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3/25/14	1	LIP	Post-Payment Review [PPR]	Staff Qualifications		Slideshow referenced Q13 on the LIP Review Tool – I do not see a question 13 for LIPs . . .will LIPs still need to have a staff record available for review showing training, etc.?
3/25/14	2	LIP	QA Projects			Do LIPs have to do QA projects?
3/25/14	3	LIP	"Incident to" Billing	Service Documentation		As an LCSWA who bills incident-to a psychiatrist, I sign my notes within 24 hours or 7 days. How long does the supervising provider have to sign notes?
3/25/14	4	Complaints	No Complaints on File			If agency has no complaints, how will the agency be monitored in that section?

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3/25/14	5	Complaints	Time Frame	Sample		How far back would I be expected to have complaints available for the review in order for the review team to have a sample of ten complaints?
3/25/14	6	Supervision	Contract Staff	Agency Staff		Are "contracted staff" required to have the same supervision as agency staff?
3/25/14	7	LIP	Medication Review	Outpatient Setting		Does the medication review policy apply to those in an outpatient setting as well?
3/25/14	8	Electronic Health Record	Reviewer Access	Record Access		In the past we were able to provide hard copies. Now we have EHRs. How will this be addressed during monitoring?
3/25/14	9	Routine Monitoring	On-site Monitoring	Pre-site Monitoring		Is all monitoring on-site?
3/25/14	10	Release of Information	Disclosure of Confidential Information	SA/HIV		Are all providers required to have a statement regarding SA and HIV, CFR and do not gather and maintain?

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3/25/14	11	LIP	PCP			Do LIPs have to complete the PCP with a consumer that has a PCP with another agency?
3/25/14	12	LIP	Service Documentation			What specifically will the MCO be looking for in terms of documentation for a person receiving psychotherapy?
3/25/14	13	Implementation Date	Routine Monitoring			When is the start date for Routine Provider Monitoring to begin?
3/25/14	14	LIP	Incident Reporting	Policy/Procedure		Are LIPs required to have policies/procedures to include incident reporting?
3/25/14	15	Sample Selection	Paid Claims	Service Events		Is the sample for the review based on paid claims or service events?

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3/25/14	16	Sample Selection	Service Events	Service Records		Can I expect to need to have available for the review the same number of records as the sample size, for example, 30 individual records)?
3/25/14	17	LIP	Sample Size			What is the sample size for LIPs?

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3/25/14	18	Provider Agencies	Sample Size			What is the sample size for agencies?
3/25/14	19	LIP	Sample Size	Service Events	*	The LIP review tool says 10 records is the sample . . . is it 30 records or 10? Noted in rights notification.

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3/25/14	20	LIP	LIP Review Tool	Provider Agency Tool	*	For LIPs, when is the LIP tool used vs. the Agency Tool?
3/25/14	21	Notification	Sample	On-Site Monitoring		It was stated that a notice will be sent to the provider 3 – 4 weeks before monitoring. How many days prior to monitoring will the provider be notified of the patient names for which records will be reviewed? This process has varied among MCOs in the past.
3/25/14	22	Signature Stamp	Service Notes	Documentation		When there is a typed service note, is it acceptable to use a signature stamp?
3/25/14	23	Exit Conference	Outcome	Notification		Once the review is completed, does the provider know where they stand?
3/25/14	24	Score/Rating	Outcome	Action Taken		What kind of score will providers receive - Pass/Fail, percentage, rating, etc.?

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3/25/14	25	Unsuccessful Performance	Outcome	Action Taken		What happens if a provider does not pass the review?
3/25/14	26	Service Record	Electronic Medical Record	Paper Documents		With the movement towards EMR, what documents are required to be paper in the chart and what can be kept in an electronic format?
3/25/14	27	Medication Review	Physician's Orders	Medication Administration		In regard to a MD order, is an order required for each medication?
3/25/14	28	Medication Review	Sampling			When pulling a random sample, if no medication is provided, do we still need 5 more records?
3/25/14	29	Therapeutic Foster Care	TFC			How will Therapeutic Foster Care with more than one child be monitored?

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3/25/14	30	Therapeutic Foster Care	Post-Payment Review [PPR]	TFC		Will Post-Payment Review [PPRs] be done on TFC?
3/25/14	31	Medication Administration	In Home Services			If services are provided in the person's home, is the provider responsible for medications?
3/25/14	32	Documentation	Alterations	Service Notes		If a service note is typed by the therapist and signed, can a correction be made to service code or duration by Medical Records staff (lined out, correction made, and MR employee initials on correction) after signed by therapist?
3/25/14	33	Psychiatric Residential Treatment Facility	PRTF	Definition		What are PRTFs?
3/25/14	34	Training	Monitoring Staff	LME-MCO		Will MCOs require that all Provider Monitoring/Provider Integrity staff complete Division-led training or will the current collaborative offer training in the future as part of consistency and transparency?

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3/25/14	35	Staff Qualifications	Monitoring Staff	LME-MCO		What are qualifications for reviewers?
3/25/14	36	Gold Star Review	Exclusion	Routine Monitoring		If an agency has been in Gold Star since October are we excluded?
3/25/14	37	Train-the-Trainers	Target Audience	Training		Will the Train-the-Trainer training be open to Provider Agencies or MCO staff only?
3/25/14	38	Gold Star Tools	Routine Monitoring	New Process		If a routine monitoring was completed in December utilizing the old tool, will this count towards routine monitoring for the new tool?

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3/25/14	39	Signatures	PCP	Record Requirements		Can you speak to original signatures on PCPs and what needs to be in the file during the reviews?
3/25/14	40	PCP	Consumer Transfer	Therapeutic Foster Care		As a TFC agency when we complete a PCP for a consumer and that consumer leaves our agency and goes to another TFC agency, are we required to give that PCP to other agency? And can they just update the PCP with their information and use it with the original doctor signature? (i.e., not required to get new doctor signature since same service just different provider). . .We do release the PCP to other agencies but are running into agencies that will not release to us. It is the consumer's PCP – correct? (not to be held by an agency because they were original creators).
3/25/14	41	Referrals	Referral Form	Content		Do referrals need to be in a specific form?
3/25/14	42	Unmanaged Visits	Children	Authorized Visits		Do the 16 max visits for children without prior auth count for visits to see a psychiatrist?
3/25/14	43	Medication Management	E&M Codes	Unmanaged Visits		Do the 16 unmanaged visits include med management?
3/25/14	44	Referrals	STR	Call Center		If a client calls and asks for an appointment and an STR is done, is a referral still needed?

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3/25/14	45	Electronic Health Record	Electronic Signatures	ONC-Approved System		When using an electronic health record, we sign some forms with an electronic pen. In an audit/review, will this be considered handwritten or an electronic signature for the date requirement?
3/25/14	46	Referrals	Documentation	LIP		How should a referral from a LME-MCO or Carolina Access be documented?
3/25/14	47	"New Service"	Service Plan	Service Continuum		What does a “new service” mean?
3/25/14	48	Communication				Will e-mails to the general mailbox be answered?

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3/25/14	49	Rights Notification	Documentation			Rights and Responsibilities are in packet given to the individual and the signature form is in the record. Will this meet the requirement?
3/25/14	50	Release of Information	Documentation			When reviewing consents to release information, what are you comparing against? Are you looking at service notes or just looking to see if there is a consent completed correctly?
3/25/14	51	Referrals	HIPAA	Care Coordination		MD sends referral. We contact client/family to schedule intake appointment. Is it okay to send referral form back (prior to the appointment), saying the appointment has been set, or is that a HIPAA violation?
3/25/14	52	Frequency of Monitoring	Post-Payment Review [PPR]	DHSR		If a provider is licensed and monitored by DHSR, how often would the LME-MCO have to complete post-payment reviews? Would it follow the every two years schedule?

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3/25/14	53	Licensed Services	Exemption	Routine Monitoring		Which licensed services will not be monitored by the LME-MCO on a routine basis?
3/25/14	54	Care Coordination	Documentation	Routine Monitoring		What documentation would a provider need to show coordination of care?
3/25/14	55	Rights Notification	Consent to Treatment	Access to Treatment		For the Rights Notification questions, what is the difference between item #2 and item #3?
3/25/14	56	24/7/365 Coverage	LIP Review Tool	LIP		LIP Tool – Item 7 – They have to provide 24/7/365 – same level as an enhanced service agency?
3/25/14	57	H Codes	LIP	Associate Level Licensed Professionals		Slide 81 [Introductory workshops - February 2014] says H Codes cannot be billed. Provisionally licensed LIPs are currently allowed to bill H codes. Is there any documentation to support this? Please reference this in rule that supports no H codes.
3/25/14	58	Notification	AFL	Health, Safety and Compliance Review		Does the notification time frame requirement [21-28 days] apply to AFL? This would be hard to do.

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3/25/14	59	Notification	Routine Monitoring	Post-Payment Reviews		How will providers be notified of records chosen – US mail, email, fax, phone?
3/25/14	60	Scoring	Routine Monitoring Tool	Restrictive Intervention		Is passing review 85% or higher overall? If you score less than 85% in one area, do you fail the whole review?
3/25/14	61	Freqency of Monitoring	Post-Payment Reviews	DHSR		PPR by LME-MCO for LICENSED facilities - Is that still every 2 years?
3/25/14	62	Staff Qualifications	Training Requirements			Is there a current table or grid covering all the required personnel trainings for all the enhanced services on the Division website? This would be helpful to update annually.
3/25/14	63	Post-Payment Review [PPR]	Comprehensive Clinical Assessments [CCAs]	Diagnostic Assessments [DA]		The PPR tool for Diagnostic Assessment is not for CCAs, only DAs?
3/25/14	64	Therapeutic Foster Care [TFC]	Routine Monitoring	Post-Payment Review		Please confirm that Therapeutic Foster Care [TFC] is not monitored through the LME-MCO? Also, since State DSS does not review TFC for PPR, who will be doing that?

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3/25/14	65	Consent for Treatment	Documentation	Service Plan		Consent for Treatment – This has specific requirements per rule that would not be able to be shown if just the PCP/service plan is signed? Typically, there is a separate consent that includes all the required elements.
3/25/14	66	LIP	Service Order	Associate Level Licensed Professionals		Does the service order need to be signed the day the CCA is completed? Or is it okay to obtain the service order before therapy begins? Can provisionally licensed professionals bill H codes?
3/25/14	67	Electronic Health Record	Paper Records	Documentation		Must we have an electronic records system? Must service notes be entered electronically?
3/25/14	68	Signatures	Documentation	Initials		Service documentation – states “full signature, no initials.” Does this mean not to initial notes or that no initials can be used in the signature? DMA guidance on signatures permits initials as part of the signature.
3/25/14	69	MAR	Documentation	Medication		Medication dosages change often. How often does the MAR in our charts have to be updated?
3/25/14	70	LME-MCO Responsibility	DHSR - Frequency of Surveys	Psychosocial Rehabilitation [PSR]		Do licensed facilities such as PSR have to be monitored? If so, is it done by the LME-MCOs or DHSR?
3/25/14	71	LIP	Outpatient Services	Service Criteria		Where do I find service criteria for outpatient care?

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3/25/14	72	Electronic Signatures	Documentation	ONC-Approved System		Are electronic signatures acceptable?
3/25/14	73	Service Definitions	Navigation			Where are the service definitions?
3/25/14	74	LIP	Crisis Plan	Outpatient Treatment		Is a crisis prevention plan required for outpatient treatment consumers?
3/25/14	75	Electronic Health Record	Documentation	ONC-Approved System		If using electronic medical records, how would I document signatures on notes? Should there always be a hard copy of notes?
3/25/14	76	Signatures	Minors	Legally Responsible Person [LRP]		I will sometimes have older youth sign their treatment plans. I was told that was not allowed, that it had to be an adult. What is your perspective on that?

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3/25/14	77	On-site Review	Unlicensed AFL	Licensed AFL		Are AFL sites visited during the routine monitoring survey?
3/25/14	78	Innovations Waiver	Post-Payment Review [PPR]			DHHS PPR tool for Innovations Waiver service providers - One has 16 items and one has 11 items. Which is correct?
3/25/14	79	Provider Monitoring	Training Manual			Will the workgroup write a Provider Monitoring Manual to assist with training staff to use the tools?
3/25/14	80	LIP	Psychotherapy		*	We provide psychotherapy only. Do we have to follow the agency items?
3/25/14	81	Billing	Reimbursement	Internet Research		Can an agency bill for “researching” on the internet for consumer diagnosis, behavior modification techniques?
3/25/14	82	Service Order	Documentation	LIP		Slide 79/82 [Introductory workshops - February 2014] Service Order signed by whom? What if the individual is receiving outpatient treatment services only?
3/25/14	83	Referrals	Documentation	Verbal Referral		Slide 74 [Introductory workshops - February 2014]: Verbal referral—how do you document this?
3/25/14	84	Billing	Reimbursement	NC-TOPPS		Is there ever a time when completing the NC-TOPPS is billable, i.e., when consumer is already receiving a billable service, e.g., IIH?

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3/25/14	85	Billing	Reimbursement	Minimum Time Requirements		If inclement weather disrupts a service and the service is less than minimum amount of time required, is the amount of time spent billable?
3/25/14	86	Consent for Treatment	Documentation	Verbal Consent		#73: Verbal consent for treatment - If the consumers are not able to sign because they aren't physically in front of you, then what?
3/25/14	87	Billing	Reimbursement	Authorization		If authorization is for 1 unit, and 4 units are provided can we bill for 1 unit?
3/25/14	88	Service Notes	Documentation Time Frames	Working Days		Define working days for late notes. If the agency is closed for business due to weather conditions, are these days considered non-working days.
3/25/14	89	Referrals	Comprehensive Clinical Assessments [CCAs]	LIP		LIP gets a referral from provider agencies for a CCA only. Does the LIP have to produce the documentation of the referral? Do the verbal and written referrals have to have the referral source's name and NPI?
3/25/14	90	Service Order	Unmanaged Visits	LIP		Do service orders have to be obtained while using unmanaged visits for outpatient behavioral health?

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3/25/14	91	Criminal Background Checks	Documentation	Post-Payment Review [PPR]		Criminal Background checks: Only a consent for a state and/or national background check before conditional employment is needed during monitoring, not the actual results from the state and or national background are reviewed?
3/25/14	92	Referrals	Documentation	LIP		Is the referral needed prior to or on first date . . . when does that need to be obtained?
3/25/14	93	Referrals	B-3 Services	Documentation		For B3 services, are referrals by CCNC/CA, physician, primary care provider, the PIHP, or a Medicaid-enrolled psychiatrist required?
3/25/14	94	Referrals	Documentation	LIP		What does the verbal request look like on paper?
3/25/14	95	Off-Site Review	Documentation	Transportation of Records		Can LME-MCOs require providers to bring all records to them?

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3/25/14	96	Referrals	Documentation	LIP	*	Will LIPs be held accountable for the requirement to obtain a referral? This is something we were just made aware of.
3/25/14	97	Provider Requirements	Policy Updates	Communication		There are so many changes. As a provider, how do I keep up with all these changes? Will I be penalized for not knowing about a specific requirement?
3/25/14	98	Licensed Services	DHSR	Post-Payment Review [PPR]		Am I subject to this monitoring process if I am licensed by DHSR?

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3/25/14	99	Electronic Health Record	Signatures	ONC-Approved System		We are moving toward electronic records which provide for electronically signed and dated signatures. Will this be acceptable?
3/25/14	100	Medication Review	Documentation	Drug Regimen Reviews		For drug regimen reviews, does a monthly check with the psychiatrist count?
3/25/14	101	Funds Management	Documentation	Personal Needs		Managing funds – are you talking about $40.00 per month, and does that count for personal needs?
3/25/14	102	Unmanaged Visits	Tracking Service Utilization	LIP		Is there any way to find out how many unmanaged visits have been used?
3/25/14	103	Service Plans	Signatures	LIP		Who signs the LIP treatment plan?
3/25/14	104	Criminal Background Checks	Post-Payment Review [PPR]	Associate Level Licensed Professionals		What about provisionally licensed professionals? Do they need background checks?
3/25/14	105	Notification	Date of On-Site Review	Communication		Will the review date be in the letter of notification from the LME-MCO announcing the review?
3/25/14	106	Score/Rating	Post-Payment Review [POC]	Action Taken		Since the minimum score for passing is 85%, does it mean that a POC will only be required on the PPR tools if the provider scores less than 85%?
3/25/14	107	Physicians	Service Order	Referral		If a physician provides the service, does the physician need a referral and a service order?

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3/25/14	108	Licensed Psychologists	Service Order	Referral		Can a licensed psychologist make their own referral and service order?
3/25/14	109	Phyisican Extenders	Service Order	Referral		Do physician extenders need a referral and service order to provide services?
3/25/14	110	Documentation	Group Notes	Interventions		For group therapy notes, is it acceptable for the “intervention” section to be the same for multiple consumers as long as the “effectiveness” is individualized?
3/25/14	111	Documentation	Service Notes	Progress Towards Goals		When documenting assessment of progress towards goals, is it referring to just the progress during the session or since the start of services?

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3/25/14	112	I/DD	Clinical Supervision	Templates		Are there any resources for clinical supervision training, templates or anything really as it relates to the I/DD?
3/25/14	113	LME-MCO Responsibility	ICF/IID Services	On-Site Monitoring		Will ICF/IDD providers be monitored at all by the MCOs - NO monitoring, no routine, no post-payment? If anybody does any monitoring it will be Licensure?
3/25/14	114	LIP	Office Site Review Tool	New Site		Does the monitoring team complete a site visit when a fully credentialed LIP changes or adds an address?
3/25/14	115	LIP	Referrals	Documentation		How do you provide evidence of referrals for Medicaid clients under the age of 21?
3/25/14	116	Consent for Treatment	Requirements			What makes a valid consent for treatment (what elements need to be there)?

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3/25/14	117	Medication Education	Documentation	Service Record		How do you provide documentation/evidence that the client was educated on medication?
3/25/14	118	Medication Education	Prescribing Physician	Medication Administration		Who had responsibility to provide the med education … for example, if you had a facility that did not prescribe, but did administer, who then had responsibility?
3/25/14	119	Post-Payment Review [PPR]	Optional Items		*	There was an item in the PPR tool listed as optional -- #13 – there were some questions as to why this would be optional. “We do this all the time”

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3/25/14	120	Service Order	Signatures			What does appropriate signature for service order mean? Who can sign?
3/25/14	121	Medication	Samples	Storage		What do you do with “samples of” medication given to the consumer in the psychiatrist's office?

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3/25/14	122	Incident Report Logs	Requirements			After reading the rules 27E .0104 and 27G .0603 & . 0604, what specific parts in the rules cover the log requirement for incident reporting that need to be reviewed during the monitoring and what is required in the log?
3/25/14	123	Restrictive Intervention Logs	Requirements			After reading the rules 27E .0104 and 27G .0603 & . 0604, what specific parts in the rules cover the log requirement for restrictive interventions that need to be reviewed during the monitoring and what is required in the log?
3/25/14	124	Inter-Rater Reliability	Communication			When will there be information regarding inter-rater reliability of the tool?
3/25/14	125	Contested Findings	Reconsideration	Appeal		What is the process of appealing a finding that the provider disagrees with?

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3/25/14	126	National Accreditation				Some inconsistent messages: at the eastern meeting there was discussion re: provider accreditation remaining in place; in the western meeting this week, it was suggested that accreditation requirement was possibly going away.
3/25/14	127	On-Site Monitoring	Record Reviews	Pre-Site Monitoring		Is all monitoring on-site? Have heard that provider monitoring is to occur on-site; in another training it was indicated that all “record” reviews were to occur at the MCO (i.e., we bring the records to them).
3/25/14	128	Service Order	Qualified Professional [QP]	State-Funded Services		Can a QP sign the PCP in the service order section for group living or other state-funded services?

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3/25/14	129	Consent for Treatment	Service Plan	Signatures		In reference to treatment plans being signed by client or parent of client vs consent for treatment, please reference the policy/procedure that addresses this. Also, how long has this practice been acceptable?

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5/14/14	130	LIP	Training Requirements	Outpatient Treatment		I have a question in regards to the personnel files and trainings required for persons who only conduct medication management and outpatient or psychotherapy. There is no information on the monitoring tools regarding this.
5/14/14	131	LIP	Medication Management	Outpatient Treatment		For those agencies that only provide medication management and outpatient or psychotherapy services, are those agencies to go by the LIP monitoring checklist?
5/14/14	132	Incident Reporting	Sampling	Sample Size		Reviewers will look at the last year of complaints from their catchment and pull up to ten (if there are that many), is that correct?

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5/14/14	133	LIP	Consent to Treatment	Access to Treatment		I understand that these same questions are on the LIP tool and the Agency tool and that Item # 2 speaks to the individual's right to consent to or refuse treatment [decision to accept treatment]; item # 3 speaks to the individual's right to receive treatment [access] whether for medical or behavioral health issues. What I would specifically like to know is whether or not as an outpatient mental health provider I need to include anything about the right to access medical services other that behavioral services?
5/14/14	134	Notification of Rights	Access to Medical Care	Access to Treatment		How should a mental health agency that does not provide medical care inform clients of their rights to medical care?
5/14/14	135	Unmanaged Visits	Service Authorization			How are providers supposed to know for sure how many unmanaged visits remain? Are those visits just for that one provider or shared?

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5/14/14	136	LIP	Telemedicine, Telepsychiatry, Telehealth	Prior authorization		Are agencies required to have prior approval from an MCO to provide Telehealth or are they able to bill using the codes listed in the policy just as they would with a face-to-face service?
5/14/14	137	LIP	Telemedicine, Telepsychiatry, Telehealth	Provider Type		As an independent practitioner, what kind of approval would I need to provide telehealth independently?
5/14/14	138	Care Coordination	LIP	Provider Agencies		Is care coordination billable?

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5/14/14	139	Training	Transition from Gold Star			Is this training replacing the Gold Star Monitoring system? If we attended training for Gold Star, is this training necessary?
5/14/14	140	Training	Webinars			Which trainings have space available?
5/14/14	141	Frequency of Monitoring	Transition from Gold Star	Lead LME-MCO		Our agency was previously monitored extensively by an MCO (not the lead LME-MCO) utilizing the full Gold Star tools. How will this be factored or accepted by the lead LME-MCO? Before the monitoring was accomplished, we were authoritatively informed that this would count for our review. The lead LME-MCO has also requested a copy of the results of the review.

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5/14/14	142	Frequency of Monitoring	Transition from Gold Star	Advanced Placement		If a provider has already undergone monitoring under the previously used tools within the last six months, will they be required to go through the monitoring process again prior to the two year routine audit process?

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5/14/14	143	Medication Administration	Self-Administration	Rights		We provide ADVP services in a CRP setting and do not administer medication. Some of our consumers have legal guardians but most are their own guardians. We were advised by an MCO representative of your workgroup that our medication policy (which has previously been acceptable in the monitoring process) may be inadequate because we do not address self-administration of meds any further than the statement below. Our current policy simply reads: "The staff of DOI does not administer, handle or store any type of medication. If it is necessary for a consumer to take medication during business hours and the consumer is not capable of self administration, an appropriate family member, group home representative, guardian, etc. may come to the facility to assist the consumer in this procedure." And our consumer handbook has the following: Medication: It is important for YOU to let Program Staff know what medicines YOU take. The staff of DOI does not administer, handle or store any type of medication. If it is necessary for YOU to take medication during business hours and YOU are not capable of self-administration, a designated family member, group home representative, guardian, etc. my come to the facility to assist YOU in this procedure. Could you please advise as we do not want to infringe on consumer's rights. Specifically, do we have the right to treat a person with a disability differently by requiring that they present us with documentation stating that they are capable of self administration when this is not required of non-disabled persons? If so, is this policy/handbook inadequate? Could you please advise?

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5/14/14	144	Health, Safety & Compliance Review	Unlicensed Services	Duplication		Under what circumstances is the “Health, Safety, & Compliance Tool for Initial Reviews” supposed to be completed? For current providers for whom this tool has never been completed? For providers adding a site (as a part of the credentialing process)? For providers adding a service at an existing site? Considering the items, it doesn’t seem to make sense to complete this worksheet for licensed facilities as the items would duplicate what DHSR reviews. Is the tool intended to be used for licensed facilities?
5/14/14	145	Referrals	Children	Adults		Does the NPI # for referrals refer to just children services, or is it required for adult, non-self referrals also?

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5/14/14	146	Electronic Format	Navigation	Review Tools		Would you please send me a copy of the new provider monitoring tool? For some reason I cannot access this information.
5/14/14	147	Outpatient Clinics	Medication Management	Medication Samples		A question was raised at the CoastalCare provider network meeting: for outpatient clinics who might handle med management or hand out samples, what level or kind of applicability of monitoring is to occur or be handled by the LME MCO?
5/14/14	148	Acronyms	PowerPoint Presentations	Training		If a PowerPoint/presentation [Introductory workshops - February 2014] is going to include acronyms it would be helpful to have a slide that includes all the acronyms referenced in the presentation and the full spelling of the words to which the acronyms refer.

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5/14/14	149	Acronyms	Level of Care Criteria			What do the acronyms in the PowerPoint presentation mean - CALOCUS, LOCUS, CASII, ASAM?
5/14/14	150	Opioid Treatment	E&M Codes	Post-Payment Review		My medical practice is entirely focused on the provision of evaluation and management services for patients with Opioid Dependence. I wanted to know if my colleagues in Family Practice, Internal Medicine, OB-GYN have to provide the same data to the DMA as I am supposed to provide for the LME-MCOs.
5/14/14	151	Rights Notification	Access to Medical Care			The new audit tool states that providers must “inform the individual of right to treatment including access to medical care.” If I’m a MH agency that does not provide medical care, how do we meet this criteria?
5/14/14	152	Unmanaged Visits	Prior Authorization			How are unmanaged visits supposed to be verified? Are those visits just for a single provider or shared among several?

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5/14/14	153	FAQs	Navigation	Web Posting		I attended one of the workshop sessions and wanted to know how I would see the answers to the various questions? Please direct me to the appropriate site where the questions with the answers are listed.
5/14/14	154	FAQs	Navigation	Web Posting		Please advise me as to where to go to look at answers to questions submitted by providers during the workshops that were held across the state.
5/14/14	155	Innovations Waiver	Person-Centered Thinking	Training		Is Person-Centered Thinking a required training for Innovations Waiver staff since it is not listed on any of the service definitions we provide (Inhome Skillbuilding, Personal Care, Respite, Specialized Consultative Services, or Natural Supports Education). The definitions do state the staff requirements and list CPR/ First Aid but do not list PCT or NCI. The only definition that lists NCI is Crisis Services.
5/14/14	156	Consent for Treatment	Documentation	Requirements		What constitutes a valid consent for treatment?

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5/14/14	157	Service Order	State-Funded Services	Signatures		What does appropriate signature for Service order mean? Who can sign? Can a QP sign the PCP in the service order section for group living or other state-funded services?

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5/14/14	158	Self-Audit	Navigation	ADVP		We operate an Adult Developmental Vocational Program. I am looking for a monitoring tool checklist so we can make sure we have everything in place when we are monitored. At this time we have not been scheduled for a monitoring visit, but want to be prepared. I have looked on line for monitoring tools but could not find one.
5/14/14	159	Tool Automation	Navigation	Guidelines		On the Provider Monitoring Guidelines page where the instructions are to double click the Adobe icon, the link seems to be corrupt. I have tried to open the link on three different computers and I am getting a message "cannot start the source application for this image, there may not be enough memory to open" My supervisor drug the icon to his desktop and says it is an image only, not a document. Can you please advise if I need to do something differently?

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5/14/14	160	Medication Review	Change in Dosage	Residential Substance Abuse Facility		We are a residential substance abuse facility for adults and adolescents. Based on the medication review sheet, it states “medication label matches order”. This is not always true for us. A client may come in on a medication and during his time in treatment the dosage changes. Example: Take one twice a day. Family doctor increases order stating Take one three times a day. While the doctor does fax us this signed order, we have no way to change the label. Will we be faulted for “medication label matching order”?
5/14/14	161	Medication Review	Sample Medications	Residential Substance Abuse Facility		We are a residential substance abuse facility for adults and adolescents. A client is admitted to Swain and they bring 4 boxes of sample medications, all the same. However there is no label on these samples. We do have a written signed med order for these, just no label on boxes. In past we have been told we cannot “put a label on these” because we cannot label medication. Is this correct?
5/14/14	162	FAQs	Navigation			Where do I find the frequently asked questions to review?
5/14/14	163	Contracts with Multiple LME-MCOs	Single Review	Administrative Burden		Since the new provider monitoring tool is now standardized and uniform for all MCO, can DHHS please consider conducting only 1 review for those agencies that have multiple contracts? Currently, our agency has contracts with 4 MCO's, and for us to have to complete 4 reviews is labor intensive and an administrative burden on our staff.

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5/14/14	164	Typographical Errors	Updated Tools		*	We are using the link provided in the 2/4/14 Joint Communication Bulletin. The ppt. presentation is current – updated 2/26/14, but the monitoring tools for provider agencies had references to Gold Star Monitoring and tools dated 2/2013 or earlier. Are new tools available and posted? Am I missing something? Please advise.
5/14/14	165	Release of Information	Disclosure of Confidential Information	Rights Notification		We provide Day Supports to I/DD individuals using IPRS funds only. Regarding Item #5 on the monitoring tool, the PowerPoint handout says that on the Authorizations to release information sheet agencies "must include a statement regarding the protection of HIV and SA information and disclosure requirements under 42 CFR Part 2". I am unclear as to how the statement should be phrased and I want to make sure that the required information is included. Do you have any suggestions or guidance regarding a statement that would cover the required information?

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5/14/14	166	Rights Notification	Policy Revisions	Time Frames		My agency has a comprehensive Rights Policy that clients and/or legally responsible person (LRP) reviews and signs. On the new provider monitoring tool, we have discovered 2 items we need to add to our policy to meet "met". The items are: 1. how to obtain a copy of one's service plan 2. right to individualized written treatment plan and right to access medical care. We are revising the Rights Policy to include those 2 items. When we are monitored, will we be marked as "met" if we have implemented the revised policy, but all clients and LRPs haven't signed the revised policy? In other words, the revised policy is not in all files at the time of the monitoring, but we show the revised policy is being signed at the next face to face supervision with the client and LRP?
5/14/14	167	Rights Notification	Time Frame			Bullet # 3 on Slide 32 [Introductory workshops - February 2014] is not clear. I read it to say the information re: rights policy is to be provided to clients/LRP within 3 visits (required of all providers); however, for residential providers within 72 hours.....

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5/14/14	168	Post-Payment Review [PPR]	Routine Monitoring	Targeted Reviews		I thought the new Routine monitoring process would not require a PPR to be completed for each Routine Monitoring. I don't see anything that determines that a PPR is NOT completed at each Routine Monitoring. If the intent is that the PPR is NOT to be completed each time, how will we know when to use or not to use?

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5/14/14	169	Referrals	Service Authorization	Unmanaged Visits		Regarding Out Patient Behavioral Health, I question whether Licensed Therapists need to have a referral for the unmanaged sessions. That information was not correct. Not only this, but the number of unmanaged sessions was recently increased from 8/16 to 24 (for all consumers) at the LME-MCO that I contract with. I talked with Provider Relations and it was confirmed that we do not need a referral for unmanaged sessions since there is a closed network. 8C also clearly states this. It is only after the initial unmanaged sessions, that a written referral is required.
5/14/14	170	Medication Review	LIP			The PowerPoint presentation [Introductory workshops - February 2014] indicates the end of the LIP portion and launches into other issues including Medications. Medical Doctors are also LIPs. Does the medication information apply to MDs?

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5/14/14	171	FAQs	Navigation			During the collaboration workshops in Durham, we were furnished note cards to ask questions. We were told there would be answers posted on the website by March 1. I have reviewed all of the pages and cannot find the section with Q/A. Can you please provide the address for this?
5/14/14	172	Application Policy & Procedure Review	Provider Enrollment			I am unable to pull up a copy of the Policy and Procedure Review Tool on the DHHS website. When I type in the link provided by in my routine monitoring letter it states the file specified cannot be located.
5/14/14	173	EPSDT	Medicaid-Funded Services			Are services under the 1915 (b)(c) waiver subject to EPSDT for Medicaid-eligible children?

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5/14/14	174	Medication Review	Home-Based Services	Medication Administration Record (MAR)		In the training sessions and PowerPoint for Routine Monitoring, there is information about what is required for medication administration for residential facilities. However, it isn't clear what is needed for agencies that do not do residential. For agencies who only provide services to individuals who live in their own home, do we need to have anything in writing from the physician prior to giving meds and/or nutritional supplements? We train all staff in medication administration annually and have them complete a MAR for any meds given. What I cannot find anywhere in writing is exactly what we need to have, if anything, from the physician.
5/14/14	175	Service Order	LIP	Documentation		Question 108 states: "Can a licensed psychologist make their own referral and service order?" Answer: "No. Per CCP 8C, physicians are the only practitioners that are exempt from the requirement of needing a referral or a service order to provide treatment. A licensed psychologist would need to obtain a referral and service order for the services the psychologist provides." I understand a PhD Licensed Psychologist needs a referral for an individual under 21 years of age but the requirement for a Service Order for outpatient/basic services is inconsistent with 8-C. Licensed Psychologist (PhD) are authorized to sign Service Orders for basic benefits so why would we now need a Service Order?

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5/14/14	176	Referrals	State-Funded Services	Documentation		On slide 74 of the revised 2/26/14 “An Introduction to Routing Monitoring of MH/DD/SA Providers by LME/MCOs”, does the item“ Is there a referral from an approved source prior to the date of service, if applicable” refer to State Funded services, such as Developmental Therapy H2014HM and Personal Assistance YP020?
5/14/14	177	Unmanaged Visits	Documentation	LIP		Do the documentation requirements only apply after a consumer has been authorized? If a client is only utilizing their unmanaged units, what exactly is required for the temporary service? Do you all provide templates for each of the documents required?
5/14/14	178					
5/14/14	179	Service Plans	Time Frame	Documentation	*	I have a question regarding the timeframe for LIP providing outpatient treatment to complete a Service Plan. The guidelines for the monitoring tool state, “The individualized PCP/Service Plan is required by the end of the first unit of service…” The CCP 8C states, “7.3.4 Individualized Plan - An individualized plan of care, service plan, treatment plan, or PCP, hereinafter referred to as “plan,” consistent with and supportive of the service provided and within professional standards of practice, is required within 15 business days of the first face-to-face beneficiary contact.”

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5/14/14	180	Notification of Tool Revisions	Record Release Checklist	HIV/AIDS Information	*	My team had a routine monitoring this week and had been preparing the information for the review over the past few weeks. When the team arrived for the monitoring on 4/28/14 and accessed the tool from the website, it was discovered that two additional questions (10 and 11) had been added to the record release tool related to substance use and HIV. When were these questions added to the review tool? Is there going to be information disseminated to us regarding this recent change? How are MCOs to get these updates?
5/14/14	181	Transition from Gold Star	Frequency	LIP		I am an LIP and was audited by Sandhills Center last year. I received a 100% compliance. I have been notified that I am being audited again less than a year later. Are the reviews supposed to be every two years? How do I address this without compromising my contract?

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5/14/14	182	LIP	Personnel Files	Training		I have a question in regards to the personnel files and trainings required for persons who only conduct medication management and outpatient or psychotherapy. There is no information on the monitoring tools regarding this. Also, are those agencies to go by the LIP monitoring checklist? This information is a little unclear. I have reviewed the frequently asked questions. I'm not sure if I've missed something in the interpretation or not.
5/14/14	183	Consent for Treatment	Access to Treatment			I understand that these same questions are on the LIP tool and the Agency tool and that Item # 2 speaks to the individual's right to consent to or refuse treatment [decision to accept treatment]; item # 3 speaks to the individual's right to receive treatment [access] whether for medical or behavioral health issues. What I would specifically like to know is whether or not as an outpatient mental health provider I need to include anything about the right to access medical services other that behavioral services?
5/14/14	184	LIP	Primary Care Physician's Office	LIP Review Tool		Will the LIP review tools apply to clinicians working in primary care physicians offices?

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5/14/14	185	LIP	Integrated Care Practices	LIP Review Tool		Will the LIP review tools apply for CCNC or integrative care grants which are been so aggressively promoted in our state? If the answer is no, please explain the double standards?
5/14/14	186	LIP	Duplication	Oversight by Licensure Boards		LIPs are already being monitored by NC DMA and their respective licensing boards, is this creating another layer of bureaucracy to discourage solo-private practitioners to practice?
5/14/14	187	Rural Areas	Provider Shortage Areas			Has the provider monitoring committee considered the negative implications these rules will have on rural areas or provider shortage areas?

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5/14/14	188	Innovations Waiver	PCP Thinking	Staff Qualifications		I have a question regarding the Provider Monitoring, Innovations Staff Qualifications Tool. The tool lists PCP Thinking, which was part of CAP-MR/DD Core Competency Training in the past, as part of the Innovations Staff Qualification. We are unable to find anything current in writing that this is a required training for Innovations staff and we have looked at everything (8P, Innovations Manual, Innovations Service Definitions, State site, implementation updates, etc.). Was there ever written documentation from the State clarifying that Innovations requires person centered thinking, the number of hours that are needed, etc.? I know that there was recent clarification regarding the 12 hour person centered thinking required for CABHA's/Enhanced services, and that Implementation Update # 86 (2011) still stands, but I cannot find anything regarding Innovations Person Centered Thinking. Any feedback or insight you could provide, would be most appreciated. Thanks.
5/14/14	189	Routine Monitoring	Written Manual			Will there be a written process and/or manual developed to address the updated Provider Monitoring Process

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5/14/14	190	ICF/IID Facilities	LME-MCO Responsibility	DHSR Responsibility		It is my understanding that the LME-MCO's will no longer monitor ICF/IDD residential facilities. To be clear, can you please confirm that I am understanding it correctly, that the LME-MCO's will not complete the routine monitoring tool and also will not complete the post payment tool for ICF/IDD residential facilities? What I am understanding about the new process following the revision of the monitoring tools is that any issues or complaints regarding ICF/IDD facilities will be referred to DHSR licensure for them to investigate. Is that correct?
5/14/14	191	Optional Questions	Post-Payment Review (PPR)	Standardization		There are questions on both the Generic PPR Tool and the Innovations tools where there is a statement that some questions are optional. Does that mean that some MCO's may choose not to ask these questions? It appears in order to have standardization of these reviews, and the importance of these questions i.e. "Does the documentation indicate that the requirements of the service definition/rule were met?" I think either all MCOs ask this question or none. There are 4 other questions on the attachment that need to be standard questions that all MCOs ask take off the tool.

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5/14/14	192	Documentation of Additional Sample	Individual Records List		*	The overall spread sheet only allows for 30 consumers. How are we to add consumers if additional records need to be pulled to meet the 5 medication and 5 funds management requirements? (if we do not get these numbers out of our initial random pull) I recommend if we are doing a random sample of 30 charts, if we get 5 clients that are receiving medication management, then good, and if we get less than 5 in the 30 that we pulled, then we don't need to pull any additional charts.
5/14/14	193	I/DD Services	State-Funded Services			For provider monitoring, we need to be clear whether or not state-funded (not Innovations) I/DD services are included.
5/14/14	194	Referrals	LIP Review Tool	Agency Review Tool		Slide 74 of the PowerPoint for the Introductory workshops - February 2014 states, "Is there a referral from an approved source prior to the date of service, if applicable?" But it only lists the location of this item within the LIP monitoring tool. At the routine monitoring workshop, the facilitators made it seem as though this would a requirement for agencies that provide outpatient as well.

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5/14/14	195	Generic Post-Payment Review Tool	Staff Qualifications			Are the staff questions in the generic post payment tool to cover all personnel questions except for the service specific tools?
5/14/14	196	Emergency Information	Health, Safety and Compliance Review Tool	Unlicensed AFL Review Tool		Emergency information, first aid, CPR, and poison control protocol or numbers are posted or easily accessible for staff and individuals to utilize. 10A NCAC 27G .0207 (b) The plan shall be made available to all staff and evacuation procedures and routes shall be posted in the facility. (d) Each facility shall have basic first aid supplies accessible for use. We are an office who does primarily MST but has some OPT therapy appointments held on site. What is meant by protocol? Are we supposed to have protocols for First aid CPR, etc. posted or just the numbers?
5/14/14	197	Referrals	ICF/IID Facilities			For Children under 21, having verbal and written referral from CNC Access, LME-MCO, or Medicaid Enrolled Psychiatrist. Does this refer to ICF/IID services? What services does this apply to?

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5/14/14	198	Internal Quality Assurance	Test Data	Review Tools		The monitoring tools indicate “test tools,” are these the instruments that we should use for internal auditing or will other tools be available?

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5/14/14	199	Audit Period	Sample Selection	Sample Size		Number of events to be monitored when a LIP receives notice of a review? And specifically- My remembrance is that the window for selection is three months forward from a date six months prior to the date of the review????? I.E., Date of review December 30th so window of opportunity is July 30 -October 30? Paid services within that window would be subject to review? Or paid services and then the charts for those persons would be up for review? Ten charts, ten paid services??? And perhaps I am misremembering the number ten.

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5/14/14	200	Multiple LME-MCO Reviews	Post-Payment Reviews (PRR)	Routine Monitoring		What is the status of multiple MCOs monitoring one provider?
5/14/14	201	Training	Webinars		*	At a recent statewide training regarding new monitoring tools, it was announced that there will be webinars made available to staff, does anyone know when?
5/14/14	202	Provider Advancement	PEGS Status	Incentives		Are there any updates for the Gold Star monitoring status and will there be new incentives?
5/14/14	203	LIP Review Tools	Documentation	Service Events	*	Currently the LIP Post-Payment Review Tool does not include room for 30 events when you are reviewing an agency that is made up solely of LIPs and only delivers outpatient services. Due to this, the overall summary cannot be tabulated with final results. Is there any time frame for this to be corrected?

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5/14/14	204	Health, Safety and Compliance Review Tool	Unlicensed AFL Review Tool			Slide 125 [NC TIDE Conference] talked about the initial Health and Safety review checklist that providers are responsible for. When, if at all, is the provider required to submit this to the LME-MCO? Would this checklist be submitted to the LME-MCO prior to conducting a site review and prior to placement of a consumer in an unlicensed AFL?
5/14/14	205	Post-Payment Review [PPR]	PCP Due Date			On the Post-Payment tool, item #4 indicates the Plan is due by the first unit of service. Clinical coverage Policy 8C, 7.3.4, says within 15 business days. Which is to be followed?
5/14/14	206	Routine Agency Tool	Workbook	Incidents, Restrictive Interventions and Complaints	*	In reviewing the routine monitoring tool, the numbers horizontally across the spreadsheet represent information on a member, so if information is randomly being selected to address incidents, restrictive interventions and complaints, how will this information affect information regarding the noted members chosen for the record review, how is this information separated out since the reports may not apply to the members being reviewed for the record review.
5/14/14	207	Innovations PPR Tool	Guidelines	Omitted Guideline	*	On the Innovations PPR Tool, there is a number 2 but the guidelines skip this question. This is throwing the corresponding numbers off.

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5/14/14	208	Incident Reporting	Sampling			Reviewers will look at the last year of complaints from their catchment and pull up to ten (if there are that many), is that correct?
5/14/14	209	Routine Review Tool	Unlicensed AFL Services			My agency provides Unlicensed AFL services in addition to other IDD services. For routine monitoring, which tool will be used?
5/14/14	210	Routine Review Tool	Unlicensed AFL Services			For a routine review that involves Unlicensed AFL services, is the routine review tool used.
5/14/14	211	Audit Period	Sample Selection			What is the rationale for going back six months and then counting forward 90 days? Wouldn't it be simpler to just randomly select from the last 90 days? Counting backwards is very confusing!
5/14/14	212	LOCUS/CALOCUS	Training Requirements	Documentation		Do all staff have to have CALOCUS/LOCUS training in a personnel record?
5/14/14	213	LOCUS/CALOCUS	Training Requirements	Certification		Does LOCUS/CALOCUS training have to be done by a certified LOCUS/CALOCUS trainer?
5/14/14	214	ASAM	LOCUS/CALOCUS			Can ASAM be completed in lieu of LOCUS/CALOCUS?

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5/14/14	215	LOCUS/CALOCUS	Service Authorization	ITR		Do LIPs have to do a LOCUS/CALOCUS on consumers if there is no need for an ITR?
5/14/14	216	LOCUS/CALOCUS	Service Authorization	LIP		Does the LIP have to do a LOCUS/CALOCUS?
5/14/14	217	Special Health Care Needs Population	LOCUS/CALOCUS			What is a special health care needs population?
5/14/14	218	CALOCUS	CASII			What is the difference between the CASII and the CALOCUS?
5/14/14	219	LOCUS/CALOCUS	Required Time Frame	Service Authorization		At what point is the LOCUS/CALOCUS required -- prior to service provision, prior to service authorization or before or after unmanaged visits have been used up?

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Date Posted		Primary Keyword	Related Keyword	Related Keyword	*	Question
5/14/14	220	Medication Education	Responsibility of Prescribing Physician	Responsibility of Provider Agency		Can you please clarify the following as to which is correct regarding medication education? Here is what it states in 10A NCAC 27G.0209(g)(1): Medication education: Each client started or maintained **by an area program physician** shall receive either oral or written education regarding the prescribed medication by the physician or their designee. In instances where the ability of the client to understand the education is questionable, a responsible person shall be provided either oral or written instructions on behalf of the client. Here is what the PowerPoint states: (May 1, 2014 edition): Sample size is same 5 records from Item 14. * Documentation of medication education provided to the individual/LRP should be reviewed for each prescribed or over-the-counter medication **if ordered by the agency physician**. And finally this is what the monitoring worksheet states: For each service recipient receiving medication, the service recipient/legally responsible party shall receive education regarding the medication prescribed. All instances of medication education are documented by staff. [This item is automatically scored based on results from the Medication Review worksheet].

FREQUENTLY ASKED QUESTIONS ABOUT DHHS ROUTI

May 14, 2014

Topical Index

Date Posted		Primary Keyword	Related Keyword	Related Keyword	*	Question
5/14/14	221	Comprehensive Clinical Assessment	Level of Care	LIP Post-Payment Review Tool		Would #14 on the LIP PPR tool [Do the results of the Comprehensive Clinical Assessment [CCA] support the level of care [CALOCUS/CASII/LOCUS/ASAM] for the treatment service recommended?] be N/A since LOCUS/CALOCUS is not required unless ITR is necessary?
5/14/14	222	FAQs	Web Postings			How often are the questions submitted uploaded online? It appears from the dates on the Excel document that only one upload has occurred?
5/14/14	223	Local Monitoring	National Accreditation	Deemed Status		How does deemed status and provider monitoring meet? If an agency is nationally accredited, why must we be monitored by an MCO as well?

FREQUENTLY ASKED QUESTIONS ABOUT DHHS ROUTI

May 14, 2014

Topical Index

Date Posted		Primary Keyword	Related Keyword	Related Keyword	*	Question
5/14/14	224	Coordination of Care	Day Programs			How do providers, especially day programs who are not involved with primary care physicians, demonstrate integrated care? With care coordinators having a more limited role, who is responsible for communicating the necessary information?
5/14/14	225	Medication Review Requirements	Independent Living	Medication Administration		Is our agency responsible for an individual and family members completing a MAR when the medication is administered in the person's non-licensed apartment or in their own home?
5/14/14	226	Tool Revisions	Updates		*	Provider monitoring is still changing despite the state's commitment to a 6-month freeze on changes. Four changes were made in April and significant changes were added to questions.

FREQUENTLY ASKED QUESTIONS ABOUT DHHS ROUTI

May 14, 2014

Topical Index

Date Posted		Primary Keyword	Related Keyword	Related Keyword	*	Question
5/14/14	227	Communication	Updates	Announcements		How are we to know when changes in the process have been made? Providers and MCOs are expected to periodically check the web page. Unless something new has been posted, we still don't know what changes have been made.
5/14/14	228	Outpatient Therapists	Staff Qualifications			I am still having trouble monitoring outpatient therapists/visits in an agency. There is no way to document staffing qualifications except under the LIP provider tool.

NE PROVIDER MONITORING

Answer
The slide [Introductory workshops - February 2014] is referencing Q13 from the DHHS Post Payment Review Tool for Licensed Independent Practitioner (LIPs) rather than the LIP Review Tool. For LIPs, staff qualifications to provide a service is determined at the credentialing level. As long as the LIP is practicing within their scope of practice and the LIP is in good standing with their licensure board, documentation of training would only be required if the service provided has specific training requirements.
No. There is not a requirement per rule for QA projects to be completed. Completion of QA projects is at the discretion of the provider.
In order for a service to be billable, the note must be written or dictated in accordance with guidance from the Records Management and Documentation Manual (APSM 45-2) and documented by the staff who provided the service. The supervising provider's responsibilities are outlined in the Medicaid Bulletin dated March 2009 - Behavioral Health Services Provided by Provisionally Licensed Professionals in Physician Offices. For reimbursement purposes, the signature of the person who provided the service is required. Some agencies require that notes of paraprofessionals, associate professionals or provisionally licensed individuals are co-signed as a means of indicating that clinical supervision occurred. Co-signing notes is not a requirement of the state. If requiring the supervising provider to co-sign your notes is a part of the supervision agreement, you would be expected to comply with the stipulations, timelines and procedures outlined in that agreement.
The LME-MCO will go back one year to obtain a sample of complaints to review. If there are no complaints received in that time period, this item will be scored as Not Applicable (N/A).

NE PROVIDER MONITORING

Answer
The review involves a random sample of ten complaints that were incurred over the past year. The reviewer will go back up to one year from the date of the on-site to try to obtain a sample of ten complaints. If, over that time period, there are fewer than ten complaints, the monitoring team will review those complaints that have been received.
You do not make a distinction between clinical supervision and administrative supervision. In terms of clinical supervision, if the person's level of experience and qualifications (e.g., a paraprofessional or associate professional or licensure status) or the type service provided requires clinical supervision, the provider must ensure and document that clinical supervision is provided whether the person providing the service is "contract staff" or agency staff. The requirement for administrative supervision depends on the provisions of the contract and agency policy.
This requirement is not applicable (N/A) for LIPs since LIPs would not be administering or dispensing medications unless there is a MD in the group.
Reviewers should be given access to the EHRs in order to complete the record reviews. They may also request to print copies of some documents for verification of identified out-of-compliance issues.
The majority of the routine review is conducted on-site, especially those aspects that involve record reviews. There are some pre-site activities that are done by the LME-MCO via desk review prior to the on-site (e.g., review of Level II and Level III incidents in IRIS or a request to submit policies and procedures before the on-site).
Authorizations to release information are specific and must include a statement regarding the protection of HIV and SA information and disclosure requirements under 42 CFR Part 2. This is applicable to all providers of all services. Authorizations are to be completed at the time of the request for release/disclosure and are not to be signed and placed in the chart prior to the specific request.

NE PROVIDER MONITORING

Answer
LIPs working with consumers who are receiving enhanced services should be included in PCP. If the LIP is working independently and the consumer is not receiving enhanced services, the PCP is not required.
The basic requirements for documentation are addressed in the Records Management and Documentation Manual (APSM 45-2), which include a service note, service plan and on each page name, number, the goal(s) addressed during the visit, the individual's response to the intervention; the note should be signed and dated, the credentials of the therapist should be noted and the duration of the service should be noted.
The implementation date for the new routine provider monitoring tools is March 1, 2014.
LIPs performing basic benefit services are not subject to the IRIS reporting requirements. Incidents for these practitioners are reported to, investigated and handled by the appropriate licensing board. For LIPs that work in an agency setting where other MH/IDD/SA services are provided and the agency is subject to IRIS reporting, the agency is required to have policies and procedures for handling incidents.
The sample is based on service events where the records chosen for the review are based on certain criteria. For the most part, the sample is based on paid claims. Each paid claim represents a service event. There are other items where the sample is selected from a pool of records where certain specific activities occurred (e.g., medication review, funds management, complaints, incidents, restrictive interventions).

NE PROVIDER MONITORING

Answer

The number of service records would only equal the sample size if only one service event was included in the sample for each individual. However, usually a sample contains multiple events for the same individual, thereby reducing the number of individual records in the sample as a whole. For example:

* For a solo LIP practice where the sample size is 10, the 10 paid claims (i.e., service events) may only involve 4 records because the sample only involve 4 individuals where number of service events in the sample for each individual was 4, 3, 2 and 1 respectively or

* The number of records involved in the review of a provider agency was 9 -- there were 5 service events selected for 2 people, 4 service events selected for 3 people, and 2 service events for 4 people.

For incidents, complaints, restrictive interventions, medication review, funds management and protection of property, the sample is based on individuals for whom these activities occurred. These for the most part are individual records or events.

The LIP Review Tool is designed for practices where basic benefit (outpatient) services only are provided.

The sample size is 10 service events for LIPs in solo practice or for LIPs in a group practice where each LIP has a separate contract with the LME-MCO and bills under their own provider number.

The sample size for a group practice where all the LIPs bill under the group provider number is 30.

NE PROVIDER MONITORING

Answer
The agency tool is used for agencies, including CABHAs, that provide enhanced services or a variety of state and/or Medicaid-funded services. The sample size for provider agencies is 30 service events. Some of the events in the sample for provider agencies are selected on the basis of having met certain criteria based on whether those services, interventions, or activities are applicable to the agency (e.g., medication review, funds management, restrictive interventions).
As a point of clarification, the sample size is based on paid claims (i.e., service events) -- not on individual service records. The number of service events reviewed for a LIP practice is determined by whether the LIP is in a solo practice or a group practice where each LIP in that group bills under the same provider number. The sample size for a LIP in a solo practice is 10 service events. The sample size for a group of LIPs who bill under the same billing provider number is 30 service events. In those cases where a group of LIPs share the same office space but each of them has their own billing provider number (i.e., each LIP has a separate contract with the LME-MCO), the sample size for each LIP is 10 service events. For LIPs that provide services in a setting where other enhanced services are provided (e.g., a CABHA), the services provided by the LIP are included in the billing by the agency where the sample size for the agency is 30 service events.

NE PROVIDER MONITORING

Answer
The LIP Review Tool is used for an LIP in a solo practice or LIPs in a group practice when only basic benefit (outpatient) services are provided. The Provider Agency Review Tool is used when a LIP is a part of an agency that provides other enhanced services (e.g., a CABHA).
Provider agencies and LIPs will be notified of the specific service records needed for review no less than 5 business days prior to the date of review.
No, the signature must be the actual handwritten signature of the person writing the note. CMS does not allow the use of rubber stamps except in the case of ADA-approved accommodations. Signatures must also be hand-dated with the date the note was written, not typed in or stamped. Refer to APSM 45-2 – Chapter 9 -4.
The purpose of the exit conference is to give the provider general feedback on trends noted including major areas of non-compliance where follow-up in terms of a plan of correction or technical assistance may be required. The review team will not be able to give the provider an exact score during the exit conference. They will need to review the findings. The provider will receive a formal report within 15 calendar days of the conclusion of the on-site review.
The threshold for passing the review is a minimum overall score of 85% on the routine and post-payment review. On the routine tool, the provider must achieve a score of 85% on each section of the tool in order to pass that section. The only exception is for the Incidents, Complaints and Restrictive Intervention section of the routine agency tool where if a provider fails the restrictive intervention item, the provider fails that entire section. In order for that provider to attain an overall score of 85%, the provider must perform exceptionally well on all other sections of the tool.

NE PROVIDER MONITORING

Answer
If the provider has an unsuccessful outcome, one or more of the following dispositions may occur, specific to individual LME-MCO policy: Technical Assistance Plan of Correction Recoupment (for Post-Payment Reviews only) Targeted Investigation Referral to an Internal Review Committee within the LME-MCO to determine the provider's status LME-MCOs will inform providers and LIPs of their process for appeal or reconsideration.
This will be determined by the system that is used, whether it is a hybrid system where both paper documents and documents in electronic format are used or a full electronic system where all documents are either originated electronically or scanned in as part of an approved record storage system per the Department of Cultural Resources. The EMR is an electronic medical record so all required service record documents that are required per the APSM 45-2 may be maintained in an electronic format.
Yes, a specific physician's order is required for each medication.
The reviewer will request up to 5 additional records of individuals who receive medication if that number was not in the original sample. If medication is not administered to any individuals in the program, this item is scored N/A.
Therapeutic Foster Care (TFC) is excluded from the routine monitoring process. TFC programs fall under the jurisdiction of DSS.

NE PROVIDER MONITORING

Answer
Post-Payment Reviews [PPRs] will not be done on TFCs at this time pending further research and discussions with DSS.
No.
No, all alterations to an authenticated note must be completed by the staff who wrote and authenticated the note.
A PRTF is a Psychiatric Residential Treatment Facility - a free-standing facility for the treatment of seriously and persistently mentally ill (SPMI) children. PRTFs are excluded from routine monitoring.
It is the responsibility of the MCO to ensure that staff is trained in the monitoring process in accordance with the guidelines for using the tools and information posted on the Provider Monitoring web page. This is typically done through in-service training and supervision of monitoring staff to achieve internal consistency among staff. As a follow-up to the introductory workshops, webinars are being taped and will be posted on the web page. These webinars, which will be in modules, cover the topics presented during the workshops and other important information to facilitate successful implementation of the workshop. No additional training has been planned by the collaborative in the immediate future. Implementation is being monitored by the collaborative. Strategies for achieving inter-rater reliability across LME-MCOs is one of the next issues that will be addressed by the collaborative.

NE PROVIDER MONITORING

Answer
Reviewers have demonstrated to the LME-MCO the competency to carry out the roles and functions associated with provider monitoring and the assessment of provider performance. The determination of the competency to perform the job is made by the hiring LME-MCO. The experience, credentials and qualifications of reviewers range from qualified professionals to licensed professionals.
The term "Gold Star" has been used in two different contexts -- to refer to the overall process of routine monitoring and to refer to the highest level of advanced standing a provider agency can attain. Because of this confusion, the term "Gold Star" is no longer used to refer to routine monitoring. It is not clear which type of monitoring was conducted at your agency -- routine or advanced standing. Cardinal Innovations is the only LME-MCO who has been authorized by the State to award advanced Gold Star status. Beginning March 1, 2014, all providers will be monitored within a two year window. If a provider was monitored within the past few months, the next routine review would be within two years of the date of the last review.
No train-the-trainer events have been planned by the collaborative at this time. For any training event, the appropriate participants in the training are determined by the specific goals and focus of the training. Some training may be specifically targeted for LME-MCOs. The members of the collaborative will be involved in the planning and development of training curricula.
Beginning March 1, 2014, all providers will be monitored at a minimum of every two years. If a provider was monitored within the past few months, the next routine review would be within two years of the date of the last review.

NE PROVIDER MONITORING

Answer
Reviewers will need to have access to the medical record whether in paper format or in an EMR if your agency has an electronic medical record system. Each format should have a way for original signatures to be documented on the PCP.
The original PCP and any other original documents stay in the original medical record with the provider who created that record. When a consumer is transferred to another provider, copies of the consumer's information, including the PCP, can be sent to the receiving provider. The PCP is a dynamic document. When a transfer occurs, the receiving provider is responsible for updating the PCP. With the transfer, the case is no longer under the supervision of the original physician who ordered the service; the individuals providing direct services have changed; the previous authorization is no longer valid.
No; there is not a required form but the name and NPI number must be included for the provider. It is okay to create your own agency form as long as it complies with 8C requirements. A good source of information about the referral process is the CCNC website.
Yes; the 16 unmanaged visits per calendar year for children under 21 apply to any outpatient service – per recipient, not per therapist.
The 16 unmanaged visits per calendar year for children under 21 apply to any outpatient service unless E&M codes for medication management are billed. Services billed under E&M codes do not require prior authorization and not counted towards the 16 unmanaged visits.
Yes; STRs are completed in the call center. There is designated staff at the LME-MCO to approve referrals.

NE PROVIDER MONITORING

Answer
As long as your agency is using an Office of the National Coordinator for Health Information Technology (ONC)-approved electronic record system, this would be considered an electronic signature. Your agency policy must authorize the use of electronic signatures. In addition to the RM&DM, please see Implementation Update #90 and the September, 2011 Medicaid Bulletin for further guidance on electronic signatures.
There is no prescribed form or format for documenting the referral. Documentation may be a note containing the referral information in the service record and/or filing the referral form in the service record. For children funded by Medicaid or Health Choice, the referral information must include the name and NPI number of the individual or agency [CCNC/CA, primary care provider, the PIPH, or a Medicaid-enrolled psychiatrist] making the referral. For Medicaid beneficiaries ages 21 and over, outpatient BH services may be self-referred or referred by some other source. If the beneficiary is not self-referred, documentation of the referral must be in service record.
The term "new" service is generally used in two contexts: For individuals in treatment, a "new service" is a different service that is offered or provided in addition to the one currently being provided, based on the individual's needs. For example, if an LIP is providing outpatient treatment services, and the individual needs an additional service outside the scope of outpatient treatment, then that would be a "new service." When a provider adds a service to their service array or continuum of services, the service which is being added is referred to as a "new service." There may be additional monitoring requirements associated with the "new" service, depending on whether the service is in a new location or site.
Yes, questions directed to provider.monitoring@dhhs.nc.gov will be answered. Some questions are routed to the appropriate subject matter expert(s) for feedback before replying to the sender.

NE PROVIDER MONITORING

Answer
Information about rights must be provided to the individual in writing, and include the following elements: 1. Rules that the individual is expected to follow and possible penalties for violations of the rules; 2. documentation that the individual/LRP has been informed of the procedure for obtaining a copy of their treatment plan; and 3. the individual/LRP has been informed of their right to contact Disability Rights North Carolina (formerly the Governor's Advocacy Council for Persons with Disabilities). If your agency has met the above requirements, then what you describe in terms of your process and documentation of notification would be sufficient. As long as the information in the Rights and Responsibilities packet contain these elements and there is documentation that the individual was notified of their rights, the requirement for this item will have been met.
The purpose of this requirement is to ensure that authorizations completed by the agency to release information meet all the required elements outlined in the review item.
Except for substance abuse information which has more restrictions on disclosing information, the HIPAA privacy rule and the state confidentiality law permit the sharing of service recipient information for purposes of coordinating care and treatment without the service recipient's written consent or authorization. Under the HIPAA privacy rule, a covered provider may use or disclose protected health information for its own treatment activities or the treatment activities of another health care provider. Service recipient authorization is not needed when sharing information for these purposes.
The LME-MCO conducts Post-Payment Review [PPR]s on all services that are licensed by DHSR-MHL regardless as to whether the service is surveyed by DHSR-MHL on an annual basis or not. The schedule for Post-Payment Reviews [PPRs] for these services is every two years.

NE PROVIDER MONITORING

Answer
The following services that are licensed by DHSR do not fall under the LME-MCO routine monitoring process: PRTFs, ICF/IID facilities and inpatient hospitalization. Therapeutic foster care (TFC) programs, which are licensed by DSS, are also not monitored by the LME-MCO on an annual basis. While the LME-MCO does not do routine monitoring of residential services and opiod treatment services, the LME-MCO conducts post-payment reviews on those services.
Care coordination activities would be documented in the service record. The provider must present documentation that demonstrates coordination with another agency, organization, or natural support as described by the service definition and individualized to the consumer. Examples of where this would be found in the record include the PCP or service plan, service notes, etc.
These same questions are on the LIP tool and the Agency tool. Item # 2 speaks to the individual's right to consent to or refuse treatment [decision to accept treatment]; item # 3 speaks to the individual's right to receive treatment [access] whether for medical or behavioral health issues.
LIPs must either provide, or have a written agreement with another entity, for access to 24-hour coverage for behavioral health emergency services. LIP providers shall arrange for coverage in the event that he or she is not available to respond to a beneficiary in crisis.
H codes are no longer available for associate level licensed professionals, formerly known as provisionally licensed professionals; instead, when billing ‘incident to,’ the modifier SC must be used after the CPT codes. In CCP 8C, Attachment A, Sections C and D speak to the billing codes available for LIPs. Specifically, Section D outlines the billing requirements for associate level licensed professionals. There are no rules that can be cited regarding the discontinuation of H-Codes.
Yes, the 21-28 day notification applies to all services that are subject to routine monitoring including unlicensed AFLs and those services requiring a Health, Safety and Compliance Review.

NE PROVIDER MONITORING

Answer
Provider agencies and LIPs will be notified of the upcoming monitoring in writing 21 – 28 calendar days prior to the date of review. Provider agencies and LIPs will be notified of the specific service records needed for the review no less than 5 business days prior to the date of review. Each LME-MCO has its own system for confirming that the notification was sent and received (e.g., certified mail, UPS, FedEx, return receipt, etc.). Because of the difficulty in verifying that a notification was done by phone, it is unlikely that a provider would be notified on the on-site review by phone.
The threshold for passing each section of the routine review tool is 85%. (Exception: On the Routine Monitoring Tool, if the Restrictive Interventions item is missed, the entire section on Incidents, Restrictive Interventions and Complaints is failed). The minimum overall passing score for the routine review tool is also 85%. It is not possible to fail one section of the review tool and still pass the whole review.
Yes, post-payment reviews are conducted on a two-year cycle.
No. There is a listing of the required training on the Staff Qualifications worksheets in the post-payment review sections of the agency tool. Many of the service definitions contain training requirements for that specific service, but they do not contain all the training required in a finite listing.
Yes, while a CCA may be similar to a DA, a CCA is not a service definition.
Routine monitoring of TFCs is not done by the LME-MCO at this time. A decision about whether PPRs will be conducted at TFCs will be made by the workgroup after further review and discussion with DSS.

NE PROVIDER MONITORING

Answer
The individual's/LRP's signature on the service plan validates consent for treatment. A separate consent for treatment form may also be used, but it is not required. While there may be other consents that are sought by the provider, the consent for treatment is the focus of this particular review item. If written consent is not obtained, the provider must have written documentation of efforts to obtain consent and why consent could not be obtained.
There is no requirement for the service order to be signed on the day that the CCA was completed; however, it would be prudent to do so. As long as the order is signed prior to or on the day the service begins, the requirement is met. H codes are no longer available for associate level licensed professionals; instead, when billing 'incident to,' the modifier SC must be used after the CPT codes. See Attachment A in CCP 8C.
There is no requirement to use an electronic record system; however, movement in that direction is evident.
This means that a person's initials may not be used in lieu of entering their full signature. Of course, if the person signs his name as John Q. Public, "Quincy" does not have to be written out; the "Q" within the person's signature is acceptable. "JQP" is not.
The MAR must be updated whenever there is any change in medication.
Not all licensed facilities are monitored by the LME-MCOs. However, all GS §122C MH/IDD/SA services that are licensed by DHSR, but are not surveyed annually by DHSR are monitored by the LME-MCO, and PSR is one of those services. The Frequency - Licensed Facilities chart in the agency workbook identifies how often DHSR surveys licensed services.
Clinical Coverage Policy 8C contains all the service criteria for outpatient treatment behavioral health services. The clinical coverage policies are found on the DMA website in the Provider Portal. The Behavioral Health policies are in section 8 of the CCPs.

NE PROVIDER MONITORING

Answer
Yes, as long as your agency is using an Office of the National Coordinator of Health Information Technology (ONC)-approved electronic record system and your agency policy authorizes the use of electronic signatures, an electronic signature is perfectly acceptable. Please see the additional requirements outlined in the RM&DM, Implementation Update #90 and the September, 2011 Medicaid Bulletin for further guidance on electronic signatures.
State-funded service definitions are found on the DMH/DD/SAS web site, and Medicaid services are found on the DMA web site. On the DMH/DD/SAS web site, go to A-Z and choose "S" and then Service Definitions. On the DMA web site, click Providers, and then click Medicaid Clinical Coverage Policies and Manuals and scroll down. Most of the relevant service definitions are found in the Behavioral Health section on that page. Each policy starts with the number 8, as in 8A. The services are defined within each policy.
Per CCP-8C, if the licensed professional utilizes any of the Psychotherapy for Crisis codes, and the disposition is not an immediate transfer to acute or more intensive emergency services, the disposition must include offering a written copy of an individualized crisis plan, developed in the session for the purpose of handling future crisis situations, including involvement of family and other providers as applicable. The plan must include a scheduled outpatient follow-up session.
An electronic record system that is approved by the Office of the National Coordinator (ONC) of Health Information Technology enables the user to enter his or her secure signature on the notes. When using an electronic record system, there is no need to have a hard copy of the notes. Please see the requirements outlined in the RM&DM, Implementation Update #90 and the September, 2011 Medicaid Bulletin for further guidance on electronic signatures.
It is important to discuss with minors their treatment plan and to ascertain that they understand the plan for treatment with which he or she is expected to engage. Having the child/adolescent sign their treatment plan is considered best practice. While the parent or LRP is required to sign the minor's service plan, the child/adolescent's consent to the plan [as well as assisting in the development of the plan] can be a vital key to its success.

NE PROVIDER MONITORING

Answer
Yes. Unlicensed AFLs are monitored by the LME-MCO. Licensed AFLs are monitored by DHSR.
There are eleven items on the PPR tool for the Innovations Waiver.
No, there are no plans to write a Provider Monitoring Manual. Orientation workshops have been presented statewide. Webinars are being recorded as a follow-up to the training. An FAQ document has been compiled and will be updated frequently to disseminate clarifications of questions providers and LME-MCOs have.
No, the LIP Routine Review Tool and the LIP Post-Payment Review Tool are used to monitor LIPs who provide outpatient (basic benefit) services only. This applies whether the LIP operates a solo or a group practice. The key consideration here is the type services provided.
No. While such activities may be helpful or informative to the clinician, they are not billable interventions or treatment.
Per CCP-8C, psychotherapy, outpatient, assessment, and psychological testing services beyond the unmanaged allowances per calendar year require a written order by a physician, licensed psychologist (doctorate level), nurse practitioner, or physician assistant.
Documentation for a verbal referral may be a note containing the referral information in the service record, or the agency may capture the referral information on their own referral form. For children funded by Medicaid or Health Choice, the referral information documented must include the name and NPI number of the individual or agency [CCNC/CA, primary care provider, the PIPH, or a Medicaid-enrolled psychiatrist] making the referral.
No, the time spent completing the NC-TOPPS is time performing a separate and distinct function from direct service delivery. Completing the NC-TOPPS is not billable and may not be blended into service delivery.

NE PROVIDER MONITORING

Answer
If a service requires a minimum amount of time to be spent providing the service for the service to be billed, such as 1 unit = 1 hour, and the full hour required for the service was not provided, then that service event is not billable. There is no provision for reimbursement for partial units. In addition, service units vary from service to service, and service definitions may have additional requirements. It is best to consult the service definition for specific requirements for service delivery and billing.
There should be very few instances when written consent cannot be obtained. If written consent is not obtained, the provider must produce a written statement as to why consent could not be obtained.
Yes, you may bill for the services that you were authorized to provide, and you may provide more than what was authorized, but you may not bill for more than what was authorized. In the situation described, the provider would only be reimbursed for the number of units authorized (i.e., 1 unit).
Working days are based on the staff person's days at work. If the agency closes for weekends, holidays, weather conditions, or if the staff person is on leave, then these are not considered working days.
Yes, referral information must be documented in the client record. If the referral was called in, documentation may be in the form of a note containing the referral information, or the agency may capture the referral information on their own referral form. If the referral was made in writing, the agency may file the referral form in the service record. For children funded by Medicaid or Health Choice, the referral information must include the name and NPI number of the individual or agency [CCNC/CA, primary care provider, the PIHP, or a Medicaid-enrolled psychiatrist] making the referral. For Medicaid beneficiaries ages 21 and over, outpatient BH services may be self-referred or referred by some other source. If the beneficiary is not self-referred, documentation of the referral must be in service record.
No, an order is not required for unmanaged visits but will be required for authorization after the unmanaged visits have been used. If it is anticipated that there will be a need for services beyond the unmanaged allowances, providers need to obtain the appropriate order before the unmanaged visits are exhausted so that there is no unnecesary disruption in services.

NE PROVIDER MONITORING

Answer
The reviewer is verifying that the record check was submitted by the agency within 5 days of conditional employment to the DOJ to conduct the criminal background check. The results of the background check are not part of the review process for monitoring purposes.
The referral is required prior to the initial date of service. The referral by the physician authenticates the need for the service and that the service is appropriate for individual. This requirement is in CCP-8C but has been in effect since at least the publication of the May 2005 Special Medicaid Bulletin IV.
No, these referrals are required only for outpatient services under CCP-8C. B3 services are generally not outpatient services. Most B3 services are C waiver services that are being used for non-waiver consumers so the service definition dictates the need for an order or who can order the service.
There is no set template for documenting a referral received verbally. The provider needs to retain evidence of the referral with the necessary information, including the name and NPI number of the individual or agency making the referral [CCNC/CA, primary care provider, the PIPH, or a Medicaid-enrolled psychiatrist] for children funded by Medicaid or Health Choice. If the referral was called in, documentation may be in the form of a note containing the referral information , or the agency may capture the referral information on their own referral form. This information is filed in the client record.
Yes, the LME-MCO can require that providers bring all records to them. Typically, the review is done on-site at the provider agency. The decision of the location for the review should be a collaborative, coordinated process between the LME-MCO and the provider. If transporting the records presents a hardship for the provider, the provider should express their concerns to the LME-MCO.

NE PROVIDER MONITORING

Answer
The requirement to obtain a referral from the appropriate professional has been in place since at least May 2005 as outlined in the Special Medicaid Bulletin IV. It appears as if some providers were not aware of this requirement. Providers will be expected to have obtained a referral from the appropriate professional.
Providers are expected to be in compliance with the rules and regulations that are in force at the time of service delivery. Some of these regulations often precede the provider's enrollment in the network; therefore, it becomes incumbent upon the provider to know the rules and regulations for the provision of publicly-funded services. These requirements are found in a variety of sources, including but not limited to GS § 122C, the administrative code, the Records Management and Documentation Manual (APSM 45-2), Medicaid Clinical Coverage Policies, the Medicaid Billing Guide and the contract between the provider and the LME-MCO. Policy clarifications and updates and new requirements are published in communication bulletins and Special and monthly Medicaid Bulletins. When a provider is monitored, the documentation is evaluated against the requirements that were in place on the date the service was delivered.
Yes. All services that are licensed by DHSR except for those which are exempt from routine monitoring by the LME-MCO (e.g., PRTFs, ICF/IID facilities and inpatient facilities) are subject to post-payments reviews by the LME-MCOs. In addition, those services for which DHSR does not conduct annual surveys are also subject to a routine review by the LME-MCO. Residential services and opiod treatment services are the only services which DHSR surveys on an annual basis (every 12-15 months).

NE PROVIDER MONITORING

Answer
As long as your agency is using an ONC-approved electronic record system and your policy authorizes the use of electronic signatures, you should be fine. Please see the additional requirements outlined in the RM&DM, Implementation Update #90 and the September, 2011 Medicaid Bulletin for further guidance on electronic signatures.
Yes, if the psychiatrist is reviewing all medications. This review can be conducted by a physician or a pharmacist.
Yes, any funds received by the provider on behalf of the individual, including any money designated for personal use, are accountable to the rule.
No. There is no way of knowing how many unmanaged visits have already been used. This is why it is recommended that providers submit authorization requests to the LME-MCO for all individuals who are expected to continue receiving services beyond the unmanaged visits.
The clinician and the person receiving services [and the LRP as appropriate] sign the plan.
No, associate level licensed professionals [formerly known as provisionally licensed professionals] are not subject to criminal background checks as this has already been done at credentialing and by the licensure board.
Yes.
No. The overall percentage rating lets the provider know their percent of compliance across all tools. For the PPR tools, the concept of pass/fail is irrelevant. A POC is required for systemic issues. A provider could have 90% compliance, but still have a POC. Furthermore, recoupment will be required whether the provider was 99% or 12% compliant for anything called out-of-compliance. If the out-of-compliance findings send up a red flag to the LME-MCO about suspicious activity, then the LME-MCO would also proceed with an investigation/targeted review.
No. Services provided by physicians do not require a referral or service order.

NE PROVIDER MONITORING

Answer
No. Per CCP 8C, physicians are the only practitioners that are exempt from the requirement of needing a referral or a service order to provide treatment. A licensed psychologist would need to obtain a referral and service order for the services the psychologist provides.
Yes, while physician extenders and nurse practitioners are able to order services, they must obtain a referral and service order before providing services.
Yes, you may describe a group intervention in the same way for a group session provided the intervention remained constant throughout the session and there were no special interventions made (e.g., to engage a resistant participant or to address a specific dynamic that occurred during the group session); however, the clinician needs to make sure that the response to the intervention for each member of the group is indeed individualized and specific to each person who participated in the group.
One of the purposes of documenting services is to account for the person's progress. At a minimum, when you document the service event, you must show the person's response to your interventions on that particular day [event] to account for the time billed. However, it can be very useful to document the person's response over time, and providers are encouraged to do so.

NE PROVIDER MONITORING

Answer
We are unaware of any templates that have been developed to address the supervision and training needs of staff that work with individuals with I/DD. Supervision plans should be individualized and tailored to the experience and areas of professional development needed by the staff person. Supervision and training requirements can be found in the service definitions and rule. The Innovations Waiver manual also gives specific guidelines for the provision of waiver services. In developing an individualized supervision plan or a training plan, it is important to make sure that staff understands the nature and manifestations of the diagnostic conditions of the people they support, the provisions of the service definition, the treatment goals of the people they support and records management and documentation requirements of service provision. This is not an exhausive list of areas that would be important to include in a supervision/training plan.
ICF/IID -formerly ICF/MR-facilities are exempt from routine monitoring by the LME-MCO. DHSR has responsibility for monitoring ICF/IID facilities.
Yes, when a LIP moves to a new location, the LME/MCO will conduct an on-site review of the new location using selected items from the LIP Office Site Review Tool that are pertinent to assessing the facility's compliance with ADA, accessibility and HIPAA requirements, etc.
The referral may be verbal or written from a CCNC/CA (Carolina Access) primary care provider, the LME-MCO or a Medicaid-enrolled psychiatrist. The referral documentation which may be either verbal or written referral must include the name and NPI # of the individual or agency making the referral. Services provided by a physician do not need a referral
The signature of the individual/LRP on the treatment plan or PCP validates consent for treatment. A separate consent for treatment form may be used but is not required. If written consent is not obtained, the provider must document efforts to obtain written consent and the reason why written consent was not obtained.

NE PROVIDER MONITORING

Answer
Medication education may be given orally or in writing. The documentation may be in the prescribing physician's note and/or may be documented in writing according to agency policy [N/A for over-the-counter medication or medication prescribed by a physician not employed or contracted by the agency].
The prescribing physician has the responsibility for providing medication education for each medication that is prescribed.
Optional items on the PPR tools will be discussed at our next workgroup meeting. Look for further clarification and/or a change in this area within the next month.

NE PROVIDER MONITORING

Answer
“Appropriate service order” refers to the discipline(s) permitted to determine medical necessity and issue an order for a particular service, based on that medical necessity. There are many services which require an order by a physician or other licensed professional who has expertise in a certain area. Because the signatories vary, it is always best to consult the specific policy or service definition to ascertain the service order requirements that are specific to that service. Most Medicaid services require a service order. For State-Funded Enhanced MH/SA Services, a service order is recommended, and providers shall coordinate with the LME/MCO regarding their requirements for service orders; for the Existing State-Funded DMH/DD/SAS Services [1/1/03, rev. 7/13], you will need to consult the specific service definition. Please see the various Behavioral Health clinical coverage policies beginning with the number eight on the DMA web site for the Medicaid requirements at http://www.ncdhhs.gov/dma/mp/index.htm. For the State-Funded Enhanced MH/SA Services, please go to the DMH/DD/SAS web site at: http://www.ncdhhs.gov/mhddsas/providers/servicedefs/index.htm and click on State-Funded Enhanced Mental Health and Substance Abuse Services. For the Existing State Funded DMH/DD/SA Service Definitions [1/1/03, rev. 7/13], please go to the same link above and click on Existing State Funded DMH/DD/SA Service Definitions [7/13].
Any medication samples received from the physician must be stored in the same way as other medications.

NE PROVIDER MONITORING

Answer
The rule in its entirety identifies all of the specific parts that are required for the reporting and follow-up of incident reports. The pre-site review will consist of reviewing incidents in IRIS. The on-site review will determine if follow-up was completed and recommendations implemented for outstanding Level IIs and IIIs. Each provider has their own system of organizing and filing incidents. The term "log" is used to refer to whatever system the provider has in place. There is no prescribed method for recording and tracking incidents.
The rule in its entirety identifies all of the specific parts that are required for the use of restrictive interventions. The pre-site review will consist of reviewing the agency's policy and procedure on Restrictive Interventions. Each RI sampled must be in the submitted corresponding Quarterly Summary and in IRIS. The on-site review will consist of reviewing a sample of restrictive interventions to ensure compliance with rule. There is no prescribed method for filing and cataloguing restrictive interventions. The term "log" is used to refer to the tracking/filing system the provider has in place.
There are several issues which are of special significance in the successful implementation of the new provider monitoring process. The completion of inter-rater reliability studies is important to the standardization of the process. Some LME-MCOs are addressing inter-rater reliability as they train their reviewers in using the new tools. In other instances, some LME-MCOs are working together to establish uniformity and consistency. The workgroup will be looking at conducting a formal inter-rater reliability study over the next few months.
The provider should discuss any findings with which they disagree with the review team when the issue arises. If the differences in perspective cannot be resolved, request reconsideration by the LME-MCO. The provider contract will include information on the procedure for requesting reconsideration or the appeal of a finding.

NE PROVIDER MONITORING

Answer
The message was consistent across the state concerning national accreditation -- there is recognition that this is an issue that needs to be addressed (a parking lot issue), however, no definitive decision has been made one way or the other regarding the future of the national accreditation requirement in the system. Different perspectives on the role of national accreditation vs local monitoring were discussed in varying amounts of detail as examples of some of the considerations around this issue. Such policy decisions would be formally announced in a communication bulletin and not during the course of a workshop absent such a formal communication.
There are some pre-site monitoring activities done at the LME-MCO prior to the on-site review (e.g., review of IRIS reporting, review of requested policies and procedures). Record reviews are done at a mutually agreeable location for the LME-MCO and the provider. That location is generally at the provider agency. The presenters do not recall any statement made to the effect that "all record reviews would occur at the MCO."
According to the Existing State Funded DMH/DD/SA Service Definitions [1/1/03, rev. 7/13], Group Living does not require a service order. As for other state-funded services defined in this policy, you will need to consult the specific service. In terms of the QP signing the PCP in the service order section, if a licensed professional is not required to order the service, or if the service itself does not require an order [as in Group Living], then it is recommended that the QP who is responsible for the plan sign his or her name in Part III, SECTION B on the Signature Page of the PCP to confirm that medical necessity criteria have been met for the services included in the plan. If not confirming medical necessity, the QP must still sign as the person responsible for the PCP in Part II of the Signature page.

NE PROVIDER MONITORING

Answer

Written consent for treatment in the plan is in rule – 10A NCAC 27G .0205(d)(6). The RM&DM requires written consent for treatment and it has to be filed in the record. There is no requirement for the consent to be on a separate form in rule or in the RM&DM.

Perhaps the practice of using a separate consent form came about in the past because there are other specific consents [seeking emergency treatment, research, use of restrictive interventions] that are needed other than for consent for treatment and maybe a form was used to obtain whatever type of consent was needed. However, since the PCP was implemented, those things are likely to be captured on the PCP, or at least they should be.

If there are other consents that are needed that are not listed on the PCP, then a separate form would be needed.

This all goes without saying – An authorization [often referred to as “consent”] for release of information is required to be on a separate form per event with all the required elements – Could this also be the cause of the confusion?

NE PROVIDER MONITORING

Answer
For LIPs, staff qualifications to provide a service are determined at the credentialing level. As long as the service(s) for which the LME-MCO has contracted with the LIP to provide do not have specific qualifications and/or training requirements as outlined in the service definition and the LIP is practicing within their scope of practice and the LIP is in good standing with their licensure board (which includes having met the necessary continuing education requirements), the LIP is considered to be qualified to provide the service. Refer to Clinical Coverage Policy 8C which contains all the service criteria for outpatient treatment behavioral health services. Outside of service definition-specific training requirements (e.g., for evidence-based treatment modalities such as Multi-Systemic Therapy), the training requirements for the LIP are determined by the respective licensure board. Documentation of continuing education credits is submitted to the licensure board and falls outside the scope of routine monitoring.
Yes, if the LIP only provides basic benefit services (e.g., medication management, psychotherapy or other outpatient services), the LIP Review Tool and the LIP Post-Payment Review Tool are used for routine monitoring.
Yes, you are correct. The reviewers will look at up to ten complaints that have occurred within the past 12 months of the on-site review.

NE PROVIDER MONITORING

Answer
Yes, all providers should address the right to access medical care and rehabilitation services regardless of the individual's age or degree of mh, idd, or sa impairment as part of the rights notification process. This includes access to both medical and behavioral health services.
The expectation is not that the mental health provider needs to provide medical care; however, it is the responsibility of the mental health provider to inform the individual of their right to seek and obtain necessary medical treatment (e.g., encouraging the individual to see their primary care physician for the assessment of any known or suspected medical conditions). The mental health provider's responsibility per rule is to notify the individuals in their care that they have the right to access needed medical and behavioral health services and to provide documentation to the reviewer that such a process for notification is in place.
Unmanaged visits are based on the calendar year. There is no way of knowing how many unmanaged visits remain because the unmanaged visits may be used to see a number of different practitioners. The unmanaged visits are cumulative across all providers -- not per individual provider. Because it is impossible to know how many unmanaged visits have already been expended, it is recommended that the provider request authorization as soon as possible upon a person's enrollment in services.

NE PROVIDER MONITORING

Answer
Telemedicine and telepsychiatry are methods of providing treatment from a distance through the use of technology. The use of telemedicine and telepsychiatry, when following the requirements of DMA Clinical Coverage Policy 1H, is considered a face-to-face contact. It is the billable service for which prior approval is obtained when the service requires prior approval based on the service type or diagnosis as outlined in the requirements in the clinical coverage policy for that service rather than the method of treatment. When telemedicine and telepsychiatry are used, no other approval from the LME-MCO is required other than the prior approval that would be required for the service being provided. For more information on telemedicine and telepsychiatry, this is the link to Clinical Coverage Policy 1H: http://www.ncdhhs.gov/dma/mp/1H.pdf.
There are many types of "independent practitioners," and it depends on the type. Please see Clinical Coverage Policy 1H, specifically section 6.2, as there are only certain provider types who are able to provide services utilizing telemedicine and telepsychiatry. Note: Not all of the provider types eligible for independent practice outlined in the outpatient Clinical Coverage Policy 8C are eligible to provide services under Clinical Coverage Policy 1H. If your discipline is listed in section 6.2 as one of the providers eligible to bill telemedicine and telepsychiatry, then you would be able to utilize telemedicine and telepsychiatry as a way of providing services to Medicaid beneficiaries, as long as you follow all of the requirements outlined in the telemedicine and telepsychiatry policy.
No, care coordination is not billable. While it is a vital part of any service, care coordination is not a direct intervention, and there is no billing code available in the provider's service array for care coordination. With that said, a record of care coordination activities must be documented in the individual's service record. There is no format for this, but there should be enough information in the documentation for a reviewer to ascertain the essence of each activity - what was done, who was involved, disposition, etc.

NE PROVIDER MONITORING

Answer
Yes, the previous Gold Star monitoring system has been re-tooled. Therefore, providers need to attend training because the process has been streamlined and it is important that providers understand the changes. The term "Gold Star" has been used in two different contexts -- to refer to the previous process of routine monitoring and to refer to the highest level of advanced standing a provider agency can attain. Because of this confusion, the term "Gold Star" is no longer used to refer to routine monitoring.
The trainings took place across the state in February and are now complete. There are no immediate plans to offer additional training. However, the PowerPoint of the workshop is posted on the DMH/DD/SAS website under Provider Monitoring - Workshops, Trainings and Conference Presentations. As a follow-up to the introductory workshop, a series of webinars has been taped and are also posted on the website.
It is not clear which type of monitoring was conducted at your agency -- routine or advanced standing. Cardinal Innovations is the only LME-MCO which has been authorized by the State to award advanced Gold Star status. Beginning March 1, 2014, all providers will be monitored at a minimum of every two years. If a provider was monitored within the past few months, the next routine review would be within two years of the date of the last review. Keep in mind that there are two components to routine monitoring -- the routine review and the post-payment review. At the present time, we are in discussions with the national accrediting bodies for the LME-MCOs concerning the delegation of the routine review to the lead LME-MCO. No decision has been reached on this. As far as the post-payment review, each LME-MCO is responsible for conducting post-payment reviews on the providers with which they contract. Consequently, if a provider contracts with more than one LME-MCO, the provider will have a post-payment review by each LME-MCO with which the provider contracts.

NE PROVIDER MONITORING

Answer

It is not clear which type of monitoring was conducted at your agency -- routine or advanced standing. Cardinal Innovations is the only LME-MCO which has been authorized by the State to award advanced Gold Star status.

Beginning March 1, 2014, all providers will be monitored within a two year window. If a provider was monitored within the past few months, the next routine review would be within two years of the date of the last review.

If you are a provider with advanced standing (Preferred, Exceptional, or Gold Star status) with Cardinal Innovations and was re-certified by Cardinal Innovations within the past few months, you are not due for another re-certification at this time.

NE PROVIDER MONITORING

Answer

If staff comes from a group home or any agency that does administer medications, it should be documented by that provider. Meds self-administered in an assisted living facility do have to be documented. Only if the person is living at home would they not have to document.

It is unclear as to why this is looked at as a possible infringement of a person's rights. This rule applies to the responsibility of the provider when the provider administers medications while an individual is in their care or when a service recipient self-administers medications while in the treatment program, all the protocols and guidelines for self-administration are expected to be complied with. In addition to compliance with rule requirements, this is a risk management safeguard for the provider.

NE PROVIDER MONITORING

Answer
This tool is not intended for facilities that are licensed by DHSR. The Health, Safety, and Compliance Review Tool is only for the initial review of services that operate out of a setting that is not licensed by DHSR (e.g., Unlicensed Supervised Living Programs). It is also used when an unlicensed service moves to a new location or adds a site which is not co-located with a licensed service. If the service is provided at a site where a licensed service is also located, the Health, Safety, and Compliance Review Tool is not used but rather the fact that DHSR has already conducted a survey of the core rules at that site is sufficient; therefore, there is no duplication in the role of DHSR in this area.
The requirement for including the name and NPI number on the referral only applies to children funded by Medicaid or Health Choice. The referral information must include the name and NPI number of the individual or agency [Community Care of North Carolina (CCNC)/Carolina Access (CA), primary care provider, the PIPH, or a Medicaid-enrolled psychiatrist] making the referral. For Medicaid beneficiaries ages 21 and over, and for non-Medicaid-eligible individuals, outpatient BH services may be self-referred or referred by some other source. If the beneficiary is not self-referred, documentation of the referral must be in service record.

NE PROVIDER MONITORING

Answer
There are no available copies of the tool in hard copy, and the tool is administered electronically. The link to the tool is found on the DMH/DD/SAS Provider Monitoring page: http://www.ncdhhs.gov/mhddsas/providers/providermonitoring/index.htm#faq On the DMH website, click on the For Providers portal, then A-Z Topics. Scroll down to P, then click on Provider Monitoring. This will take you to the Provider Monitoring web page. If you click on Provider Monitoring Tools, you will find the review tools. The review tools for LIPs and Provider Agencies are located in separate workbooks. Click on the set of tools of interest to you. There is a test copy and a review copy for each workbook.
The Medication Review section of the provider agency tool does not apply to outpatient practices that provide basic benefit services only. The Medication Review questions apply to agencies where medication administration occurs. Medication review is not a part of the review of LIPs. Medication management in outpatient clinics occurs under the supervision of a physician where it is expected that the practice follows the protocols for medication education and the storage of medication samples.
Thank you for bringing this matter to our attention. With such a diverse provider network in terms of areas of specialty areas and amount of experience in the public system, your question points out that we have probably errored on the side of assuming some of the acronyms are not as universally understood as others. We will take your suggestion into consideration in the documents we publish in the future. In addition, we would like to point you to the Acronyms page on the DMH website: http://www.ncdhhs.gov/mhddsas/acronyms1.htm. This is where you will find some of the more commonly used acronyms in our system.

NE PROVIDER MONITORING

Answer
The acronyms which you have noted here refer to different levels of care criteria that have been developed to help identify the level of service need for individuals in certain age and population groups: CALOCUS - Child and Adolescent Level of Care Utilization System (the precursor to the CASII) LOCUS - Level of Care Utilization System for Psychiatric and Addiction Services CASII - Child and Adolescent Service Intensity Instrument ASAM - American Society of Addiction Medicine Patient Placement Criteria
Yes, that is correct. LME-MCOs do not monitor E&M codes by primary care or OB-GYN physicians. Since opioid treatment is a licensed service that is surveyed by DHSR-MHL on an annual basis, the LME-MCO is only responsible for conducting post-payment reviews on opioid treatment services.
The provider agency is not responsible for ensuring that a person receives medical care, although it would be expected that the provider would encourage the individual to do so and assist in any way possible as part of care coordination efforts and integrated care activities. However, in the tool, the provider has to assure that the individual has been INFORMED of his or her right to treatment, including access to medical care. It does not mean that as an LIP, you have to take the person to medical appointments, etc.
Unmanaged visits cannot be verified through the LME/MCO. Unmanaged visits are tied to the individual receiving services, not providers. This is why it is advisable for providers to go ahead and request prior authorization early, just in case the individual has seen another provider.

NE PROVIDER MONITORING

Answer
An FAQ document has been compiled and will be updated periodically to disseminate clarifications of questions providers and LME-MCOs have. It is on the Provider Monitoring page of the DMH/DD/SAS website, found here: http://www.ncdhhs.gov/mhddsas/providers/providermonitoring/index.htm#faq
An FAQ document has been compiled and will be periodically updated to disseminate clarifications of questions providers and LME-MCOs have. It is on the Provider Monitoring page of the DMH/DD/SAS website, found here: http://www.ncdhhs.gov/mhddsas/providers/providermonitoring/index.htm#faq
Person-Centered Thinking is not required for Innovations Waiver staff. As for NCI training, providers are required to have training in restrictive intervention if the agency has a policy allowing restrictive intervention, or if it is a 24-hour facility per NCAC 27D .0101 and NCAC 27E .0104. They must have training in Alternatives to Restrictive Intervention training per NCAC 27E .0107, regardless of type or place of service.
A consent for treatment is valid when the individual and/or the legally responsible person signs the service plan. The signed consent covers the services and supports that are outlined on the plan. Written consent for treatment in the plan is required by rule: 10A NCAC 27G .0205(d)(6). A separate consent for treatment form may also be used, but it is not required. Regardless of an agency's use of a separate consent form, written consent for treatment must be entered on the plan. While there may be other consents that are sought by the provider, the consent for treatment is the focus of this particular review item. If written consent is not obtained, the provider must produce a written statement as to why consent could not be obtained.

NE PROVIDER MONITORING

Answer

“Appropriate service order” refers to the discipline(s) permitted to determine medical necessity and issue an order for a particular service, based on that medical necessity. There are many services which require an order by a physician or other licensed professional who has expertise in a certain area. Because the signatories vary, it is always best to consult the specific policy or service definition to ascertain the service order requirements that are specific to that service.

Most Medicaid services require a service order. For State-Funded Enhanced MH/SA Services, a service order is recommended, and providers shall coordinate with the LME/MCO regarding their requirements for service orders; for the Existing State-Funded DMH/DD/SAS Services [1/1/03, rev. 7/13], you will need to consult the specific service.

Please see the various Behavioral Health clinical coverage policies beginning with the number eight on the DMA web site for the Medicaid requirements at http://www.ncdhhs.gov/dma/mp/index.htm. For the State-Funded Enhanced MH/SA Services, please go to the DMH/DD/SAS web site at: http://www.ncdhhs.gov/mhddsas/providers/servicedefs/index.htm and click on State-Funded Enhanced Mental Health and Substance Abuse Services. For the Existing State Funded DMH/DD/SA Service Definitions [1/1/03, rev. 7/13], please go to the same link above and click on Existing State Funded DMH/DD/SA Service Definitions [7/13].

NE PROVIDER MONITORING

Answer

We commend you for wanting to implement an internal quality assurance program to ensure that your program is in compliance with the requirements monitored during this review. Routine monitoring consists of a routine review and a post-payment review. The tools that will be used to monitor an ADVP service are the Routine Review Tool for Provider Agencies and the Generic Post-Payment Review Tool. These tools are found in the Provider Agency workbook on the Provider Monitoring web page. There you will find a tool with test data to give you an example of how to complete the tool. There is also a review tool that you can complete for your internal review.

The link to the tools and other information about provider monitoring is found on the DMH/DD/SAS Provider Monitoring page: http://www.ncdhhs.gov/mhddsas/providers/providermonitoring/index.htm#faq

We encourage providers to use the tools and the resource materials on the web site to strengthen their internal quality assurance program. We commend you for taking the lead in this area.

The file and link are not corrupted. The Guidelines are in pdf. If you double click on the icon, it will open the file. You may want to re-start your computer and try again. Use this same technique to open any of the other pdf files in the workbooks.

NE PROVIDER MONITORING

Answer
If they are finishing a prescription and you have the order, the LME-MCO may check to see when the prescription was filled and when the new order was written. However, when the prescription is refilled, it should match the most recent order.
Yes, that is correct. You cannot label the boxes because you did not dispense the samples. The sample boxes should have the name of the medication, the number of pills in the box, and the strength of the medication, plus the expiration date.
FAQs are posted on the Provider Monitoring page of the DMH/DD/SAS website: http://www.ncdhhs.gov/mhddsas/providers/providermonitoring/index.htm#faq
This is a concern that is shared by many providers, most of whom contract with more than one LME-MCO. This is an issue that has been brought to the attention of the Department, the DHHS-LME/MCO-Provider Collaboration Workgroup as well as the Business Practices Subcommittee. There are a host of factors to be considered in working toward a solution including, but not limited to, requirements under the waiver, national accreditation standards pertaining to delegation of functions, HIPAA, and an appropriate sampling methodology that would have generality across the system. This is a complex array of issues which are being studied but for which we do not have a solution at this time.

NE PROVIDER MONITORING

Answer
If you were able to access the revised PowerPoint presentation from the URL in the 2/4/14 Joint Communication Bulletin, you are on the Provider Monitoring web page. The new tools used the same architectural structure as the Gold Star tools. There were some instances where we failed to change the titles in the headers and footers from Gold Star to the new names for the tools when the tools were updated. We have corrected this. We sincerely apologize for this error.
Yes. DHHS has an authorization to disclose Health Information form [DHHS-1000 (4-6-05), which contains the language you are seeking. That section of the authorization form says in part, "I understand that my information may not be protected from re-disclosure by the requester of the information; however, if this information is protected by the Federal Substance Abuse Confidentiality Regulations, the recipient may not re-disclose such information without my further written authorization unless otherwise provided for by state or federal law. I understand that if my record contains information relating to HIV infection, AIDS or AIDS-related conditions, alcohol abuse, drug abuse, psychological or psychiatric conditions, or genetic testing this disclosure will include that information. I also understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment for services, or my eligibility for benefits; however, if a service is requested by a non-treatment provider (e.g., insurance company) for the sole purpose of creating health information (e.g., physical exam), service may be denied if authorization is not given. If treatment is research-related, treatment may be denied if authorization is not given." To access this form, go to: http://info.dhhs.state.nc.us/olm/manuals/dhs/pol-80/man/Use_and_Disclosure_Authorizations.pdf and click on the form at the bottom of the page.

NE PROVIDER MONITORING

Answer
When a new or revised policy that affects individuals receiving services is implemented, it is incumbent on the part of the provider that the individuals receiving services are informed and that there is documentation to support it. As you develop or revise your policies and implement them, the LME/MCO will be looking for evidence that each person was informed. So, if you add the two items on rights that you mentioned to your policy, the LME/MCO would be looking for some documentation that each person receiving services has been duly informed. You did not say what type of service you provide, but keep in mind that an individual must be informed of his or her rights within 3 visits, or for residential services, within 72 hours.
Yes, an individual/LRP must be informed of his or her rights within 3 visits, or for residential services, within 72 hours.

NE PROVIDER MONITORING

Answer

At one point during the Gold Star system, a post-payment review was required any time the LME-MCO conducted a review of the provider, whether for routine monitoring or for a targeted review. This has been discontinued. No longer are post-payment reviews conducted during every on-site visit the LME-MCO makes; however, it is important to keep in mind that routine monitoring includes a routine review as well as a post-payment review.

In terms of when to know if a PPR should be done, a PPR is a component of routine monitoring and should be conducted in connection with the routine review. The PPR can occur at the same time as the routine review or it could be done at a different time; however, the routine review will not be complete so that a report can be generated until the PPR is completed.

PPRs that are done at other times (e.g., in connection with program integrity activities or quality of care concerns, etc.), the decision as to if a PPR will be done is based on the nature of the issue being investigated. The methodology used to conduct such investigations (i.e., sample selection and sample size) will be specific to the issue and is not required to be the same as with routine monitoring.

NE PROVIDER MONITORING

Answer
Clinical Coverage Policy 8C Section 5.4.1 states: "outpatient therapy and psychological testing provided to Medicaid beneficiaries under the age of 21 and NCHC (North Carolina Health Choice) beneficiaries require an individual, verbal, or written referral, based on the beneficiary's treatment needs by a Community Care of North Carolina/Carolina Access (CCNA/CA) primary care provider, the PIHP or a Medicaid-enrolled psychiatrist." A referral is required prior to outpatient treatment for persons under the age of 21, unless the provider is a physician or the service being provided is a crisis service. The referral is obtained prior to treatment and should not be confused with authorization for services or the service order. Authorization for services should be obtained after 8 visits for adult; 16 visits for children according to Clinical Coverage Policy. Some LME-MCOs have designated a higher number of unmanaged visits. At the point where authorization is required, a service order is required per Clinical Coverage Policy 8C Section 5.2.2.
The Medication Review only applies to the Agency Review Tool -- not to the LIP Review Tool. That is why the slide presentation indicates the end of the LIP Review Tool. When medication management occurs in an outpatient setting, it is done under the supervision of a physician. As such, medication management is expected to follow the protocols and standards of practice overseen by the physicians in the practice. Consequently, medication review is not a component of the routine review for LIPs.

NE PROVIDER MONITORING

Answer
The workshops were held in Durham on February 27. The new process and tools went live on March 1. There seems to have been a misunderstanding about when the FAQs would be posted. Due to the large volume of questions that we received and the process for compiling responses to the questions, it would be have impossible to publish the FAQs on March 1. The commitment was to publish FAQs by April 1 -- the first set of FAQs was posted on 3/25/14 on the Provider Monitoring page of the DMH/DD/SAS website: http://www.ncdhhs.gov/mhddsas/providers/providermonitoring/index.htm#faq
The DHHS Application Policy and Procedure Review Tool is no longer being used. This tool was primarily used when a provider was enrolling into a network. The provider networks are essentially closed at this point except when there is a need for a specific type service in the LME-MCO's catchment area. The new monitoring process has been streamlined and merged many of the formerly-used tools to make the process efficient. The current tools can be found on the DMH/DD/SAS website on the Provider Monitoring Page, found here: http://www.ncdhhs.gov/mhddsas/providers/providermonitoring/index.htm#faq. Please follow-up with the LME-MCO that sent you a letter with a link provided to the tool to determine the context in which the Application Policy and Procedure Review Tool would be used, assuming the letter you refer to is from the LME-MCO.
Yes. EPSDT is a federal Medicaid law, requiring providers to cover any medically necessary service to a Medicaid-eligible child under the age of 21 “to correct or ameliorate a defect, physical or mental illness, or a condition identified by screening,” whether or not the service is covered under the North Carolina State Medicaid Plan.

NE PROVIDER MONITORING

Answer
If an agency staff gives a medication in any location, they need to have an order from a Physician/Physician Assistant/Nurse Practitioner, and they need to document on the MAR, time, administration route, dosage, etc. If the agency staff is in a day program or elsewhere outside of the home and the consumer has the order to self-medicate and they observe this occurring, they need to document to have a record that medication (under their watch) was taken as ordered. If they are working with a consumer in the home and the consumer self-medicates or family members give medications and the agency staff is not involved, they do not have to do anything.
CCP-8C does not currently allow for any discipline other than a physician to be exempt from issuing a service order.

NE PROVIDER MONITORING

Answer

No. This slide is only addressing one of the special requirements for LIPs. However, it should be noted that for any service, referrals, like any other client-specific information, should be documented and filed in the individual's service record.

Allowing LIPs to provide a limited number of visits before requiring service orders and prior approval does not preclude a provider from their fiduciary responsibilities as a clinician in documenting service provision. Documenting services in the service record is required at the onset of services, beginning with the referral and assessment, and not when the unmanaged visits have been exhausted.

There are no prescribed formats or templates, however, the Records Management and Documentation Manual outlines the service record and documentation requirements for entering notes, etc. Please go to the following link to view the entire manual: http://www.ncdhhs.gov/mhddsas/statspublications/Manuals/rmdmanual-final.pdf.

A revision on 8/01/2013 Subsection 7.2.2 and 7.3.4 “Plan requirement was changed from same day to within 15 business days” changing the policy revision of 12/2012 back to 15 days from “end of the first session” requirement.

NE PROVIDER MONITORING

Answer
The Record Release Checklist was revised to include the two questions pertaining to the disclosure of substance abuse information and confidentiality of HIV/AIDS information when it was discovered that these two requirements were indadventently not included on the checklist. The tool was revised on 4/3/14 and posted on the web. Notification of updates and the addition of new material that is posted on the Provider Monitoring web page is found on the Announcements page of the DMH website. During the trainings, it was recommended that providers and LME-MCOs check the website every week for any new updates. The Announcement of this revision was posted on 4/3/14: "The Record Release Checklist in the routine review tools for LIPs and Provider Agencies now includes the requirement to safeguard the confidentiality and privacy of substance abuse and HIV/AIDS information. The tools can be found on the Provider Monitoring page." The link to the Announcements page is: http://www.ncdhhs.gov/mhddsas/Whatisnew/index.htm. As a new strategy, we have started sending alerts to the waiver managers, QM Directors and the lead person at each LME-MCO for provider monitoring when updates or new material is added to the Provider Monitoring page. You have implemented a good practice of downloading the tools directly from the website to ensure that you have the current tool.
You were previously audited under the old review process. The new process was to begin March 1st and all providers are to be monitored under that process. You should contact the person who scheduled the review and ask them to delay your review. It should have been scheduled in 2015, not this year.

NE PROVIDER MONITORING

Answer
Medication management and outpatient therapy are performed by licensed clinicians. For LIPs, staff qualifications to provide a service are determined at the credentialing level. As long as the LIP is practicing within their scope of practice and the LIP is in good standing with their licensure board, documentation of training would only be required if the service provided has specific training requirements (e.g., associated with an evidence-based practice requirement). Refer to Clinical Coverage Policy 8C which contains all the service criteria for outpatient treatment behavioral health services. There are continuing education requirements to maintain licensure for LIPs and there are clinical supervision requirements for some clinicians, both of which require maintaining documentation, however, these requirements are specific to licensure and are not a part of routine monitoring.
Yes, your rights notification process should inform individuals of their right to have access to behavioral as well as medical treatment regardless of their age or degree of disability.
Yes, the LIP review tool will be used to monitor licensed MH/IDD/SA clinicians who work out of primary physician offices. The LIP Review Tools are used for LIPs in a solo or group practice who provide basic benefit/outpatient treatment services only.

NE PROVIDER MONITORING

Answer
This process of routine monitoring is designed to monitor providers of MH/IDD/SA services who contract with the LME-MCO for reimbursement of publicly-funded services from state funds or under the 1915(b)(c) Medicaid waiver. The LIP review tool is used with licensed clinicians who practice in primary care and integrated care settings through a contract with the LME-MCO. We do not know what is meant by integrative care grants.
This routine monitoring process is the result of collaboration between the Division of Medical Assistance, the Division of MH/DD/SAS, and the LME-MCOs and, as such, addresses DMA's requirement for routine monitoring under the waiver. The LME-MCOs also conduct program integrity activities on behalf of DMA. The purpose of routine monitoring is to ensure that providers of MH/IDD/SA services are in compliance with important rules and regulations that provide reasonable assurance that the rights and needs of the individuals receiving services and supports are protected as well as the integrity of billing for reimbursement of services funded with publicly-funded dollars. When evaluating the possibility of duplication in monitoring efforts, it is important to consider the goals, purpose, scope and nature of the monitoring and oversight provided by the licensure boards and DMA in other contexts.
We recognize that many rural areas experience a dearth of providers. These tools look at some of the basic compliance requirements. This process is not intended to intended to have a negative impact on providers in rural areas. We are interested in hearing more from you in terms of how this process disincentivizes providers practicing in rural settings.

NE PROVIDER MONITORING

Answer
There is no PCP training requirement for the Innovations waiver providers in the policy or the waiver. The waiver does speak to person centered planning for the care coordinators. Community Guide assists the individual in the person centered planning process so the person centered planning training would be valuable to those individuals.
The tools, instructions, and guidelines for using the routine monitoring tools utilize a variety of electronic formats including the automated workbooks, PowerPoint presentations, webinars, and this document. As implementation unfolds, these various formats allow more flexibility and expediency in getting material and updates out to the LME-MCOs and providers. There are no plans to write a provider monitoring manual in the traditional sense.

NE PROVIDER MONITORING

Answer
Yes, you are correct. ICF/IID -formerly ICF/MR-facilities are exempt from routine monitoring by the LME-MCO. DHSR has responsibility for monitoring ICF/IID facilities.
The workgroup has decided to allow six months of implementation before making substantive revisions in the current process. Any revisions or tweaks done at this point are because of errors or issues that adversely affect the fidelity of the process. As we monitor implementation of the new process, we are making note of the feedback we receive from the field. For the time being, the optional questions, all of which occur on the PPR tools, will continue to be optional and are left to the discretion of the LME-MCO as to whether these questions will be asked on a case-by-case basis or across-the-board. We understand that for providers that contract with more than one LME-MCO, these questions may be asked by some LME-MCOs and not by others.

NE PROVIDER MONITORING

Answer
The 5 records for the individual review and the 5 records for funds management are not a part of the sample of 30 events. For this section of the review, the provider is asked to provide a list of individuals for whom meds are administered and/or their funds are managed and a sample of up to 5 records is pulled for the record review. Documenting the results of the medication review and funds management review do not necessitate additional space. The results of the record review are recorded on the tool in the respective medication review or funds management section of the tool in the same section of the tool where the first 5 records in the sample of 30 service events is recorded (i.e., on fields C-G and rows 23-30). The names of those individuals whose records are reviewed for the medication review and/or funds management are recorded on the Individual Records List. Although the Individual Records List is set up for 30 individuals, additional names can be added without interfering with the automation of the tool. The Individual Records List helps the LME-MCO to identify which individuals were included in the sample. It is not linked to any of the tools. Its purpose is for record-keeping only.
State-funded as well as Medicaid-funded services are included in the routine monitoring done by the LME-MCOs. This includes I/DD services with the exception of ICF-IID facilities which are surveyed by DHSR.
The requirement to obtain a referral from the appropriate professional is applicable not just for outpatient services provided by LIPs but for other services provided by agencies. The question regarding the referral, however, is only on the LIP post-payment review tool. This does not mean that this requirement does not apply to provider agencies. It's just that there are other items on the PPR tools for agencies.

NE PROVIDER MONITORING

Answer
Yes.
If your question is whether this requirement applies to your practice, the answer is yes. These items are on the Health, Safety and Compliance Review Tool for Initial Reviews and on the Unlicensed AFL Review Tool. Based on the services that you provide, this item would be looked at when you first apply to contract with the LME-MCO or if your office moves to another location to a site that is not co-located with a licensed facility where this requirement would have already been a part of the licensure survey for the other service. The easy accessibility of emergency information is expected to be in place at all times.
Clinical Coverage Policy 8E for ICF/IID services stipulates that for reimbursement, the provider shall comply with all Medicaid or NCHC guidelines, including obtaining appropriate referrals for a beneficiary enrolled in the Medicaid or NC Health Choice managed care programs. For children funded by Medicaid or Health Choice, the referral information must include the name and NPI number of the individual or agency [CCNC/CA, primary care provider, the PIHP, or a Medicaid-enrolled psychiatrist] making the referral. For more information on the referral requirements, see the May 2005 Special Medicaid Bulletin IV.

NE PROVIDER MONITORING

Answer

You can use either the test tools or a clean copy of the review tool for your internal QA monitoring. The test tools have dummy data to show how the tools work. You can overwrite the dummy data if you wish to use the test tools rather than a clean copy of the review tool.

NE PROVIDER MONITORING

Answer

As a point of clarification, the sample size is based on paid claims (i.e., service events) -- not on individual service records.

The number of service events reviewed for a LIP practice is determined by whether the LIP is in a solo practice or a group practice where each LIP in that group billing under the same provider number.

In the scenario you presented, if the date of the on-site review is December 30, the period from which paid claims would be drawn would be from June 30 - August 30, that is starting six months before the date of the on-site and counting forward ~ 90 days.

The sample size for a LIP in a solo practice is 10 service events. The sample size for a group of LIPs who bill under the same billing provider number is 30 service events.

In those cases where a group of LIPs share the same office space but each of them has their own billing provider number (i.e., each LIP has a separate contract with the LME-MCO), the sample size for each LIP is 10 service events.

For LIPs that provide services in a setting where other enhanced services are provided (e.g., a CABHA), the services provided by the LIP are included in the billing by the agency where the sample size for the agency is 30 service events.

There is not necessarily a one-to-one correspondence between the size of the sample and the number of individual records pulled for the review. There might be several claims for one individual that is included in the sample. This would reduce the number of records needed to complete the review accordingly.

NE PROVIDER MONITORING

Answer
As far as post-payment reviews are concerned, each LME-MCO conduct PPRs on the providers with which they contract. As far as the routine review tools are concerned, there is not a central repository of provider information that the LME-MCOs can go to find out which providers they share in common so they could coordinate their monitoring efforts. We understand that NC Tracks will have that capability. The ability of LME-MCOs to share and accept each other's monitoring or the delegation of monitoring responsibilities to another LME-MCO must be approved by the national accrediting organizations for the LME-MCOs. Both the workgroup and the Business Practices Subcommittee are working on this issue.
A series of nine (9) webinars were posted on the Provider Monitoring web page on May 10, 2014. The webinars are a follow-up to the introductory workshops that were presented in February. The webinars cover the topics presented during the webinar in more depth than was possible during the statewide training and address some of the frequently asked questions about the monitoring process and tools.
Over the past several months, the focus has exclusively been on routine monitoring. There will be some incentives; however, since we have not discussed advanced placement, it is unclear what those incentives would be. In the Gold Star system, there was three levels of advanced standing – Preferred, Exceptional and Gold Star. Those providers who achieved PEGS status through Cardinal Innovations have retained that status. We are not sure what the new configuration and incentives will look like.
The number of events on both the LIP Post-Payment Review Tool and the LIP Review Tool has been expanded to allow you to document the results for 30 service events when monitoring LIPs in a group practice billing under the same provider number who provide outpatient/basic benefit services only. The results will be reflected on the Overall Summary worksheet. Thank you for bringing this issue to our attention.

NE PROVIDER MONITORING

Answer
The Health, Safety and Compliance Review Tool is completed by the LME-MCO during the initial inspection of a program that operates an unlicensed site-based service [this is typically done before the LME-MCO contracts with the provider] or when the service moves to another location that is not co-located with a licensed facility. This on-site inspection is completed by a LME-MCO reviewer. This is not a pre-site checklist that is completed by the provider and submitted to the LME-MCO. In the case of unlicensed AFLs, subsequent reviews of the unlicensed AFL would use the Unlicensed AFL Review Tool. The Health, Safety, and Compliance Review Tool is used for the initial review or when the program changes locations..
The Clinical coverage Policy 8C, 7.3.4, requirement which is that plan is due within 15 business days after first face to face is to be followed.
Depending on the services provided, up to seven different samples may be drawn. While the workbook was set up to allow reviewers to record the results for the number of individuals in the sample that is required, there was only one Individual Records list in the workbook. That list was designed to record the names of the individuals who were included in the sample for Rights Notification, Coordination of Care, Service Availability and the Post-Payment Review. Additional individual record lists have been added to the workbook to allow the reviewers to record the names of the individuals included in the review of Level I incidents, Level II and III incidents, restrictive interventions, complaints, funds management, and the medication review. This information is important to the provider and the reviewer in communicating and following up on specific findings.
Thanks for bringing this discrepancy to our attention. A guideline for item #2 has been inserted and new guidelines were posted on the web on April 16, 2014.

NE PROVIDER MONITORING

Answer
Yes.
The Unlicensed AFL tool will be used to monitor the Unlicensed AFL services. The routine review tool will be used to monitor all other services.
The routine review tool is used except when the agency provides only Unlicensed AFL services.
With the exception of the items on the agency tool that have to do with incidents, complaints, and restrictive interventions, the record reviews for provider monitoring are based on paid claims. In order to ensure that the sample only includes "clean claims," i.e., claims which have been submitted and for which the provider has been paid, the audit period is determined this way to maximize the chances that the claims have been fully adjudicated. The goal is to avoid including claims in the sample which have been pended or are still in process.
No. Licensed clinicians are not required to receive training prior to using the LOCUS/CALOCUS; however, there must be documentation on file that qualified professionals have been trained to use these tools. The LOCUS/CALOCUS are not just used by licensed clinicians. Care coordination and UM staff interpret the results of the LOCUS/CALOCUS in making placement and authorization decisions. Some of these staff are not licensed clinicians but are qualified professionals. While training is optional for licensed clinicians (some of whom elect to take the training), it is required for qualified professionals who are not licensed.
Yes.
Yes, if the person has a primary SA disorder, ASAM can be used in lieu of the LOCUS/CALOCUS. LOCUS/CALOCUS assesses both psychiatric and addiction disorders.

NE PROVIDER MONITORING

Answer
A LOCUS/CALOCUS score is required for service authorization. Because you cannot predict when a service authorization will be needed, especially in light of there being no way to determine how many unmanaged visits have been used or when a crisis situation might occur, it would be wise to to do a LOCUS/CALOCUS when a person first presents for treatment. The LOCUS/CALOCUS is part of the assessment process to establish the appropriate level of care the individual needs as well as medical necessity for the service.
The LOCUS/CALOCUS is required for service authorization. It is recommended that the LOCUS/CALOCUS be completed during the initial assessment to ensure that a level of care assessment is in place at the time service authorization is needed. The LME-MCO is also required to use the LOCUS and CALOCUS scores to substantiate medical necessity for mental health and psychiatric services.
The DMA contract with the LME-MCOs indicates that an enrollee must have a diagnosis that an enrollee must have a diagnosis that falls within a particular diagnostic range as well as a specified LOCUS/CALOCUS score in order for the enrollee to be considered part of the Special Health Care Needs population. Children with serious emotional disturbances, adults with severe and persistent mental illness, an Innovations Waiver participant, opiod dependent IV drug users, or individuals with co-occurring disorders, etc. are considered to be members of a special health care population.
The Child and Adolescent Service Intensity Instrument replaced the Child and Adolescent Level of Care Utilization System (CALOCUS).
The LOCUS/CALOCUS is required before a provider can obtain authorization for services. Because it is difficult to get a handle on the number of unmanaged visits that have been utilized, it is recommended that the LOCUS/CALOCUS be included as part of the initial assessment to avoid the situation of the provider being put in the position of having provided unauthorized services.

NE PROVIDER MONITORING

Answer

It is the responsibility of the prescribing physician to provide medication education for both prescription and over-the-counter medications. 10A NCAC 27G.0209 was written during the time when area programs were service providers. For purposes of this review, this question is only applicable when the agency's physician is the prescribing physician. If the prescribing physician is not employed by the agency that is being reviewed, this question would be rated N/A. However, it is best practice to inquire whether medication education was done by the prescribing physician and document to that effect in the person's record.

NE PROVIDER MONITORING

Answer
This question should not be rated N/A. CCP 8C 7.3.3 states that the results of the CCA provide the clinical basis for the development of the treatment/service plan. 7.3.3.1 states that it's required to demonstrate medical necessity (paraphrased) unless (7.3.3.2) outpatient therapy is provided for the first 6 sessions in an integrated (medical) setting or before psychotherapy for crisis or for medical providers billing E&M codes for medication management.
There is not a specific timeframe within which FAQs are compiled and posted on the web. When the FAQs documented is updated, a note to that effect is placed on the Announcements page under What's New. The date the update was posted also appears next to the link to access the FAQ. Postings are listed in chronological order. The most recent postings appear at the bottom of the spreadsheet. If you scroll down to the date listed on the posting, this is where the new batch of FAQs begins.
There are a number of federal and state regulations that mandate certain oversight and regulatory responsibilities to the LME-MCO as the local MH/IDD/SA authority operating a Pre-paid Inpatient Health Plan. GS § 122C-81 requires that providers of certain Medicaid-funded and State-funded services be nationally accredited. 10A NCAC 27G.0601 stipulate that LMEs are responsible for local monitoring of publicly-funded (both state-funded and Medicaid-funded) services in their catchment area. Medicaid provider requirements are laid out in GS § 108C, in the clinical coverage policies and in the Innovations Waiver. Monitoring compliance with these requirements are the responsibility of the LME-MCO. The interface of national accreditation and local monitoring is an issue which will be reviewed from the standpoint of added value and possible duplications.

NE PROVIDER MONITORING

Answer
Provider involvement in coordination of care has to do with looking at the individual holistically and interacting with other providers who support the individual to maximize the person's functioning and well-being across the board with the person's consent. Coordination of care can be demonstrated by coordinating with other providers of services to the individual (e.g., the primary care physician, mental health providers, vocational rehabilitation and participating in treatment team meetings with other providers and/or in the child and family team meetings). Care coordination is a distinct function which is outside of the scope of this review item.
The medication review requirements on the agency tool only apply to those situations where medication is prescribed by your agency physician or when medication is administered while the individual is participating in your program, including the person who self-administers their meds. These requirements do not apply in the person's residence or home -- only to the treatment program the individual participates in.
The state has maintained its commitment to wait at least six months before doing a massive overhaul or re-tooling of the process. Invariably when a new process is implemented, errors or omissions are discovered even with the best due diligence that can be employed. Revisions and updates are currently only being done to correct errors or omissions which would be detrimental to the accuracy and integrity of the process to delay or to make enhancements to improve the efficiency of the process based on feedback from the field. Examples of some of the revisions that were done include updates to the Staff Qualifications worksheets to improve their accuracy. In another instance, a guideline was missing on one of the PPR tools as were a couple of requirements for the release of information. It would have been more damaging to wait and let these errors/omissions persist than to fix them to improve the accuracy and efficiency of the process. With these revisions, the basic integrity of the tools has remained intact. Future enhancements to the process are among the parking lot issues that have been identified and will be rolled out in future phases of implementation.

NE PROVIDER MONITORING

Answer
When anything is posted on the Provider Monitoring web page (whether an update/revision or new material), a description of the update is made on the Announcements ("What's New") page on the website. There is a link to the Provider Monitoring page with each announcement. In order to increase the dissemination of information across the system, notices of new postings and updates will be sent to the lead person for provider monitoring, the waiver managers and QM directors at the LME-MCOs as well as to the provider organizations.
Outpatient therapists are licensed clinicians. Their qualification to do outpatient therapy is based on their licensure status. It is not necessary to complete a Staff Qualifications checklist for LIPs that work in an agency.