical peer of the provider who is the subject of the dispute; and copies of supporting documentation submitted by the provider. The Provider Affairs Specialist calls a meeting of the panel. The panel will meet within 20 business days of receipt of the Provider Dispute Form. The provider is informed of the date, time and place of the meeting and is invited to attend to present a summary if so requested on the Provider Dispute Form. When the provider has requested to be present at the panel meeting, notification of time and place of meeting is made to the provider at least five business days in advance of the scheduled meeting day. A decision regarding the dispute/problem will be mailed to the provider via registered mail by the Provider Affairs Specialist within 5 business days of the date of the panel's decision. The notice will include information regarding how the provider can access the next level of resolution. If resolution is not achieved at the first level, the provider has the right to consideration by a second-level panel. A second-level panel review must be requested in writing by the provider and via certified/registered mail.

Consumer Safety

In the event that CenterPoint learns of an alleged provider issue that could have a negative impact on the safety of a consumer, a mechanism is in place to allow for an immediate suspension in order to protect the consumer. A suspended participating provider will not receive funding to continue service or receive new referrals from CenterPoint.

The Medical Director (and only the Medical Director) has the authority to impose a suspension on any provider who, in his/her opinion, believes that allowing the provider to continue to see CenterPoint consumers may risk the health, safety or welfare of consumers. An expedited investigation follows.

Written notification of the intent to suspend the provider pending investigation is sent to the provider via certified mail within one (1) business day of the discovery of the alleged issue. The dispute resolution process and the mechanism for initiating the process are explained to the provider in the written notification.

As with other types of disputes, the provider may contact the CenterPoint Provider Affairs Specialist to provide any information that he/she believes may bring about a favorable outcome. That information is taken into account through the investigation.

CenterPoint makes every effort to expedite these cases, given that the provider has been suspended. However, CenterPoint will not compromise the outcomes to complete the case quickly. The steps of the process for this type of situation are the same as outlined above in the process involving panels.

All allegations of abuse, neglect and exploitation will be reported to the Provider Affairs Department. The Provider Affairs Specialist will report directly, or confirm report by others, to regulatory and oversight bodies as applicable (e.g. Department of Social Services, Division of Health Services Regulation, and Division of Mental Health/Developmental Disability/Substance Abuse Services – Program Integrity Unit).

***Responsibility Paragraph***

The Chief Information/Quality Management Officer is responsible for the administration of all Department Procedures which are consistent with applicable Federal and State Law, rules, regulations, decisions, Board Policies and LME Procedures.

Forms Follow Below:

## Provider Professional Competence Dispute Form

Mail completed form to: **CenterPoint Human Services, Provider Affairs, 4045 University Parkway, Winston Salem, NC 27106-3325**

Provider Demographics

_____ _____
Agency Name Contact Name and Title

_____ _____
Preferred Phone Number Preferred Email Address

_____
Preferred Mailing Address

Summary of dispute/problem:

Your position on the issue(s):

Actions you believe necessary to resolve the dispute/problem:

Do you wish to present directly to the panel (attendance by the provider is not required)? _____

For internal use only:

Complaint number _____ Date received _____

Type of Dispute: Administrative dispute

Change in provider status dispute - first-level panel

Change in provider status dispute second-level panel

**Decision Regarding the Professional Competence Dispute/Problem**

Date _____

Agency _____

Name and Title _____

Street Address or P.O. Box Number _____

City State, Zip Code _____

Dear Contact Person:

Notice of your dispute/problem was received by CenterPoint Human Services on (date). The dispute was (investigated; mediated; or reviewed) by a first-level panel or reviewed by a second-level panel. (Insert summary of actions.) Resolution (was; was not) achieved.

(Insert statement of avenues to seek further resolution, if other processes are available.)

Please contact the Provider Affairs Specialist at (336) 714-9xxx should you have questions or concerns.

Sincerely,

Name, Credentials
Title

C: file

## III. Provider Administrative Disputes

If the complaint or dispute is related to an administrative action taken by CenterPoint, such as issues related to claims or payments, access to the CenterPoint computer network, medical records, etc. the following Procedure (DP 3.01Q) shall be followed. (Please note that this procedure will never apply to any action regarding Endorsement.)

| CenterPoint Human Services<br>DEPARTMENT PROCEDURE | |
|---|---|
| **--Department Procedure Name:** | Quality Management: Provider Administrative Disputes |
| **--Department Procedure Number:** | DP-3.01Q |
| **--Approval Signature:** | |
| **--Approval Signature Date:** | |
| **--Effective Date:** | When signed |
| **--Next Review Date:** | January 2012 |
| **--Original Approval Date:** | January 2011 |
| **--Last Review w/no Revision Date:** | New |
| **--Last Review w/Revision Date:** | New |
| **--Related Board Policy Name(s):** | PO-3.01 LME Management of Service Delivery |
| **--Related LME Procedure Name(s):** | N/A |
| **--Related Dept Procedure Name(s):** | N/A |
| **--Related URAC Standard(s):** | Complies with URAC Health Network Management v.6.0, standards 13-17 |
| **--Related Lines of Business:** | All |

***Rationale/Purpose***

CenterPoint implements a mechanism to resolve administrative-type disputes with participating providers that offers the disputing provider the right to consideration by an authorized representative of the organization not involved in the initial decision that is the subject of the dispute. Examples of disputes for which this process applies include, but are not limited to:

- Issues related to timely filing of claims
- Network accessibility issues
- Failure to submit requested medical records
- Appeals of administrative denials

***Content***

The provider administrative dispute resolution mechanism is available to any contracted provider who wishes to initiate it. However not all provider grievances are subject to the dispute resolutions process. For example, when required and as specified in the written agreement, provider participation will be suspended, terminated or reduced. In such cases, the provider dispute process is not required to be available to the provider.

The Provider Affairs Specialist is responsible for receipt and processing of disputes including providing written notification of the dispute determination to the provider via registered mail (See attachment B). Quality Management Department will hire, train and maintain a sufficient number of Provider Affairs Specialists to ensure timely responses to providers. All events related to disputes are documented in the database, including but not limited to documentation of panel proceedings and correspondence.

To initiate a dispute involving an administrative matter, the provider may request resolution by:

(1) Contacting CenterPoint Provider Affairs Specialist by telephone. If the caller does not reach a person directly, he/she may leave their name, number and a message. A staff person will return the within one business day.

(2) Visiting CenterPoint and meeting with the Provider Affairs Specialist during normal business hours. An appointment is recommended but not required.

(3) Sending a letter, email, or a facsimile to the Provider Affairs Specialist stating he/she would like to file an administrative dispute against an action taken by CenterPoint.

Resolution Process
Administrative disputes/problems are mediated and investigated by the Provider Affairs Specialist. The provider initiates an administrative dispute via one of the methods identified above. The Provider Affairs Specialist requests the provider submit a "Provider Dispute Form" (See attachment A). This document includes:

(1) Provider demographic information
(2) Summary of dispute/problem
(3) Provider's position on the issue(s)
(4) Actions the provider believes necessary to resolve the dispute/problem
(5) Request for supporting documentation as the provider determines necessary/relevant

A Provider Affairs Specialist not involved in the initial decision that is the subject of the dispute will review the particulars of the complaint and work with the provider to resolve the complaint. When appropriate and agreed upon by all parties, informal mediation by the Provider Affairs staff is offered. The provider may provide any information that he/she believes may bring about a favorable outcome. That information is taken considerably into account through the investigation.

In such cases, mediation occurs within 20 business days of the provider's agreement to seek resolution via informal mediation. Written notification including outcome of the mediation is sent via certified/registered mail within 30 business days of the provider's agreement to seek resolution via informal mediation.

In the event that an investigation is necessary for the purpose of gathering relevant information, the Provider Affairs Specialist will typically conduct an on-site provider review. Formal investigations must be completed as soon as possible, but no later than 20 business days of receipt of the request for resolution. The Provider Affairs Specialist provides written notification of the dispute resolution to the provider via certified/registered mail within 30 business days of initial receipt of the dispute. The notification includes additional steps the provider may take with the dispute/problem.

CenterPoint provides written notification to the Division of Health Service Regulation (as applicable), the Department of Social Services, and the Division of Mental Health/ Developmental Disability /Substance Abuse Services – Program Integrity Unit (as applicable).

Information pertaining to each administrative dispute is noted in the designated database. The Quality Management Data Analyst creates a quarterly management report for presentation to the various quality

committees for tracking and trending. When patterns emerge, the appropriate quality committee oversees actions to bring about improvements.

***Responsibility Paragraph***

The Chief Information/Quality Management Officer is responsible for the administration of all Department Procedures which are consistent with applicable Federal and State Law, rules, regulations, decisions, Board Policies and LME Procedures.

Forms Follow Below:

**Provider Administrative Dispute Form**

Mail completed form to: **CenterPoint Human Services, Provider Affairs, 4045 University Parkway, Winston Salem, NC 27106-3325**

Provider Demographics

_____ _____

Agency Name Contact Name and Title

_____ _____

Preferred Phone Number Preferred Email Address

_____

Preferred Mailing Address

Summary of dispute/problem:

Your position on the issue(s):

Actions you believe necessary to resolve the dispute/problem:

Do you wish to present directly to the panel (attendance by the provider is not required)?
Yes or No ? _____

**For internal use only:**

Complaint number _____ Date received _____

Type of Dispute: Administrative dispute_____

Change in provider status dispute - first-level panel _____

Change in provider status dispute second-level panel _____

**Decision Regarding the Dispute/Problem**

Date

Agency
Name and Title
Street Address or Post Office Box Number
City State, Zip Code

Dear Contact Person:

Receipt of your dispute/problem was received by CenterPoint Human Services on (date). The dispute was (investigated; mediated; or reviewed by a first-level panel or reviewed by a second-level panel. (Insert summary of actions.) Resolution (was; was not) achieved.

Insert statement of avenues to seek further resolution, if other processes are available.

Please contact the Provider Affairs Specialist at (336) 714-9xxx should you have questions or concerns.

Sincerely,

Name, Credentials
Title

C: file

### Have Questions About Appeals ???????

For questions about the Community Support Appeals Process or the petition, contact:
DHHS Hearing Office
(919) 647-8200

For questions about the appeal process for services other than Community Support, contact
DMH/DD/SAS Operations Section
(919) 715-2780

For questions about denial and/or withdrawal of an endorsement, contact:
CenterPoint Human Services
4045 University Parkway
Winston-Salem, North Carolina ~ 27106
336-714-9100

Denise Mannon
Manager of Provider Operations
dmannon@cphs.org

Denise Price
Lead Endorsement/Monitoring Specialist
dprice@cphs.org

## B. Technical Assistance and Training Collaboration Requests

CenterPoint provides timely and reasonable technical assistance. *See* §2.18 State Funded Contract; §1.6 Medicaid Funded Memorandum of Agreement (MOA). Technical assistance and/or training is scheduled and provided considering staff capacity and other relevant factors. Requests are submitted on the "Technical Assistance/Training Request Form" found on page 9.

CenterPoint provides training and technical assistance during monitoring and endorsement activities, upon request, or as part of supporting corrective action efforts by providers. Provider orientation includes information on business operations of CenterPoint, e.g. authorizations, submission of claims and reporting requirements. CenterPoint is not able to provide technical assistance and/or training that is considered "normal operational procedure" (e.g. accounting principles, employee leave policies, etc.) to any provider that has not yet implemented previous technical assistance recommendations. Under no circumstances will CenterPoint provide any legal advice.

# Provider Operations Department
# Technical Assistance / Training Request Form

**Provider Name**_____

**Agency Address**_____

**Contact Person** _____**Phone**_____

**E-mail Address** _____

**Description of Technical Assistance needed (please be specific):**

_____
_____
_____
_____
_____
_____
_____
_____

**How immediate is your need ?** _____

**Dates you are available:** _____

_____

_____

**Agency Administrator (Please Print):**

_____

**Signature**_____

**Date**_____

**Mail, email or fax to:**

**Provider Operations Department**
**CenterPoint Human Services**
**4045 University Parkway**
**Winston-Salem, NC 27106**
**Fax: 336-714-9111**
**E-mail: ewilkins@cphs.org**

**CPHS Use Only:**

Training Provided on:_____ By:_____

Provider's site or CPHS? _____

Number Attending: _____

Handouts Provided? _____ Type_____

## C. Notification of Change of Address

**Notification of Change of Address:** Formal timely change of address shall be given by the provider utilizing the following form.

# Notification of Provider Change of Address:

**Name of Provider**:_____

**Old Address**: _____

_____

_____

**Check Here the Address Change is for ___ Service Site ___ Corporate Site ___ Both**

**NOTE: If the service site change is outside of CenterPoint's area, then please include a revised NEA from your home LME.**

**New Address**:

_____

_____

_____

**Effective Date of Change**: _____

**Verify the Billing/Contracts Address to be used (The address to be maintained for "official" mailings):**

_____

_____

_____

**Phone:** _____

**Fax** _____ **E-Mail:**_____

**Other Information**

_____

_____

_____

_____

_____

**** Please be sure to include detailed information regarding the address change if you are NOT changing both site *and* corporate locations. Failure to do so may result in a delay in transmittal of contracts or payments.**

**MAIL FORM TO:** **Provider Operations**
**CenterPoint Human Services**
**4045 University Parkway**
**Winston-Salem, NC 27106**

**OR SEND ELECTRONICALLY TO:** ewilkins@cphs.org

**FOR MEDICAID CHANGES:** http://www.dhhs.state.nc.us/dma/formsprov.html#admin

## D. Notification of Change of Name

**Notification of Change of Name:** Formal notification of change of name is required by your Agreement with CenterPoint. Please complete all items below. Section 3.12 of the MOA for Enhanced Services provides that Area Authority/County Program may terminate this Agreement in its discretion if Provider is acquired, merged or experiences a change in ownership or control.

# Notification of Provider Change of Name:

**Former Name of Provider**:_____

**New Name**:_____

**Former Tax Identification Number:** _____

**New Tax Identification Number:** _____
**(Please Complete both Tax ID lines even if Tax ID has not changed)**

**Effective Date of Name Change**:_____

**Verify the Billing/Contracts Address to be used (The address to be maintained for "official" mailings) :**

_____

_____

_____

**Phone:** _____

**E-Mail:** _____ Fax/_____

**Please list any changes in officers, directors, or management:**

_____

_____

**Other Information:**

_____

### **** REQUIRED ATTACHMENTS:

- □ **You must include a copy of your Certificate of Insurance with coverage in the new name**
- □ **If you have a license, you must attach a copy of the license in the new name**
- □ **You must include a copy of any DMA, Medicaid, or NPI numbers in the new name**
- □ **If your company is a corporation or LLC you must include a copy of the "Articles of Amendment" that have been filed with the Secretary of State when returning this Form.**
- □ **If you are a corporation or LLC that is keeping your corporate name but operating under a name other than your registered name; OR if you are a partnership or sole proprietorship that is changing its name, you must include a copy of the Assumed Name Certificate that has been filed with the Recorder of Deeds in the CenterPoint counties (Forsyth, Davie, Rockingham, and Stokes) that you physically operate in.**

| | |
|---|---|
| **PLEASE RETURN FORM AND INFORMATION TO:** | **Provider Operations**<br>**CenterPoint Human Services**<br>**4045 University Parkway**<br>**Winston-Salem, NC 27106** |

***To Report Changes to Medicaid: http://www.dhhs.state.nc.us/dma/formsprov.html#admin

## E. Endorsement

Enhanced Benefit Services submitted by DMA were approved by Centers for Medicare and Medicaid Services (CMS) in 2005. To deliver any service defined as an "Enhanced Benefit" a provider must be endorsed by an LME and enrolled with the DMA as a Medicaid Provider of Enhanced Services.

For Endorsement information visit the NC DMH Division of MH/DD/SA services at
http://www.dhhs.state.nc.us/mhddsas/stateplanimplementation/providerendorse/index.htm

Information as to the Service Definitions for Enhanced Services visit
http://www.dhhs.state.nc.us/mhddsas/servicedefinitions/index.htm

## F. Screening, Triage, and Referral (*See also* Section III below for detailed STR Information)

CenterPoint works with community agencies to help ensure that individuals can enter the system through many avenues in order to receive timely and effective service(s). An individual may seek access to the service system by contacting CenterPoint (24/7 screening/triage/referral [STR] line at ACCESS 1-888-581-9988), providers, or other community agencies. Individuals seeking access to services shall have an initial screening and triage by CenterPoint in order to determine if an MH/DD/SA need exists and ensure appropriate disposition. Following completion of the initial screening, STR staff will contact the provider of choice (or in the absence of consumer preference an appropriate provider who represents an appropriate consumer-provider match) to complete a comprehensive assessment. TTY capability for persons, who have a hearing impairment, and foreign language interpretation, are available at no cost.

Providers shall submit to CenterPoint Urgent, Emergent and Routine consumer data as required in the State Performance Agreement.

## G. Licensure Verification

For all licensed facilities and services (residential facilities, Day Treatment Programs, Substance Abuse Outpatient Services or Psychosocial Rehabilitation), the provider shall submit a copy of the initial and subsequent licenses prior to billing for services. The provider shall notify CenterPoint of any suspensions, Plans of Correction, fines or licensure issues for facilities or services within twenty-four (24) hours of notification by NC Division of Health Services Regulation.

Licensed Professionals shall provide proof of current licensure.

## H. General Guidelines and Expectations of CenterPoint Providers

### 1. Notification of Change of Provider Status

Provider shall notify CenterPoint Provider Operations of any change including:

- Change of Main Contact Person
- Change of Email Address
- Any legal action by either a private complainant or a government department/agency
- Insolvency/Bankruptcy or conditions supporting Involuntary Bankruptcy
- Any changes in the location of service records
- Any other occurrence that may impede your ability to deliver quality services

# Section II
# List of State and Federal Requirements

This document provides direction to Providers for accessing pertinent rules, regulations, standards, and other information referenced in Article I, §1.2 of the Endorsement MOA, and §1.1 of the Contract for State and/or County Funded Services.

Requirements change for numerous reasons including, but not limited to, federal and/or state legislation and/or policy changes. It is the responsibility of providers to routinely and frequently check sites and other resources for changes. For questions, contact Lori Setchell at lsetchell@cphs.org.

***PLEASE NOTE:** Website addresses are subject to change. Perform an internet search for current information, if necessary.

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| **10A NCAC 27G (formerly APSM 30-1) (Rules for MH/DD/SA Facilities & Services)**<br><br>**APSM 45-1** (Confidentiality)<br><br>**APSM 45-2** (Records Management and Documentation Manual", formerly "Service Record Manual")<br><br>**APSM 45-2a** (Service Records Resource Manual)<br><br>**APSM 95-2** (Client Rights)<br><br>**APSM 95-1**(Human Rights for Clients in State Facilities)<br><br>**APSM 10-3** (Records Retention and Disposition Schedule)<br><br>**APSM 1026** (Old Service Definitions Manual)<br><br>**APSM 75-1** (Area Programs Budget Procedures Manual Revised Record )<br><br>**APS-R 110-12** (Policy on Placement of Long Stay Patients ) (replaces APS-R 110-12 Discharge Policy)<br><br>**45CFR & 164 HIPAA**<br>(Privacy and Security of Health Information) | Contact:<br><br>DMH/DD/SA Manuals Communications & Training 3022 Mail Service Center Raleigh, NC 27699-3002 | www.dhhs.state.nc.us/mhddsas/rules/index.html#APPROVEDPERMANENTRULES<br><br>Link to All Manuals listed in the first column at the Division Page :<br><br>http://www.dhhs.state.nc.us/MHDDSAS/statspublications/manualsforms/index.htm<br><br>http://www.hhs.gov/ocr/privacy/hipaa/administrative/privacyrule/index.html |
| **Medicaid-covered services definitions**<br>**Medicaid Services Guidelines**<br>**Medicaid Communiqués** | | http://www.dhhs.state.nc.us/dma |
| **Health Care Personnel Registry** | (919) 733-8500<br>(919) 715-0562 | www.ncnar.org |

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| **Current Procedural Terminology (CPT) Code Book**<br>**Published by Am. Medical Assoc.** | Purchase at office supply or book store | |
| **Healthcare Common Procedure Coding System (HCPCS) Code Book** | Purchase at office supply or book store | |
| **SB 163- Monitoring of Providers** | | http://www.ncdhhs.gov/mhddsas/statspublications/archives/sb163/ |
| **Records Retention Schedule** | | http://www.records.ncdcr.gov/local/mental_health/mental_health_2006.pdf ( As of January 1, 2010. Check for updates) |
| **FEDERAL LEVEL** | | |
| **Drug Free Workplace Act of 1988 as revised** | Library-Federal Laws | http://www.dol.gov/elaws/drugfree.htm |
| **Section 503 and 504 of the Rehabilitation Act of 1973** | Library –Federal Laws | www.dol.gov<br>http://www.dol.gov/dol/compliance/compliance-majorlaw.htm#eeo |
| **Civil Rights Act of 1964** | Library-Federal Laws | www.eeoc.gov |
| **Non-Profit Agencies-Conflict of Interest 1993 Session Laws: Chapter 321, Section 16** | Library -Federal Laws | Not available |
| **Public Law 99-320, May 1986** | Library-Federal Laws | Not available |
| **Title I Protection and Advocacy Systems**<br>**Title II Reinstatement of Rights for Mental Health patients** | | http://www4.law.cornell.edu/uscode/42/ch114.html |
| **Office of the Inspector General**<br>**Exclusions "Lower-tier Transactions & Disbarment"** | Library – Federal Laws | http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&sid=65ddf95b76dbfc01a398dc81d856d555&rgn=div5&view=text&node=2:1.2.1.3.1&idno=2 |
| **Pro-children Act**<br>**Section 1041-1044 of Educate America Act of 1994**<br>Prohibiting smoking in areas used by children. | Library – Federal Laws | http://www.ed.gov/legislation/GOALS2000/TheAct/intro.html |
| **Public Law 99-319, May 1986**<br>**Protection and Advocacy for Mentally Ill Persons** | Library-Federal Laws | http://www.ssa.gov/OP_Home/comp2/F099-319.html |
| **Public Law 100-509**<br>**Protection and Advocacy for Mentally Ill.**<br>**Individual Amendments Act of 1988, October 1988** | Library-Federal Laws | http://www.law.cornell.edu/uscode/42/10801.html<br>(Use "NEXT" in the lower right corner to scroll pages) |

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| **Public Law 101– 496**<br>**Developmental Disabilities Assistance and Bill of Rights Act of 1990** | Library-Federal Laws | http://ddc.ohio.gov/pub/s1809enr.txt.pdf.pdf |
| **42 CFR Part 2 Confidentiality Regulations**<br>**45 CFR Part 160 & 164 HIPAA Standards for Privacy of Health Information** | Library-Federal Laws | Federal Regulations search:<br><br>http://www.gpoaccess.gov/cfr/index.html |
| **Office of the Inspector General**<br>(Exclusions - "Lower-tier Transactions and Disbarment" ) | Library – Federal Laws | http://oig.hhs.gov/fraud/exclusions.asp |
| **Pro-children Act of 2001** | Library – Federal Laws | http://www.ed.gov/policy/elsec/guid/prochildact01.pdf |
| **Section 1041-1044 of the Educate America Act 1994**<br>Prohibiting smoking in areas used by children. | | http://www.ed.gov/legislation/GOALS2000/TheAct/intro.html |
| **Americans with Disabilities Act** | Liberty – Federal Laws | http://www.usdoj.gov/crt/ada/adahom1.htm |

| NORTH CAROLINA | | |
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| **General Statutes**<br><br>▪ 122C-3 Definitions<br>▪ 122C-4 Use of phrase "client or his legally responsible person"<br>▪ 122C-51 Declaration of Policy on clients rights<br>▪ 122C-52 Right to confidentiality<br>▪ 122C-53-56 Exceptions…..<br>▪ 122C-57 Right to treatment and consent to treatment<br>▪ 122C-58 Civil Rights and civil remedies<br>▪ 122C-59 Use of Corporal punishment<br>▪ 122C-60 Use of physical restraints or seclusion<br>▪ 122C-61 Treatment rights in 24-hour facilities<br>▪ 122C-62 Additional rights in 24-hour facilities<br>▪ 122C-63 Assurance for continuity of care for individuals with mental retardation<br>▪ 122C-64 Human rights Committees<br>▪ 122C-65 Offenses relating to clients<br>▪ 122C-66 Protection from abuse and exploitation; reporting<br>▪ 122C-67 Other rules regarding abuse, 122C-(116,141,142,146) Local Government Entity<br>▪ 130-A-133 Communicable Diseases (Definitions and Reporting Requirements)<br>▪ 90-21.4 Treatment of Minors<br>▪ 7A 517, 452-553 Abuse and neglect of Minors<br>▪ 108A 99-111 Abuse and Neglect of Disabled Adults<br>▪ 122C-151.3 and 151.4 Resolving Disputes w/Contractors | | **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.**<br><br>www.ncleg.net |
| **NC DHHS Provider Information** | | http://www.ncdhhs.gov/mhddsas/providers.htm |
| **CAP-MR/DD Manual**<br>(CAP Providers and Core Competencies Training Requirements for MR/MI service providers) | | http://www.ncdhhs.gov/mhddsas/cap-mrdd/index.htm |
| **Residential Licensure Requirements** | **Contact:**<br>Mail Service Center, 3015<br>Raleigh, NC 27699<br>(919) 715-1294 | http://www.dhhs.state.nc.us/dss/licensing/rcc.htm<br><br>http://www.dhhs.state.nc.us/mhddsas/rules/index.html<br><br>http://www.ncdhhs.gov/mhddsas/statspublications/manualsforms/aps/apsm30-1_8-09.pdf |
| **Staff Qualifications/Competency Rules** | (919) 855-3750 | http://www.dhhs.state.nc.us/mhddsas/rules/index.html<br>Very bottom of the page the information is found under:<br>*Notes for Staff Qualifications Rules 6/24/09* |
| **Health Care Personnel Registry** | | https://www.ncnar.org/index1.jsp |

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| **SB 926- Monitoring of Providers** | (919) 733-8500<br>(919) 715-0562 | http://facility-services.state.nc.us/hcarpage.htm and<br>www.ncnar.org |
| **Performance Agreement(03-04) between DMH and Area programs-Attachment 12-prompt pay** | | www.dhhs.state.nc.us/mhddsas/performanceagreement |
| **NC Division of Medical Assistance** | | http://www.dhhs.state.nc.us/dma/prov.htm |
| **NC IPRS** | | http://www.dhhs.state.nc.us/mhddsas/iprsmenu/index.htm |
| **NC TOPPS** | | http://www.ncdhhs.gov/mhddsas/nc-topps/index.htm |
| **NC SNAP** | | http://www.ncdhhs.gov/mhddsas/ncsnap/index.htm |
| **Provider Endorsement** | | http://www.ncdhhs.gov/mhddsas/stateplanimplementation/providerendorse/index.htm |
| **OTHER** | | |
| **North Carolina Council of Community MH/DD/SAS Programs** | 4045 University Parkway<br>Winston Salem, NC 27106<br>(336) 714-9100 | www.nc-council.org |
| **CenterPoint Human Services** | | www.cphs.org |

# Section III
# Authorization Process and STR

## A. Authorization Requirements

CenterPoint authorizes publicly funded services; CenterPoint does not authorize services funded by Medicaid, Medicare or private insurance.

Authorizations for a **Medicaid Consumer/Services** are processed through Value Options at **http://www.valueoptions.com/providers/Network/North_Carolina_Medicaid.htm**

Authorization for a publicly funded service requires a fully executed contract with CenterPoint and pre-authorization. ***CenterPoint does not backdate authorizations for services.*** Detailed directions for requesting an authorization follow.

**The provider should not assume any service is authorized unless they have received written notice from CenterPoint or verbal confirmation with an authorization number. Authorization does not guarantee payment.**

In order for services to be authorized, they:

- Must be medically necessary and clinically appropriate;
- Must be provided in the least intensive and least restrictive level of care;
- Must have a goal of stabilizing crisis, maximizing the consumer's improvement, and promoting stability for those with chronic conditions, and,
- Must work to prevent the decline and decompensation of the consumer being served.

**If a consumer has another funding source (Medicaid, Medicare, private insurance, etc.), the consumer is not normally eligible for IPRS funding of services**.

## B. Utilization Management

Authorization is a clinical and administrative process that assures that eligible consumers receive needed services and that providers receive reimbursement from CenterPoint for the services they provide. CenterPoint proactively manages all available funds for the purchase of services through utilization management (UM) and the use of sound accounting practices. The Benefit Design Plan (Plan) outlines services available to consumers based on their level of acuity, their target population and the availability of funds. The Plan is approved by CenterPoint's Board of Directors, is posted on CenterPoint's website, and is subject to change during the contract year.

## C. Authorization Process

ProviderLink is the primary mechanism for submitting authorization requests to CenterPoint and receiving completed authorizations. As a secure, web-based communication tool, ProviderLink offers real-time information and immediate access for all parties involved. Authorization requests may be submitted through ProviderLink along with treatment plans and other supporting documentation attached by fax. The technology allows for little duplication of information from one form to another and date stamps every entry submitted. CenterPoint does not accept hard copy authorization requests.

Providers shall submit all required documents for the authorization request to be accepted and processed. In the event additional information is required to process the authorization request, the provider is given five (5) business days to submit the information. If the information is not received, the provider will receive a second notification of the missing information and will be notified that their request will be discarded if the information is not received within five (5) business days. If the request is discarded, a new authorization request must be submitted, and the start date of the authorization will be the submission date of that request, not the date of the original request.

1. In order for an authorization request to be accepted, it must include:

   - Comprehensive clinical assessment (For consumers with a developmental disability an NC SNAP should be part of the assessment)
   - Service Authorization Request form (Value Options forms are accepted and can be found on the Value Options website http://www.valueoptions.com/providers/Clinforms.htm**)**
   - Consumer Admission and Discharge form (including target population)
   - Person Centered Plan or Service plan (basic benefits)

2. For reauthorizations, include:

   - Service Authorization Request form
   - Updated Person Centered Plan or service plan
   - Target population/IPRS form (if update is needed)

Upon acceptance of an authorization/reauthorization request, CenterPoint UM staff will respond within fourteen (14) days to the provider. This response may be an authorization of services as requested, a denial or reduction of the request for services, or a notice that the request is pended until additional information is received. In the event an authorization request is denied or reduced, the consumer may choose to appeal the decision. If the UM decision under appeal pertains to a reauthorization of existing services, the end date of an existing and active authorization will be extended fifteen (15) days with the same intensity of services in order to accommodate the appeal process. (See Non-Medicaid appeals below.)

## D. Services Appeals (Non-Medicaid)

Authorization of services can be denied for various reasons, including but not limited to, the limits of the Benefit Plan, budgetary limitations or lack of medical necessity. When UM denies, reduces, suspends or terminates funding for a requested service:

- The consumer or their guardian is notified in writing of their right to appeal the decision. The notification letter includes the form needed to file the appeal and the contact information for the CenterPoint staff who will facilitate the appeal process.

- The request for an appeal can be filed by the consumer, their legal guardian, or another individual who does not have a conflict of interest and who has been selected by the consumer or their guardian.

- A provider may not file an appeal for a consumer but may advise the consumer of their rights and assist consumers in the process.

Please note that non-Medicaid funded services are not an entitlement. Filing a request for an appeal in no way guarantees the consumer the specified service regardless of outcome of the review.

## E. Medicaid Appeals

Consumers must follow the appeals process set out by DMA at
http://www.dhhs.state.nc.us/dma/medicaid/rights.htm

## F. Conditions for Payment

An authorization **does not** guarantee payment. Payment is dependent on:

- The service meets the terms of the authorization;
- The consumer is eligible for the benefit on the date of the service;
- All relevant rules, regulations and contract provisions are met;
- The claim is submitted accurately and within sixty (60) days of provision of service; and
- There is no reduction of funds by the Federal, State or County funding sources. Services provided prior to the date of a fund reduction will be honored.

Please note: If a consumer has another funding source (Medicaid, Medicare, private insurance, etc.), they are not normally eligible for IPRS funding of services. Exceptions to this rule are rare and require the approval of the Medical Director and the CEO/Area Director.

## G. Direct Enrolled Independent Practitioners Serving Children with Medicaid

Services provided to Medicaid recipients under the age of 21 require a referral by a Carolina Access Primary Care Provider, a Medicaid enrolled psychiatrist or CenterPoint. "Referral" for this purpose is defined as utilization of CenterPoint's NPI number. Use of CenterPoint's NPI number requires a fully executed MOA with CenterPoint. Directions on this process can be found at http://www.cphs.org/ContractingProcedures.aspx**.** Submission of a Consumer Admission and Discharge Form is required for all consumers served under an MOA.

## H. Benefit Design Plan

The current Plan available on the website under "Various Provider Forms" at **http://www.cphs.org/FormsAndApplications.aspx.**

## I. Care Coordination

Care Coordination has two main objectives: (1) to link consumers entering the mental health system for the first time with providers who are able to meet their treatment needs; and (2) to assist providers and consumers in finding the most effective treatment for consumers with complicated treatment needs. Care coordinators are available to serve as a resource for providers who are having difficulty finding the appropriate treatment for any consumer with specialized needs.

## J. Outpatient Commitment (OPC) Protocol

Consumers placed on Outpatient Commitment (OPC) to CenterPoint are likely to be individuals with high-risk behaviors about whom there is also a concern regarding treatment compliance. To assure that a strong effort is made to provide appropriate follow-up for these consumers, the following OPC procedure applies.

1. OPC is coordinated through the Care Coordination Unit (Unit) as a part of the emergency/crisis care continuum. The Unit is responsible for the monitoring, oversight, and tracking of all OPCs. The Unit receives the original OPC Order, logs the information and mails the Order to the designated outpatient provider. The provider provides clinically appropriate services for the consumer for the duration of the OPC period and maintains current records of all treatment and/or non-treatment events. This information may be requested at any time by CenterPoint. The Unit is responsible for monitoring provider compliance and communicating this information to Provider Relations. Providers showing a pattern of poor follow-up may become ineligible for referral for consumers on OPC or other appropriate monitoring or contractual action. OPC periods are typically ninety (90) days for a mental health commitment and one hundred eighty (180) days for a substance abuse commitment, but may vary on an individual basis. CenterPoint review of consumer records may be done concurrently during the OPC and retrospectively on a quarterly basis to ensure quality of care.

2. All consumers discharged from inpatient care on OPC must be seen face to face within five (5) working days of discharge. If a consumer is referred to a discharge clinic provider and a clinical home provider, the clinical home provider shall be considered the "designated provider" for OPC purposes. The designated provider will provide assertive follow-up as described below for consumers on OPC:

    a. The designated provider shall conduct outpatient face-to-face assessment and follow-up treatment with the consumer at the level clinically appropriate to the consumer's needs and condition. No consumer shall be seen less than once every two (2) weeks unless they are in a 24-hour supervised (FCH, Group Home) setting and are stable. If the provider recommends

that the consumer be seen less than bi-weekly), then a MD/PhD must review the need to continue the OPC and document the contact.

b. If the provider determines that the consumer no longer meets the criteria to continue the OPC, then the MD/PhD can sign a Change of Commitment form (Attachment A), send one copy to the Clerk of Court in the county the Order dictates (which is the county of supervision), and one to CenterPoint to log the termination of commitment. *If the consumer is initially committed as a result of conduct resulting in the consumer being charged with a violent crime, including a crime involving an assault with a deadly weapon, and the respondent (consumer) was found incapable of proceeding, a hearing must be scheduled to make any changes in the commitment. When there is doubt about the reason for the initial commitment, the Clerk of Court should be contacted for clarification.*

c. If the consumer fails to comply or clearly refuses to comply with all or part of the prescribed treatment, and the consumer continues to meet commitment criteria, the provider shall make all reasonable efforts to solicit the consumer's compliance to be documented in a letter to the court by the clinician. The provider should complete a new Examination and Recommendation for Involuntary Commitment (signed by the MD/PhD). These two documents, along with the clinician's letter, should be sent to the Clerk of Court where the commitment is being supervised along with a Request for Supplemental Hearing (Outpatient Clearly Refuses to Comply with Treatment AOC-SP-221) form. A copy of the Request for Supplemental Hearing should be sent to the LME.

d. If the consumer fails to comply but does not clearly refuse to comply, (i.e., the consumer has a pattern of scheduling appointments but does not show up) the provider may request the court to order the consumer taken into custody for the purpose of a face to face evaluation. This is done by completing a Request for Transportation Order (Outpatient Fails but Does Not Clearly Refuse to Comply with Treatment AOC-SP-220).

e. If the consumer is non-compliant and cannot be located for a pick up order, then the following reasonable professional efforts should be documented and billed, when possible, by the provider:

1. Reasonable effort is defined as documentation and billing (when possible) of at least one of the following within seventy-two (72) hours (not including holidays/weekends) of the initial missed appointment: (1) a visit with the consumer in his/her home; (2) a rescheduled office appointment that the individual keeps; or (3) a phone conversation with the individual about the services being offered. If contact efforts are unsuccessful, at least Three (3) contact attempts must be documented. These face to face contacts should be made once per week the first two weeks then one more attempt two weeks later (4th week). Any information provided to you by a family member or another person regarding the consumer's location should be pursued.

2. If the three (3) attempts are unsuccessful, these efforts should be documented in a letter to the Clerk of Court in the supervising county and a Change of Commitment form should be completed. A copy of both these forms should be sent to the Clerk of Court and a copy of the Change of Commitment should be sent to CenterPoint. *If the consumer is initially committed as a result of conduct resulting in the consumer being charged with a violent crime, including a crime involving an assault with a deadly weapon, and the respondent (consumer) was found incapable of proceeding, a hearing must be scheduled to make any changes in the commitment. When there is doubt about the reason for the initial commitment, the Clerk of Court should be contacted for clarification.*

3. If the consumer's case is Active in the CenterPoint system, the provider must keep the case open for sixty (60) days from the last contact. If the consumer cannot be located within the sixty (60) days from the last contact, the provider may discharge the consumer from services and notify CenterPoint using the normal discharge documentation and procedures.

f. If the consumer moves to another state, a Change of Commitment form is completed and sent to the Clerk of Court. A duplicate copy of the form should be sent to CenterPoint for the purposes of LME notification of receiving county authority when possible. The relevant facts are then documented in the consumer's chart.

g. If the consumer intends to move or has moved to another county within the state, the provider shall request that the Clerk of Court in the county where the OPC is supervised to schedule a hearing. The MD/PhD should fill out a new Examination and Recommendation for Involuntary Commitment and send it to the Clerk of Court with a completed Request for Hearing. A copy of the Request for Hearing form should be sent to the LME.

h. Twenty days prior to the expiration of the OPC, the clinician shall review the case with a MD/PhD and determine if the consumer still meets the criteria for OPC and whether it needs to be extended. If the consumer has been compliant and no longer meets the criteria, then a Change of Commitment form can be signed at the expiration of the commitment and sent to the Clerk of Court and a copy to CenterPoint.

i. If the provider feels the consumer continues to meet the criteria for the OPC and a rehearing is needed, then the MD/PhD will need to complete an Examination and Recommendation for Involuntary Commitment. The clinician should send it with a Request for Hearing form to the Clerk of Court and a copy of the Request for Hearing to CenterPoint.

j. If a consumer on OPC is involuntarily committed to an inpatient facility on a new petition, then the OPC is terminated and a Change of Commitment form should be sent to the Clerk of Court and CenterPoint.

k. Any questions about OPCs, can be directed to the Unit at 336-714-9100. Any documentation regarding an OPC should be faxed to the CenterPoint Care Coordination Department at 336-714-9327.

## K. Guardianship

The Clerks of Court in Forsyth, Davie, Stokes and Rockingham Counties appoint Guardians of the Person for those individuals who have been adjudicated incompetent. The guardian may be a family member, friend or a public agency. Frequently CenterPoint is appointed as the guardian in cases where the individual has a history of mental health treatment, substance abuse or a developmental disability. Guardians of the person are involved in many important decisions in the wards' lives but have no authority to make decisions regarding financial matters.

## L. CenterPoint ACCESS Department – Screening, Triage & Referral (STR)

CenterPoint's ACCESS Department provides 24/7/365 screening, triage, and referral for the entire CenterPoint four-county catchment area. The toll-free number (1-888-581-9988) is answered by qualified professionals and licensed clinicians who are trained to respond to crises and to assist consumers with obtaining appointments with providers who may help them address their problems. TTY capability for persons who have a hearing impairment and foreign language interpretation are available. During the call, screening information is collected that includes demographics, presenting clinical issues, insurance information, consumer preferences, and treatment history. Clients are triaged in regard to urgency of care and likelihood of target population, and a referral is made based on all of the above factors and information. The provider, at assessment, determines actual target population qualification. STR staff may provide a provisional diagnosis for State funded consumers but generally refers other consumers without diagnosis. All clinical, financial and demographic information should be verified with the consumer at the time of the initial face to face assessment as screening information is based solely on the information reported by the consumer during the telephone screening.

## M. Referrals, Appointments, and Authorization

Unless a specific qualified and eligible provider is requested by the consumer, the computer system generates a random selection of three appropriate providers from which consumers may choose. Provider choices take into account availability, location, specialty, consumer preferences, and indicated funding source. Appointments are offered based on web-based calendars furnished by the provider. Providers must maintain open appointments in the web based calendars to participate in the random selection process. During the regular work week, CenterPoint staff provides a copy of the screening information to the provider via fax within twenty-four (24) hours following the screening. Screenings completed during weekends or holidays are faxed the next business day. Consumer choice of provider is honored unless the clinical presentation indicates the immediate need for a service that the requested provider does not provide or the consumer does not have access to a funding source that the provider accepts. All specific provider requests are documented in the CenterPoint computer system as well as provider to whom the referral is made. Available clinical information used to guide the referral process is also documented. It is assumed that choice of providers continues to be given by the endorsed provider network at all service points.

## N. Out-of-Area Consumers

CenterPoint STR does not schedule or authorize services for consumers who reside outside of Davie, Forsyth, Stokes or Rockingham Counties. If a consumer presents to a local hospital and needs hospitalization at a State facility, one courtesy day is authorized. The only exceptions are those services funded by CASP funds such as methadone maintenance and the WISH program.

## O. State Hospital Admissions

CenterPoint STR authorizes all initial State Hospital admissions. Generally State Hospital admissions staff will not accept a patient until provided with an authorization number issued by CenterPoint. CenterPoint's Care Coordination staff, Utilization Management staff and STR staff work together to ensure that appropriate discharge planning is completed and that follow up appointments are scheduled for all area consumers prior to their leaving the hospital.

## P. No-Shows and Rescheduling

CenterPoint STR must receive daily compliance reports that provide information on whether all appointments scheduled through STR were kept, cancelled or rescheduled. Providers are strongly encouraged to follow-up with no shows by phone. Clinical home providers receiving referrals of new consumers should complete and submit this form to CenterPoint each morning by 10am regarding consumer appointments scheduled for the previous day. The Division of MH/DD/SAS requires all LME's to submit this data. See the Appointment Compliance Form at **http://www.cphs.org/Providers/ComplianceForm/ComplianceFormMain.asp**.

## Contact Information For The Clinical Services Department

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|---|---|---|
| Burch Johnson<br>~~Director of Service Management~~<br>Director of Clinical Services | 336-714-9138 | bjohnson@cphs.org |

### UTILIZATION MANAGEMENT

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|---|---|---|
| Laura Lea Harris<br>Utilization Reviewer | 336-714-9174 | lharris@cphs.org |
| Deborah Nunn<br>Utilization Reviewer | 336-714-9141 | dnunn@cphs.org. |
| Sandra Jones<br>Utilization Reviewer | 336-714-9364 | sjones@cphs.org |

### GUARDIANSHIP

| | | |
|---|---|---|
| ~~Stacey Skradski~~<br>~~Guardianship Representative~~ | ~~336-714-9104~~ | ~~sskradski@cphs.org~~ |
| ~~Cassandra Massenburg~~<br>~~Guardianship Representative~~ | ~~336-714-9139~~ | ~~cmassenburg@cphs.org~~ |
| -Burch Johnson<br>~~Director of Service Management~~<br>Director of Clinical Services | 336-714-9138 | bjohnson@cphs.org |

### CARE COORDINATION

| | | |
|---|---|---|
| Peter Rives<br>Care Coordination Manager | 336-714-9173 | prives@cphs.org |
| Jeff Payne<br>Care Coordinator-DD | 336-714-9171 | jpayne@cphs.org |
| Chad Stage<br>Care Coordinator-Hospital Liaison | 336-714-9176 | cstage@cphs.org |
| Lisa Hinson<br>Care Coordinator-Adult MH/SA/Homeless | 336-714-9172 | lhinson@cphs.org |
| Amber Humble<br>Care Coordinator-Jail Liaison | 336-714-9152 | ahumble@cphs.org |
| Jennifer Parsons<br>Care Coordinator-Child (MH/SA/DD) | 336-714-9157 | jparsons@cphs.org |
| Sharon Neville<br>Care Coordinator-Rockingham County | 336-714-9122 | sneville@cphs.org |

### Screening, Triage and Referral
### 1-800-581-9988

| | | |
|---|---|---|
| David Mazzola<br>Lead STR Clinician | 336-714-9164 | dmazzola@cphs.org |

# Section IV
# Claims

## A. CenterPoint Billing/Claims Information

Billing information is submitted by network providers as a "claim" or a "shadow claim." **How services are submitted is determined by the service contract.** Providers who are paid under a capitated fee-for-service contract submit billing as a claim; providers who are contracted as 1/12$^{th}$ contracts submit billing as a "shadow claim."

Regardless of how a provider is reimbursed, all **outpatient claims must be submitted electronically**. CenterPoint will only accept two methods of electronic claims submission. Those are:

- **ANSI 837**, or
- **EClaims, which is an online electronic claims system developed by CenterPoint**

Both electronic billing methods require substantial technical assistance to implement such as ensuring PC requirements are met to access the web portal device, claims entry training and format testing. The implementation period normally takes up to 10 business days depending on the billing method selected.

Upon contracting the provider chooses which electronic method they will use for billing. An Electronic Claims Agreement (ECS), which sets forth CenterPoint's conditions and billing requirements, must be signed. CenterPoint schedules the technical assistance and any training that is needed to ensure that the provider is in compliance with the electronic billing requirements.

A claims instruction guide is available for providers who chose EClaims as their electronic billing method. The guide is found at

http://www.cphs.org/Providers/EClaims/EClaims_Instruction_Guide%20FY2010.pdf

CenterPoint will accept UB04's for inpatient facility claims.

To ensure prompt and accurate payment for claims, Providers should be sure to obtain authorization for services as required by the provider contract. Then the services need to be billed within the contract due dates. They also need to make sure that the services are delivered as authorized.

## B. Medicaid Equivalent Service Provided to State Funded Consumers

All Medicaid equivalent services provided to State funded consumers must be billed to CenterPoint in accordance with Medicaid rules and regulations.

## C. Electronic Claims

All claims must be submitted to CenterPoint electronically via EClaims System or electronic HIPAA 837 transaction in accordance with the contract requirements.

## D. UB04s

This billing form is used only by hospital facilities to bill facility charges, e.g. inpatient.

## E. Third Party Payors

The network provider shall verify Medicaid, Medicare and/or other third party insurance coverage. CenterPoint and its contract providers shall comply with all applicable rules and regulations governing the funding source. ***Consumers who are covered by a third party payor are not eligible for State funding.***

## F. Claims Processing

- All claims for services must be submitted individually for each consumer electronically in adherence with the schedule in the contract. The claim must include the authorization number, the date of each service event, the actual units of service for each date and the appropriate service code for each billed service. All events billed must be pre-audited for documentation compliance by the provider.

- Confirmation of all claims received is provided via email or online confirmation after entering claims.

- CenterPoint is not responsible for claims not submitted electronically or received outside the established due dates.

- All claims will be adjudicated (approved, denied or additional information requested) within 18 calendar days from the date received. All claims approved for payment will be paid within the timely payment requirements. An EOB (Explanation of Benefits) will be provided for all fee-for service claims.

## G. Denials

To avoid denials, we have provided a list of the most common reasons for denial. If these items are verified and corrected prior to billing, claims payment will not be delayed for these reasons.

- Services not authorized.
- Patient identification is missing or invalid.
- Duplicate claim.
- Eligibility has lapsed.
- Diagnosis code invalid or missing.
- Exceeds units approved under the authorization.
- Service not contracted.
- Service billed prior to the date of the service.
- Missing amount billed.
- No units specified.
- Tax identification missing or does not match contract.
- Maximum units paid for date of service.
- Dates of Service Invalid.
- Faxed claim.
- Exceeds time limitation for filing.
- Claim was incomplete when submitted.

## H. Timely Filing (60 Days)

A claims filing schedule is included in every contract in "Attachment A". Billings must be submitted within the contract due dates to avoid claims being denied. Providers have a time limit to submit claims; CenterPoint refers to this time limit as a billing "window." The Provider has a 60 day window from the date of service to bill a claim. Any claims submitted beyond this time limit will be denied.

## I. Recoupments

CenterPoint reserves the right to recoup money from providers, due to errors in billing, retroactive Medicaid and/or payment, by means of automatic withholding of subsequent payments to provider. If a billing error is made by the provider, it is the provider's responsibility to notify CenterPoint in writing of the error and refund any amounts paid.

## J. Claims Training for Providers

CenterPoint's Claims staff will assist providers in need of one-on-one training upon request. CenterPoint is committed to working with providers to help the claims submission process go as smoothly and efficiently as possible.

## K. Prompt Pay

CenterPoint shall review all claims or invoices within eighteen (18) calendar days after receipt. CenterPoint shall approve payment, deny payment for all or portions of the claim or invoice, or request additional information. CenterPoint shall pay all approved or undisputed portions of claims/invoices for services performed by the Provider within thirty (30) calendar days after approval. Such payment constitutes full and final payment of the approved or undisputed portions of the claims or invoices.

If further information is needed, please refer to "Performance Agreement" at:

http://www.ncdhhs.gov/mhddsas/performanceagreement/index.htm

## L. CAP-MR/DD Purchases

**Billing Procedures for CAP-MR/DD funded items only**

The following items are to be submitted by the Targeted Case Manager (TCM) to CenterPoint for purchasing. Failure to include any necessary item will result in denial of payment/reimbursement:

### 1. Specialized Equipment and Supplies items (T1999)

a. Value Options authorization

b. Evaluation by appropriate therapist (OT/PT)

c. Prescription from physician noting item and medical necessity reason.

d. Quote from vendor that is no older than 30 days at time of ordering. If older than 30 days, TCM can contact vendor to verify quote is still current and needs to be noted and signed on quote as such by TCM and dated. If quote has changed, then new quote needs to be submitted.

e. If consumer has health insurance other than Medicaid; Targeted Case Manager will need to receive denial of item. Denial must be submitted with quote.

f. Copy of the revision/CNR requesting the TI 999 item/s

*Note: if item is over $1,000, a Purchase Order will be required and may take up to 6 weeks to complete. Anything over $5,000 is subject to bidding out and may take longer.
*Note: No DME product can be billed under T1999 which includes oral nutrition.*

## 2. Home Modifications (S5165)

a. Value Options Authorization

b. A minimum of two quotes not older than 30 days from appropriate vendors. If older, new quotes are required or TCM can write on quotes that they have verified with vendor that amount is still the same, date and sign it. It is critical that the quotes be clear on what they are providing and completing.

c. Required information indicated from the Service Records Manual (APSM 45-2) (updated 4/1/09) and CAP-MR/DD definition

d. Assessments from appropriate professional that identifies needs of consumer

e. Physician's signature of Medical Necessity for consumer

f. Copy of PCP requesting Home Modification Service

g. Letter from TCM indicating which vendor is preferred and why

## 3. Vehicle Modifications (T2039)

a. Value Options authorization

b. Assessment from appropriate therapist/vehicle adaptation specialist with the information required from the Service Records Manual (APSM 45-2)(updated 4/1/09) and CAP-MR/DD definition

c. Physician's signature certifying medical necessity for the consumer

d. A minimum of two quotes no older than 30 days must be provided. If older, new quotes are required or a note on the quote from the TCM that the amount quoted is still current, and dated and signed by the TCM.

e. Copy of the PCP requesting modification

f. A letter from the TCM justifying which vendor is preferred and why

g. If the consumer has health insurance other than Medicaid, a denial from the insurance company must be submitted.

h. Proof that vehicle is insured

**NOTE**: If over $1,000, Purchase Order will be required which may take longer to process.

## 4. Augmentative Communication Devices (T2028):

a. Value Options authorization

b. Quote from appropriate vendor with the required information from the Service Records Manual (APSM 45-2)(updated 4/1/09) and CAP-MR/DD definition.

c. Physician's statement of medical necessity

d. Assessment from Speech Therapist who must be certified in North Carolina

**NOTE:** Any equipment over $5,000 requires a bid process.

**5. Individual/Caregiver Training and Education (S5110)**
(Conference Registration/Enrollment Fees for Classes only)

a. Value Options authorization listing CenterPoint as the provider

b. Copy of Person Centered Plan (PCP) requesting service

c. Letter from TCM indicating how many hours of this service has been used this waiver year

d. Completed Registration form

**6. Transportation (T2001)**

a. Value Options authorization for transportation vendor

b. Copy of PCP requesting Service

c. Information on the selected vendor (contact, address, quote for charges, proof of insurance**)**

**7. Vehicle Modifications, Home Modifications, Augmentative Communication Devices, Individual/Caregiver Training and Educations, and Transportation**

The TCM must verify satisfactory delivery of the service, effective use of equipment, and consumer satisfaction. The TCM's signature with date, and appropriate code on the invoice document that this has occurred. This signed invoice is returned to CenterPoint, Attn. Finance Dept.

**8. Procedures for Oral Nutritional Supplements which are not reimbursed with CAP-MR/DD funding but are paid by Medicaid**

Consumers under the age of 21 should receive their Oral Nutritional Supplements from a Medicaid Durable Medical Equipment provider. *See Implementation Update #57, June 1, 2009.*

Oral Nutritional Supplements for consumers, over the age of 21, are billed to CenterPoint using the "B Codes".

TCM enters B Codes on invoices sent to them for approval for adult consumers and provides the number of units to be billed.

Prior to CenterPoint's authorization to the vendor for monthly shipments, TCM must verify that the cost of the Oral Nutritional Supplements does not exceed the Medicaid allowable including shipping.

TCM shall provide to CenterPoint a copy of the Cost Summary for adult consumers who are receiving supplements and the physician signature certifying medical necessity.

TCM is responsible for maintaining all necessary information. TCM is responsible for paybacks resulting from audits if information is not available and/or appropriate.

**NOTE:** TCM must choose Home Health or Durable Medical Equipment agencies that bill directly to Medicaid. For items not available under Home Health or Durable Medical Equipment, CenterPoint will only purchase and bill supplies defined in the CAP waiver.

# Section V
# Provider Documentation Submission Requirements

| MINIMUM PROVIDER REPORTING REQUIREMENTS | | |
|---|---|---|
| Appointment Compliance Report | Clinical Home Providers | See instructions and form on the CenterPoint website at http://207.4.163.10/Providers/ComplianceForm/ComplianceFormMain.asp |
| Incident, Death or Restraint Reports | ALL | http://www.dhhs.state.nc.us/mhddsas/statspublications/manualsforms/index.htm<br><br>Also, see Section VIII below |
| Provider Quarterly Incident Reports | ALL | Quarterly, on the 10th day of the month following the end of the quarter. See: http://www.dhhs.state.nc.us/mhddsas/statspublications/manualsforms/index.htm |
| NC SNAP | | All Consumers in NC who have a DD diagnosis and receive, or are waiting to receive, DD supports must have an NC-SNAP administered annually. For Information go to: http://www.dhhs.state.nc.us/mhddsas/ncsnap/index.htm |
| NC TOPPS | MH and SA Providers who are "Clinical Homes" for consumers age 6 or older | NC TOPPS<br>https://nctopps.ncdmh.net<br><br>Implementation Guidelines and Free on-line training can be found by going to the link above and clicking on the appropriate topic (such as "Training Support Materials" or "Frequently Asked Questions") in the left-hand column. |
| Grant Data/Outcomes | ALL | Recipients of grant funds must submit reports with requested data elements, in the format required by the LME, based on the schedule requested by the LME |

# Section VI
# Quality Improvement & Performance Monitoring
## Overview of Selected Requirements

## A. Provider Monitoring

Compliance monitoring will be conducted in accordance with SB 163 and other applicable rules and regulations. Refer to: http://www.dhhs.state.nc.us/mhddsas/statspublications/manualsforms/index.htm

## B. Client Rights Reporting

Provider and its employees, subcontractors, and assigns, is to deliver services and conduct itself in a manner that shall deter, prevent and avoid abuse, neglect, and/or exploitation of individuals in its care. Consumers shall be treated with dignity and respect and with close attention to privacy.

- Client Rights/Human Rights are verified through the monitoring process.
- Violations are reported through the Incident Reporting process described in Section C below.
- See Clients Rights Rules at the Division Website:

  http://www.ncdhhs.gov/mhddsas/consumeradvocacy/customerserviceandcommunityrights/customerserviceandcommunityrights.htm

## C. Incident Reporting

All incidents pertaining to Area Authority clients shall be report to the Area Authority and NC DHHS as required in APSM 95-2 (Client Rights) and APSM-30-1 (Quality Assurance/Improvement) and 10A NCAC 27G.0600. NOTE: See form "DHHS Incident and Death Form" and manual for incident reporting at http://www.dhhs.state.nc.us/mhddsas/statspublications/manualsforms/index.htm.

## D. Person Centered Planning

- See Communication Bulletin #34.
- Refer to http://www.dhhs.state.nc.us/MHDDSAS/pcp.htm

## E. Evidence Based and Best Practices

Evidence-based practices are proven through scientific studies to consistently result in positive outcomes for consumers. Other specific services or interventions known as “best practices” have been shown to produce benefits to consumers and their quality of life. CenterPoint supports expansion of evidence-based and best practices throughout the service system and promotes this expansion through training, education, outreach, technical assistance and service funding as resources are available.

Information about evidence-based and best practices is available at the following websites:

| | |
|---|---|
| www.ncebpcenter.org | North Carolina Evidence Based Practices |
| www.ohiosamiccoe.case.edu | Ohio SA/MI Coordinating Center for Excellence |
| www.prevention.samhsa.gov | SAMHSA's Center for Substance Abuse Prevention |

## F. Clinical Outcomes Measures

- The provider must submit any Division-required client personal outcome data.
- For NC SNAP see http://www.dhhs.state.nc.us/mhddsas/ncsnap/index.htm
- For NC TOPPS see https://nctopps.ncdmh.net
- CenterPoint clinical outcome requirements are individually specified in provider contracts in Attachment A.

## G. Audit Information

- Services provided under federal, state and/or county funds are audited in accordance with Medicaid standards.
- Medicaid Provider - http://www.ncdhhs.gov/dma/forms/index.htm

## H. Billing Errors

The following Billing Correction Form found at www.cpha.org should be completed and submitted to CenterPoint if the provider recognizes that events were billed in error.

**CenterPoint Human Services**
**Attention: Billing**
**4045 University Parkway**
**Winston-Salem, NC 27106**

### Billing Correction Form

**Provider Name:**_____ **Contact Person:** _____
**Phone #:** _____ **Email Address:** _____

| Client Name | CPHS Medical Record Number* | DOB | Service Billing Code | Event Date | Duration or Units | Reason for Error | Amount Billed Incorrectly |
|---|---|---|---|---|---|---|---|
| 1. | | | | | | | |
| 2. | | | | | | | |
| 3. | | | | | | | |
| 4. | | | | | | | |
| 5. | | | | | | | |
| 6. | | | | | | | |
| 7. | | | | | | | |

# Section VII
# LME Specific Policies/Forms

## A. State and Federal Funding Contracts - Requests for Changes

Contracts for State and Federal (Non-Medicaid) funds are issued for the fiscal year beginning July 1st in the sole discretion of CenterPoint.

When needed, a Request for Application or Request for Proposal is posted on the CenterPoint website www.cphs.org and also announced via the *Friday Email*.

Providers who have unique services or programs are invited to submit proposals at any time. Proposals should include detailed information regarding the program/service, the target population(s) to be served, outcomes as well as amounts from other funding sources and the specific amount requested from CenterPoint.

Providers who would like to add any service(s) to an existing contract must fill out a Provider Application that can be found on the CenterPoint website www.cphs.org . See "Providers", then "Forms and Applications" for the appropriate form. All requests are subject to funding constraints.

## B. Enhanced Services

Requests for Enhanced Service Endorsement are submitted to Provider Operations. Additional information regarding endorsement is available at
http://www.ncdhhs.gov/mhddsas/stateplanimplementation/providerendorse/index.htm

## C. Letters of Support

The standardized process, requirements and criteria are available at www.cphs.org.

# Section VIII
# Glossary of Terms
## Provided by NC Division of MH/DD/SA Services

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 non-comprehensive definitions are also used in existing state and Area Authority documents and are included as a helpful resource. 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**- means a person 18 years of age or older, unless the term is given a different definition by statute, rule, or policies**.**

**ADMINISTRATIVE SERVICES**- means the 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 Contractors 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 N.C.G.S.371.

**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/RETROACTIVE 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* means 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 agencyresponsible 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**-means an eligible person who is under the age of I8, unless the term is given a different definition by statute, rule or policies.

**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**.**

C**OA -**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.

**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 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 I of a calendar year through and including June 30 of the following year.

**CO-PAYMENT**- 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 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 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 this Contract and/or failure tom perform based upon defined terms and conditions the scope of work specified in the Contract.

D**E-INSTITUTIONALIZATION** – Release of people from institutions to 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 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 and 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.

**GACPD** - 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 OFNEED* 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.

**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 ASSURRANCE (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.

N**ATURAL 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 reallocate 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**-means the 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 describe 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 that 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 and 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 MHO/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 the 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 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

**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.

**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.

P**RIVILEGING** – 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 SUBSTANCEABUSE 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.

**QA** - Quality Assurance

**QI** - Quality Improvement

**QIC** - Quality Improvement Committee

**QM** - Quality Management

**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 aprocess 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 needs and recommendations 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.

**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 statue 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 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-DETERMINATI**ON – 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, 4$^{th}$ 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 SUBSTANCEABUSE 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**-means 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 se 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.

**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-**is 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 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 REVIEW (UR*)*-** is 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 IX
# Appendix of Resource List

| Topic | Resource Websites |
|---|---|
| **Enhanced Service Definitions** | http://www.dhhs.state.nc.us/mhddsas/servicedefinitions/index.htm |
| **Basic Benefit Service Definitions** | **Please note that some of these services have been eliminated. To determine if a service is still billable for the specific target population, you must check the IPRS Service Array as well as the Enhanced Definitions.** http://www.dhhs.state.nc.us/mhddsas/servicedefinitions/index.htm |
| **Medicaid Billing Guide** | **Please access Monthly and Special Medicaid Bulletins** http://www.dhhs.state.nc.us/dma/bulletin.htm **Medicaid Billing Information** http://www.ncdhhs.gov/dma/provider/claims.htm |
| **Target Population Service Array** | **To determine services eligible for reimbursement for each Target Population, check this array. Updated versions at:** http://www.dhhs.state.nc.us/mhddsas/iprsmenu/index.htm **click on "Service Array"** |
| **Target Population Determination** | **To determine which Target Population(s) a consumer falls into, check the matrix at :** http://www.dhhs.state.nc.us/mhddsas/iprsmenu/index.htm |
| **Enhanced Services/ Endorsement** | http://www.dhhs.state.nc.us/mhddsas/servicedefinitions/servdefupdates/index.htm |
| **Rates** | http://www.ncdhhs.gov/dma/fee/index.htm |
| **Medicaid Bulletins** | **For updated Monthly and Special Medicaid Bulletins** http://www.dhhs.state.nc.us/dma/bulletin.htm |
| **Person Centeredness** | http://www.ncdhhs.gov/mhddsas/pcp.htm |

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|---|---|
| **Consumer Rights** | http://www.ncdhhs.gov/mhddsas/consumeradvocacy/customerserviceandcommunityrights/customerserviceandcommunityrights.htm |
| **Medical Release Form** | **SAMPLE Records disclosure form (for reference only):**<br>http://www.ncdhhs.gov/mhddsas/statspublications/manualsforms/forms/form-dhhsreleaseofinfo8-29-03.pdf |
| **Incidents and Deaths** | http://www.dhhs.state.nc.us/mhddsas/statspublications/manualsforms/index.htm#incident |
| **CenterPoint Benefit Design** | **http://www.cphs.org/PublicationsPills.aspx** |
| **NC-TOPPS** | **http://www.ncdhhs.gov/mhddsas/nc-topps/systemusers.htm**<br>**http://www.ncdhhs.gov/mhddsas/nc-topps/reports.htm** |
| **CAP MR/DD** | **http://www.ncdhhs.gov/mhddsas/cap-mrdd/index.htm** |
| **NC SNAP** | http://www.dhhs.state.nc.us/mhddsas/ncsnap/examinerinfo.htm |
| **Check for Division Updates** | **For Implementation Updates from the Division**<br>http://www.dhhs.state.nc.us/mhddsas/servicedefinitions/servdefupdates/index.htm<br>**For Communication Bulletins from the Division please go to:**<br>**http://www.ncdhhs.gov/mhddsas/announce/index.htm** |
| **Value Options** | **Value Options Medicaid Information**<br>**http://www.valueoptions.com/providers/Network/North_Carolina_Medicaid.htm** |