



**Provider Meeting
MINUTES
May 8, 2009
9:00am-12:00pm**

Attendees:

Jill Stephenson	PBH	Arlana Sims	SCCS Inc.
Tracy Threatt	PBH	Alisa Russell	CSSI
John Giampaolo	PBH	Charlotte Badger	CSSI
David Jones	PBH	Wendy Campbell	BCH
Judy Uthe	PBH	Kim Will	Preferred Alternatives
Eliza Davis	PBH	Renee Bellemore	The Arc of Davidson County
Chuck Hill	PBH	Jennifer Sweezy	Quality Family Services
Cynthia Benjamin	PBH	LaRuth Brooks	Youth Villages, Inc.
Heileigh Thompson	PBH	Demetra Grigley	RHA – NC START
Reid Thornburg	PBH	Fonda Simmons	YACM
Shelby Marlow	PBH	Ola Cook-Mbah	CNC Access
Steve Tomlinson	PBH	Sherri Isenhour	Path of Hope
Francesca Paladu	PBH	Mary Chavis	OmniVisions
Natalie Long	PBH	James Kelley	Monarch
Beth Monaco	PBH	Gina Carriker	DDR
Tammy Gilmore	PDS	Erin McBride	Bayada Nurses
Tema Smith	PBH	Margie White	CCGH
Nancy Thompson	PBH	Sara John	Quality Family Services
Richard Topping	PBH	Michele Bell	CLC
Emily Godfrey	PBH	Brandon Lapfitte	Quality Family Services
Pam Rankin	PBH	Liberty Johnson	Thompson Child & Family
Joanne Brooks	PBH	Kim Murray	Quality Family Services
Tiffany Jenkins	PBH	Grey Krypel	Independent Opportunities, Inc.
Revella Nesbit	PBH	George Turner	MHA NC
Sasha Fierce/Darlene	PBH	Marzeth Osborn	YACM
Ted Thomas	PBH	Karen Holst	UCPS
Jana Rollins	PBH	Memoy Gargiulo	Turning Point Services
Anna Yon	PDS	Jeannie Armstrong	Turning Point Services
Carol Gouge	PBH	Laurie Hibbert	Timber Ridge
Suzanne Storch	PBH	Anna Cain	GHA
Ginger Pope	CCGH	Dee Pankey	GHA
Diana Duncan	DHI	Dawn Allen	GHA
Flay Lee	Hope Haven	Jan Daniels Breeding	GHA
Kelli Bowen	ASMC	Fonda Simmons	YACM
Melissa Rivera	RHA Howells	Melissa Kluttz	RHA
Minnie Funchess	C. F. Marketing	Tyran Lennon	Horizon Care Inc.
Charles Funchess	C.F. Marketing	Connie Transon	Dreammakers
Julie Hunter	YACM	Courtney Dabney	CHS of NC
Carlo Black	YACM	Susanna Dean	ADEPT
Nadine McNair-Smith	Horizon Care Inc.	Lisa Byrd	UCRS, Inc.
Bobbette Willis	The Keys of Carolina	Nichole Weeks	RGH, Inc.
Tim Tilley	FSDC	Vernette Dalton	RGH, Inc.
Carolyn Spence	Alexander Youth Network	Donald Bovender	RVO
Allan Azali	Independent Opportunities Inc.	James W. Johnson	STEPS Developmental Academy
		Yvette Johnson	Quality Family Services

9:15 a.m. Welcome and Call to order – Flay Lee

Flay welcomed everyone and hopes everyone takes in information and brings it back to their agency. May is mental health month. We will want to hear more about that from the mental health providers.

Meditation Reading – Flay Lee

Happiness is a decision. It is an energy that is positive and an attraction power. We attract what we send out. People prefer to be around those like themselves. Life attracts life. Repel toxic people. If you are negative and not happy, you may be alienating happy people that can help you. Happiness is your number one priority for your destiny. From the Book: On track On Fire, Barbara S. Taylor

Make happiness a part of your life and get the same back.

Role of PBH Attorney – Richard Topping

PBH recently hired an attorney. Network Council asked him to come and talk about his role. Flay introduced Richard Topping. Richard stated he is general counsel for PBH. The Network Council asked him to go over what he does and how it relates to providers. Most of his work would not be transparent. Adversarial is what providers would see. Richard is the last piece of PBH's compliance structure as the Chief Compliance Officer – the last stop in compliance chain to help providers do their jobs. We report up to the State, providers appropriately report to PBH. Before an issue goes outside PBH, the right limits are set (left and right limits), assist executives – discuss pathways and sometimes offer suggestions. Richard mostly gets questions from Directors on how to handle issues. When a provider gets an answer, it has come through Richard. The provider or consumer process - issues that can't be resolved in PBH, they come to Richard which is the adversarial level – you don't want it to get to Richard. If the issue has not worked through the processes, it comes to Richard. If Provider issues have not been able to work out, it comes to Richard – whether PBH is going to defend it with DMA/DMH or the court. Most providers won't deal with Richard. There are tools within PBH – Richard tries to push back down through the agency for resolving. Richard will only become involved when everyone has the information needed but there is no meeting of the minds. Sometimes not everyone is on the same page – don't understand the perspective.

- *Question:* Does everyone understand the process if a service is denied or what happens with the QM process?

Answer:

- Provider joins PBH Network, first stop is Network Operations to establish contract. If there are questions/changes on contract, Richard would sign off.
- Second is PBH Quality Management – QM provides technical assistance to the provider, ensures provider is compliant and providing data. If there is a QM issue and the provider and QM do not see eye to eye, i.e. payback to PBH, can't work out the issue with QM.
- The issue next goes to a Cross Functional Team that will look at everything the provider has submitted. This is the first look to determine if there is PBH action. The provider is notified of the action. If the provider agrees, the action goes into affect. If the provider disagrees, the disagreement goes to the Reconsideration Committee chaired by Steve Tomlinson.
- The Reconsideration committee consists of representatives from PBH's Network Operations, Quality Management, Finance and Richard. It is just a review – last stop at PBH. If the Provider agrees with the Reconsideration Committee, it stops. If the provider does not agree, the next stop is outside of PBH.
- The appeal would go to the Division or DMA or Office Administrative Hearing or Superior Court. Richard makes sure PBH did what they needed to do – assess agency liability. If PBH did the right thing, a settlement would be worked out but highly unlikely. If PBH crossed its Ts and did irreconcilable difference, Richard would defend PBH. All the PBH staff has an interest in your success. They make sure you are an active integral part of the network. When a Provider issue reaches Richard, he is not going to make sure the provider is successful, the opposite. Richard has worked with the process all the way through in the background. A provider does not want to work with Richard again. The process has not happened this way before – the State has a cumbersome system to address these issues. Some cases get lost, some take a long time. Hopefully in house adversarial, we can be more efficient.
- PBH does recoup payments during appeal. You have right to request payment on behalf of clients' treatments while PBH appeals. If PBH wins, you repay. There are risks for everyone. Risk if PBH is wrong, they lose and are responsible for what was wrong. If provider loses, you and family are responsible for payback.
- *Provider comment:* Payback is tough on parent.

Response: We understand. The parent gets a letter advising them of this risk. Make people understand. If you really feel you are right and want to go forward with the appeal, you are accepting the loss or win. Richard will come looking for the money.

- *Provider comment:* What if the parent is making the appeal?

Response: There is joint responsibility but it is portioned. If there are continuity of care commitments, PBH will work with the provider to make sure you make your commitments and continuity of care. If you continue care beyond that, Richard will force you with the liability. The idea/policy is to be able to resolve issues in the agency. There are situations. Richard state one issue may be due to a service definition not being clear. Different perceptions – a provider would know up front that PBH would move to let the State resolve.

- *Question:* Once an issue gets through the Reconsideration process, is there an opportunity to mediate before going to court.

Answer: Mediation to wipe the slate clean and start from a piece of negotiation. The Law was changed last year – automatic reporting to the State for mediations. It is still outside the agency. There is a chance to have a mediator paid by the State. Consumer would have already had an independent review by the PBH Medical Director.

- *Question:* If there are questions later, can providers email them?

Answer: Yes, send them to your Network representative.

- *Question:* Can people call Richard for advice?

Answer: Sure. But Richard represents his client which is PBH. Most of the Provider's process is non-adversarial – working with PBH departments. The Cross Functional Team part of the process is neutral – no jeopardy. When a provider gets to Richard, adversarial begins. No advice can be given at that point, not ethical. As far as non-adversarial or neutral, it depends on the provider. There are questions that do come up. Again, speak to your PBH representative. Ask the question to your PBH representative and they will turn it to Richard. Richard does look at pros and cons. Richard is accessible but he is part of the tools – know where you are in the process.

Flay noted that Darlene Steel mentioned at the Network Council Meeting that the Chief Compliance Officer ensures there are quality consumer outcomes, appropriate compliance and partnership with the Provider Network.

Network Council Updates – Flay Lee

Flay asked council members to stand and introduce themselves.

Flay Lee, Council President/Hope Haven

Arlana Dodson Sims, Vice President/Sim's Consulting

Diana Duncan, Secretary/Diana's Home Care

Dawn Allen, DD Rep/Executive Director of GHA

Cynthia Benjamin, PBH Network Operations

David Jones, PBH Director of Clinical Operations

Tammy Gilmore, PDS

Network Council meetings are the first Thursday of every other month. We encourage providers to set in on meeting and consider becoming a part of the council.

The Council will be requesting another retreat in July to map out next year and review past years goals.

Network Council Workgroup for Dashboard Reports - The workgroup met April 21. The reports required by Network Council By-Laws were reviewed.

The next Provider meeting is August 14. New outcomes and what the government has done with the budget will be discussed at this meeting. As we end this calendar year, make sure you are prepared to come to the November 13 Provider meeting.

Any questions, please give them to your representatives. We are planning on quarterly Provider meetings in 2010. Network Council encourages DD, MH, and SA provider to have their own individual group meetings and to bring back this information to the Provider Meetings. Flay described the SA provider group meetings and how the group established SA trainings with credit.

PBH Department Updates

1. Finance – Niels Eskelsen

No report

2. Network Operations – Cynthia Benjamin

Cynthia stated Endorsement letters are being sent out. When providers get their letters, please get the required elements in. The State is calling about endorsement expirations. Department is status quo, please call your Provider Relations Manager regarding endorsement. Focus right now is endorsement.

3. UM/Access – David Jones

There are some changes to the UM guidelines. David talked about why and what is going on. We have been doing research on our utilization patterns, amount of services authed and claimed; best practices. Outcome measurements from level of care work and SIS, and made determinations about UM guidelines. What and how much we auth for services. We found many things – got with a nationally recognized group, HSRI. They reviewed our data and confirmed where we were going with our changes. Their suggestions are to keep us in line with national trends for best practices. Our changes came from that. We are focusing on: alternate level of services. Community Support will follow with rest of State. David stated he has not heard a whole lot of issues or concerns. If providers do have concerns/issues, call UM/Access.

There have been meetings with local DD providers and trainings regarding the changes. We identified an opportunity for improvement on PBH – we are going to be asking for more data and specific data for medical necessity determination. Behavioral data; not just treatment plan – progress notes, what are the outcomes. This data will be needed to receive the service and continue the service. We need to be using more data to make those determinations. This was based on the research we did and the national consultants.

- *Question:* On the changes coming, supportive employment 10 hours, will there be any grandfathering? We have a resident that looks forward to that employment.

Answer: The changes do not mean that we are not looking at individual needs. It does not mean automatic denial. None of the benchmarks – we need additional data to make those decisions. We are going for the right service, at the right time, right frequency, and duration.

- *Question:* On DD side, high level, if it is someone being supported with high rate one to one level and we remove those supports, there is going to be issues. While data is low or non existent, can we send in reason why? There will be denials because there are no reports to support the request.

Answer: We will look at this case by case.

- *Question:* Is there a statement that can train a provider on this?

Answer: May 20 training – we did general information at our first training – this one will be very specific information so the entire network knows what the expectations are. Other thing is posting questions and answers from the trainings. Keeping you informed.

4. Quality Management: No report

Agency Spotlight:

- **The Start Program – Michelle Kluttz, RHA**

Michelle reviewed a PowerPoint presentation which is attached to the minutes. **S**ystemic, **T**herapeutic, **A**ssessment, **R**espice & **T**reatment - NC Start program innovation for crisis intervention, DD challenging behaviors. Person centered planning – supplemental service to the team, The Start Program does not replace any agency. They work with all the supports at the same time, around the table. Mediator - as a consult to assist with the crisis situations, i.e. Start Program would work with Daymark through the crisis.

The program is statewide. RHA has been awarded the Western and Eastern state contracts. We can't be first responder due to our large coverage area - reason main services have to stay.

Michelle noted the packet information had a mistake on FAQ document. The first question about eligibility – cross out primary diagnosis.

There are no funding requirements – the program will still work with the individual. If not currently in the service system, we contact ACCESS (Amy Ford) about a referral and get them connected to the system – clinical home. We offer behavioral recommendations to prevent crisis events. Respite services are in Statesville (5 mins from the highway) – trained staff ready to go. It has been opened for 3 weeks. We are not able to provide transportation – funding issue. Individual has to have a return address. We have been a step down piece. The crisis beds are certain hours for admission. We do not require authorizations from PBH or ValueOptions – does not slow down the system. Referral: 800 Phone number is wrong on handout. 888-974-2937; the direct line to Michelle: 704-796-2757. We are responsible for reporting Individual and community outcomes. Capacity to serve 120 consumers – we have 50 currently. Our crisis plans will be in attachment to the PCP and included in the plan. We can't support

active SA – must be in full remission; can't work with TBI prior to age 18; and we have to look at cognitive deficits and IQ in the mild range.

- *Question:* Is there no transportation for the entire time of stay?
Answer: While at respite facility, there is transportation for doctor visits, etc. Just no transportation to and from the respite facility.

Break for Networking with other Providers – 10:25 a.m. to 10:45 a.m.

PBH Department Spotlight:

David Jones discussed having spotlights on PBH departments during the Network Council meeting. First department spotlight is Utilization Management.

Beth Monaco, DD Manager and Pam Rankin, MH, SA Manager introduced the staff present. Pam has worked in UM for 5 years and prior to that worked as a provider with PBH 15 ½ years. She has seen the same changes as providers. Beth has been with PBH for 4 years. She moved from New York, where she had 20 years DD experience from direct care, on up. The PowerPoint presentation is attached to the minutes. Beth covered the role of care management in system of care; organization of department; list of staff – all are experienced QP; initial authorization process; concurrent review; retrospective review; medical necessity description and determination.

- *Question:* What is the status of hiring a DD psychiatrist?
Answer: The selection is going through a consultant and yes PBH feels it is a need.
- *Question:* Is this process being reevaluated for denial letter, will the provider be involved in the review?
Answer: We will be reviewing the process.
- *Provider Comment:* Some of the care coordinators may not be as accessible right on the spot and feel under the gun – work together.

Pam covered the Tar review process - timeline. There are particular federal guidelines to follow. 14 days to approve, deny or extend the request. We want to approve services – get the consumer started in the plan of care. Denials are approved by a team. A denial letter will be sent to the client and provider. Medicaid or state funding appeals – it is the consumer's responsibility to make the appeal. The provider can assist. If the consumer asks for help or is developmentally disabled, the provider can appeal on behalf of the consumer with their consent.

- *Question:* The provider only gets the first part of the packet. Many occasions, the consumer or family/guardian don't understand the paperwork. As a provider, is there a reason we don't get the full packet?
Response: The letter is sent to everyone with reason and states rules regarding appeals. We send legal guardian or consumer the reconsideration form – it is their responsibility. The provider is always welcome to call Keisher or Chris in terms of the appeal process. The letter also states that if you want a review, you can call the doctor who has denied the service to discuss the denial or next step.
- *Provider response:* We are already within a timeline and without the initial papers; it is another step to get the forms. If we don't get the full packet, it takes away from the timeframe.
Response: The provider has to get consent from the consumer or guardian.
- *Provider Comment:* You don't automatically get the paperwork from the consumer/guardian. We are trying to be proactive.
David Jones's response: Let us take this back and talk about it. We are sending out a lot of paper which needs to be considered.
- *Provider Comment:* When they place their consumer in a residential facility, they think the letter is a copy and the provider is taking the lead.
Dr. Carroll Lytch responded: We will discuss. There are two different letters: initial of original request (sometimes we don't know the provider) and continuation request. The letter copy to the provider is a courtesy.

Pam continued reviewing UM and the PCP/ISP; PCP/ISP changes; how to change in services; State Funding is limited; Medicaid card; EPSDT and Children's Services; Appeals; rights of Medicaid recipients; non-Medicaid appeals; discontinued service – send in TAR to terminate the service.

- *Question:* Tars are time stamped? So if we submit on Thursday, the week starts that day.

Answer: Yes. I recommend providers attend Provider Direct Training for detail TAR information. Make sure you put a comment on the TAR.

- Question: Will we get the follow up from Network.

Answer: UM will do a communication bulletin.

- Question: Discharge denial – can you give an example of denial?

Answer: Provider requests discharge from a service but we felt they needed to keep working with the individual to change the stages. Anna Yon, PDS, provided an example also. If the guardian wants to keep a service open, UM will make the decision.

- Provider Response: Can we have a DD residential example?

Answer: Level of care change, we would need document to see why they need discharge. If we find they are still eligible, we would deny the discharge. It is not common. David Jones provided an example for Inpatient. We have a hospital that wants to discharge patient, but UM looks at the data and sees patient is not ready for discharge or there is no where to discharge to at that level of care. Hospital feels they have been there long enough. We would challenge that with a denial.

- Provider Comment: I have heard a person may not want to be discharged but there may be something to support the discharge.

Answer: That is limited and case specific but we will work with the provider to try and transition if there are other issues. We are there to do the care management. There are UM companies that all they do is look at a piece of paper and say yes or no. We do not want to be perceived as that. We want to work as a partnership to get the right level of service, at the right time, right frequency, and duration.

- Provider Comment: What if the provider has serviced as much as we can, there is no progression and we send in a discharge. It is like enabling people to stay where they are at.

Answer: We will work with the provider on transitioning and may be the same level of care. It may take some time.

- Provider Comment: Most guardians have signed consents to the provider so they may act on their behalf. Is there not a way you can make a form section on their website?

Answer: That is what we are doing – a dedicated UM website. In the Interim, we can have it posted on the website so it will be there. The current website is cumbersome to find items. It will be in the communication bulletin.

Reid Thornburg, Provider Relations Manager, comment: It has not been my experience of denial to be same day, there should be a plan with a timeline. David Jones responded yes. We are working on a report by provider about requests – show timeframe allowed for UM. We have seen a lot of requests for next day. This makes it difficult to turn around that fast.

Question: What is the timeline for tar submission?

Answer: within 14 days, no less than 30 days.

Flay stated Council would like to continue the department spotlights. We appreciate the generation of Questions and Answers.

Topics of Interest:

Subcommittee on Dashboard Reports

There is a group dealing with reporting system part of the **bylaws for council**: we have learned from what have we tried and what have we learned. The next part is to solidify the information and put it into an action plan. The group includes James Johnson, Chuck Hill, Diana Duncan, Dawn Allen, Peggy Terhune, and Flay Lee.

The required reports are:

1. Referrals Made vs. Referrals Accepted per services per provider – quarterly
2. Wait List/Registry of Unmet Needs – quarterly
3. Number of Consumers receiving Services per Provider – quarterly
4. Number of Discharges from Providers by provider name and reason for discharge (treatment completed, consumer discontinued, etc.) – quarterly
5. Trend Analysis – annual
6. Provider Satisfaction Survey results, analysis and actions – annual
7. Capacity Study and Gap Analysis – annual

8. Accessibility Study – at least annually

Additional reports desired by the council are:

1. Global and Individual provider status and trends regarding the PBH Provider Performance Profile (Gold Star) process – yearly
2. New Service Initiatives and gaps – quarterly
3. Breakdown of the number and types of providers under contract and trends – quarterly
4. Trainings offer to providers (include name, type of training, number of attendees) – quarterly

Additional report elements desired by the council are:

1. Reports should be easily understood.
2. Report should be more than just a data table; it should also include some explanation/interpretation of the data.
3. Whenever possible, the report should be summarized with detailed data available if questions arise or further discussion or analysis is desired.
4. When possible, use graphs.
5. Presentation of the reports and discussion should be brief as possible.

Frequency of Reporting recommended by the Network Council is quarterly at the Network Council meeting. This will be monitored to determine if the amount of reporting is too ambitious or could be better monitored by splitting the reporting between monthly meetings.

Provider Questions/Updates/Concerns/Suggestions

- Ethics training LCSW June 5 10 -3 Family Services in Davidson County
- Index cards passed out – use them to write questions for Richard or PBH departments. Give them to your Network Council reps before you leave.
- SA providers – workshop next Thursday ethical dilemmas – free and 3 hours credit.
- Quarterly provider meetings next year – come back in August with nominee names for Network Council

Motion to ADJOURN 11:45 a.m.

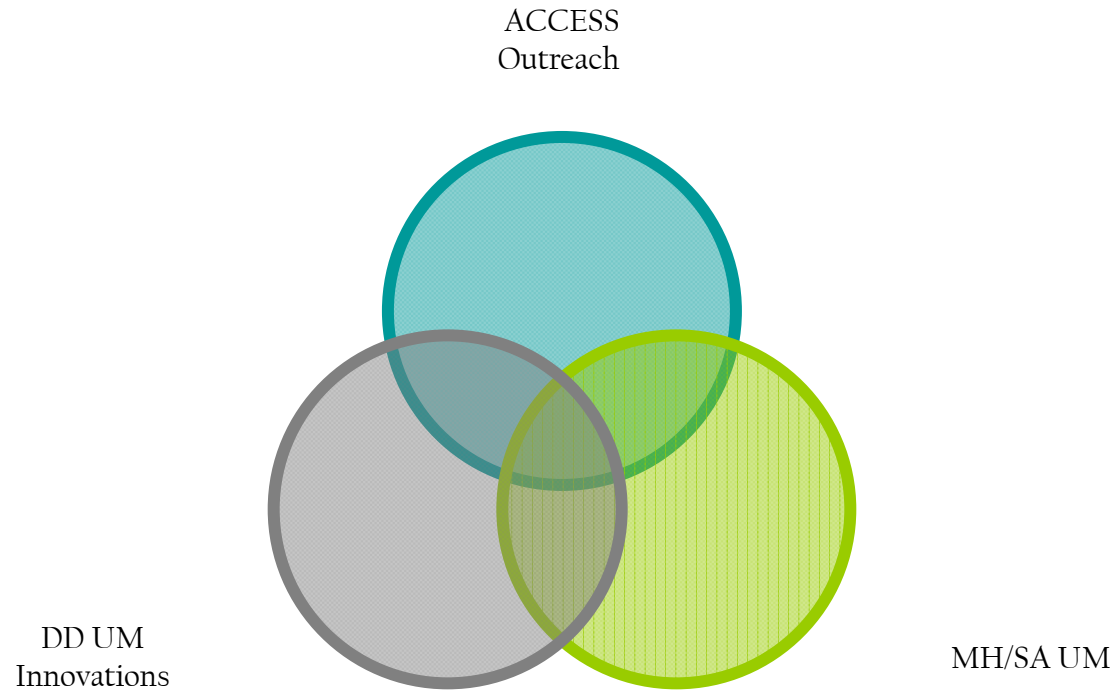
PBH Utilization Management

Developed and Presented by:
PBH Utilization Management Dept. May 2009

The role of care management in the PBH System of Care

Care Management is accomplished through consistent and uniform application of Piedmont's Clinical Criteria for each consumer's individual clinical needs to determine the appropriate type of care, service, frequency of services, and intensity of services, in the appropriate clinical setting. Care Managers also assist the provider in care coordination and linkage of services. Our goal is to ensure that consumers receive the right service at the right level creating the most effective and efficient treatment possible

Organization of the Access/Utilization Management /Outreach Department



UM Department Staff

David Jones - Director of Clinical Operations

Chris Jacobson- Director

Dr. Carroll Lytch - Senior Psychologist

Dr. Kristen Baker - Clinical Director

Dr. Craig Hummel - Medical Director

- Pamela Caviness Rankin-MH/SA
UM Manager
- Joanne Brooks – Support Staff

Care Managers

- Christine Beck
- Crystal Howard
- Donna Travis
- Emily Godfrey
- Francesca Paladino
- Melissa Covert
- Nancy Thompson
- Natalie Long
- Tema Smith
- Tiffany Jenkins

- Beth Monaco – DD UM Manager
- Shelia Rabon- Support Staff

Care Managers

- Carol Grant
- Jane Austin
- Janet Garvin
- Jessica Moore
- Timothy Schmitz
- Tina Cagle

SIS Evaluators

- Ann Rudd
- 2 Vacant

Initial Authorization

- The UM decision made at the time the clinical assessment and plan for treatment are reviewed with the provider. At PBH this is done via the internet, known as the Provider Direct System (PD) .
- Once a service is approved, authorization letters are automatically uploaded to a provider folder in PD.
- Basic Augmented services are requested using the Treatment Authorization Request (TAR) .
- If Enhanced Services the PCP/ISP with corresponding TAR will act as the initial authorization of all services and the TAR will be submitted for reauthorization.

Concurrent Review

- Client treatment progress and requests for continuing treatment authorizations are reviewed concurrently.
- Renewal requests are reviewed by Care Management staff for client progress, the continuing presence of impairments in functioning and crisis situations, and adherence to the treatment plan.

Retrospective Review

An analysis conducted after services are rendered. This review considers medical records, self reporting, interviews with significant others and other collateral sources (i.e. documentation of skills/deficits) which document health services provided to a member and the member's condition at the time of the service

What is Medical Necessity?

- Medically necessary treatment shall be defined as those procedures, products and services that are provided to Medicaid recipients (excluding Qualified Medicare Beneficiaries) and are:
- Necessary and appropriate for the prevention, diagnosis, palliative, curative, or restorative treatment of a mental health or substance abuse condition;
- Consistent with Medicaid policies and National or evidence based standards,
- Department of Health and Human Services defined standards, or verified by independent clinical experts at the time the procedures, products and the services are provided;
- Provided in the most cost effective, least restrictive environment that is consistent with clinical standards of care;
- Not provided solely for the convenience of the recipient, recipient's family, custodian or provider;
- Not for experimental, investigational, unproven or solely cosmetic purposes;

How is Medical Necessity Determined?

- Medical Necessity is determined through the review and evaluation of the clinical information submitted to the Utilization Management department in the request for services. (Treatment Authorization Request) The clinical information is applied against the established medical necessity definition listed above and the established admission, continuation, and discharge criteria for the service being requested.
- If the information in the request meets or exceeds the criteria for the admission or continuation, this will result in an authorization of services based on the Utilization Management Authorization guidelines. If the information does NOT meet the criteria, this will result in an extension of the request in order to gather more data in an attempt to determine if Medical Necessity is met, or a denial of the request based on a lack of clinical justification.

How is Medical Necessity Determined Continued?

- Furnished by or under the supervision of a practitioner licensed (as relevant) under State law in the specialty for which they are providing service and in accordance with 42 CFR, the Medicaid State Plan, the North Carolina
- Administrative Code, Medicaid medical coverage policies, and other applicable Federal and state directives;
- Sufficient in amount, duration, and scope to reasonably achieve their purpose and
- Reasonably related to the diagnosis for which they are prescribed regarding type, intensity, and duration of service and setting of treatment.

How is Medical Necessity Determined Continued?

- Within the scope of the above guidelines, medically necessary treatment shall be designed to:
- Be provided in accordance with a person centered service plan which is based upon a comprehensive assessment, and developed in partnership with the individual (or in the case of a child, the child and the child's family or legal guardian) and the community team;
- Conform with any advanced medical directive the individual has prepared;
- Respond to the unique needs of linguistic and cultural minorities and furnished in a culturally relevant manner; and
- Prevent the need for involuntary treatment or institutionalization.

TAR review process

- **Approve-14 days or less**
- **Expedited- 3 days or less (for health and safety)**
- **Extend -14 additional days, Consumer and provider will be notified in writing of missing information**
- **Deny -Services are based on Clinical Review or Consumer is not eligible for the Benefits**
- **Medicaid Appeals**
- **State Funded Grievances**

UM and The PCP/ISP

- Review of the PCP/ISP and other clinical documentation to determine if the consumer's needs as outlined meet medical necessity for a given treatment authorization request.
- Determine if the goals outlined for the consumer match the appropriate intensity, frequency, and duration of the service requested.
- Review for use of Best Practices with Level of Care offered thru PBH waivers.

What if the PCP/ISP changes?

- All changes in Enhanced Services will require that an Update is completed for the PCP/ISP. A TAR for the services will be created by the provider, services/ frequency should match the PCP/ ISP.
- Once the Update is approved then services will be authorized
- Reauthorizations will be completed based on the information found in the PCP/ISP and other clinical documentation.

How do I let someone know if I need to make a change in Service?

- PCP/ISP- you need to let the Community Support Worker or Support Coordinator know that a change needs to occur. As a team update the PCP/ISP
- If Basic Augmented –the treatment team should make changes in the TAR and submit it to UM. Note on the TAR the changes and the clinical reason for changes.
- Additional information may be requested to establish medical necessity for services.

Important Things to Remember when Submitting Referrals for State Funding

- State Funding is not an entitlement
- State Funds are the last payer resource and the Individual receiving services must meet the IPRS Priority Populations. These “target pops” can be found at the NC MH/DD/SAS web site.
- Funding is limited and only available to Individuals for the period of time that they meet eligibility criteria.
- Recipients of this funding will be assessed ongoing for potential step down in intensity and frequency of service provision.

Medicaid

- The individuals Medicaid card will have PCHP in the corner of the card.
- PCHP means Piedmont Cardinal Health Plan - The name of the 1915-B waiver covering Cabarrus, Davidson, Rowan, Stanly and Union Counties.
- If the Medicaid does not originate from a PBH county, services will reviewed by Value Options

EPSDT and Children's Services

Federal Medicaid law @ 42 U.S.C. § 1396d(r) of the Social Security act requires Medicaid requires states to provide periodic screening, diagnosis and treatment (EPSDT) for recipients under the age of 21. Within the scope of EPSDT benefits under the Medicaid law, states are to cover any service that is medically necessary “to correct or ameliorate a defect, physical and mental illness, or a condition identified by screening”, whether or not the service is covered under the state plan.

EPSDT qualifying services:

- Must be ordered by a physician or other licensed clinician
- Cannot be experimental or investigational, unsafe, or ineffective.
- Does not eliminate the need for prior approval
- All services covered by Medicaid are subject to budget limits imposed by the CAP Waivers (Innovations)

So...

Services Were Reduced,
Suspended, Terminated or Denied:

An Overview of the PBH Appeals
Process

Reasons for a Medicaid Appeals

A Medicaid recipient may appeal when PBH reduces, suspends, terminates or denies a requested service.

- Denial: The decision by PBH not to authorize a newly requested covered Medicaid mental health services that meets NC Medicaid Service Definition or a service of higher intensity than the service currently being received due to lack of medical necessity.
- Suspension: The decision by a PBH to temporarily stop an enrollee's previously authorized covered Medicaid mental health services.
- Reduction: The decision by PBH to decrease an enrollee's previously authorized covered Medicaid mental health services.
- Termination: The decision by PBH to stop an enrollee's previously authorized covered Medicaid mental health services..

Rights of Medicaid Recipients

- Clients must be informed of their rights to appeal.
- Client will receive a copy of the brochure 'Piedmont Cardinal Health Plan: Medicaid Appeal Rights' when they access services.
- This brochure must be made available in both English and Spanish.
- The PBH Access Department will notify the consumer by mail of their rights in common areas so that individuals may access the information.

Non-Medicaid Appeals

A Non-Medicaid Appeal may be filed if:

- A state funded service is suspended, denied, reduced or terminated.
- The Consumer files directly with PBH
UM/ACCESS
- There are no rights to a fair hearing (formal hearing).

Provider Responsibilities for Submitting Requests to Terminate, Suspend, or Reduce Services

- Submit an electronic TAR indicating request to terminate, suspend, or reduce within 14 days of the service change to UM.
 - Provide justification for the change in the comments section of the TAR.
 - Indicate if the individual receiving the service agrees to the change.
 - Document all changes in the individuals clinical record.
- Document the service change on the PCP/ISP and submit to UM.

UM Responsibilities for Denial, Reduction, Termination, or Suspension of Medicaid Services

- UM prepares a letter to the client (using the standardized letter format).
- The letter must be mailed to the individual (not delivered in person)
 - A copy will be mailed to the provider.
 - The letter must be mailed the same day as it is written.
- UM staff will track each letter that is sent
- UM will coordinate appeals with consumer and provider

Questions?

PBH Utilization Management and ACCESS

845 Church St NE Suite 201

Concord, NC 28025

(704) 743-2100 or

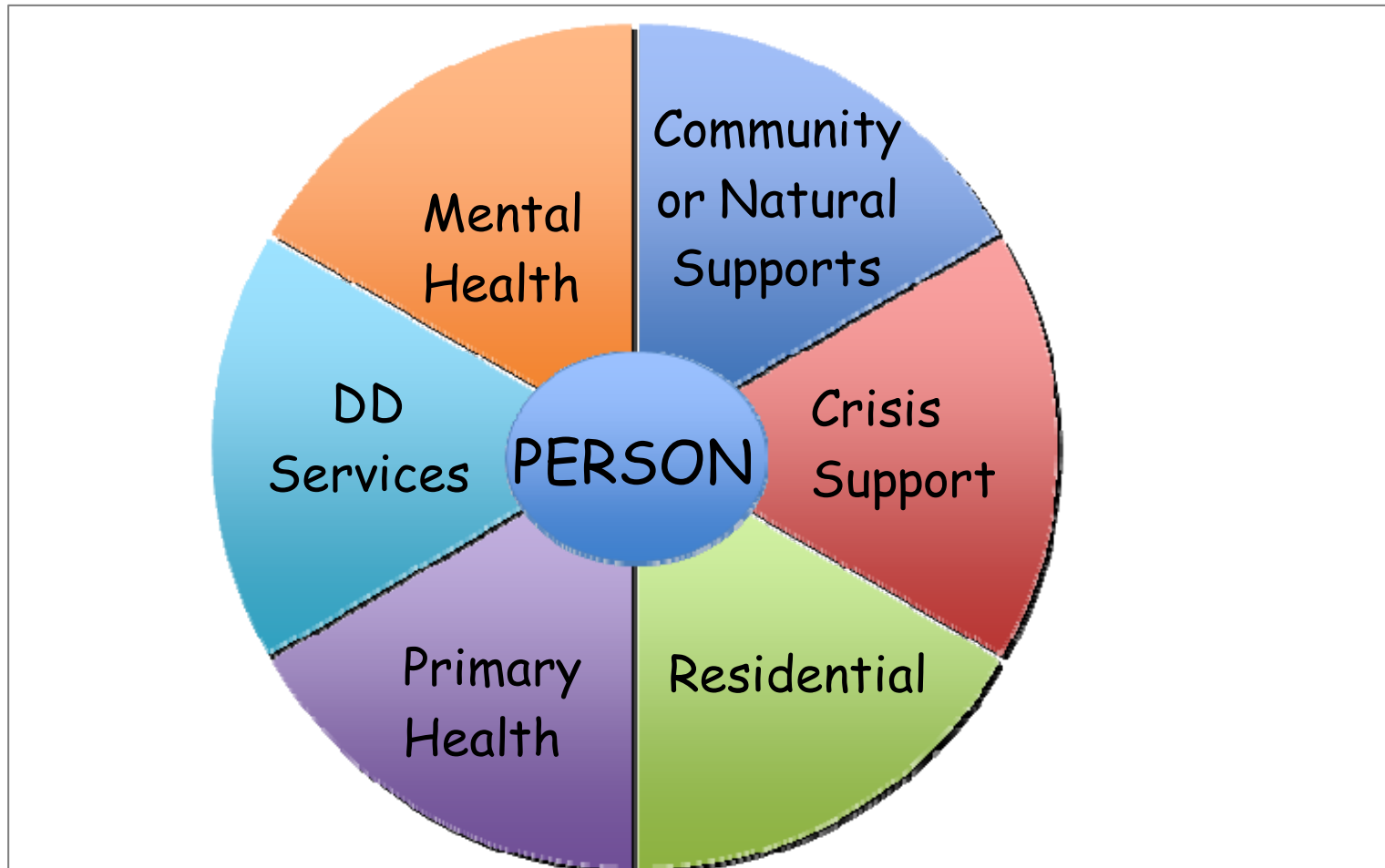
Fax (704) 743-2130



Systemic, Therapeutic, Assessment, Respice & Treatment

- *Community Crisis Prevention & Intervention*
 - To **Support** people with Developmental Disabilities who experience crisis due to mental health or complex behavioral issues
 - To **Enable** individuals to remain in home or community living placement

NC START - Bringing it all together



Key Principles Summary

- START is not a separate system, but focuses on establishing integrated service linkages.
- START does not replace current First Responder services, but serves as a secondary clinically-based support for the individual, First Responders and other providers.
- START emphasizes crisis prevention through knowing high-risk individuals, involvement in developing crisis plans, training, and technical assistance.

NC START

Organizational Description

- **START – West (RHA)**
 - Clinical Teams: Asheville and Concord
 - Respite Home: Statesville
 - Psychiatric and Psychological Consultants
- **START – Central (Easter Seals UCP)**
 - Clinical Teams: Durham and Greensboro
 - Respite Home: Franklinton
 - Psychiatric and Psychological Consultants
- **START – East (RHA)**
 - Clinical Teams: New Bern and Wilmington
 - Respite Home: New Bern
 - Psychiatric and Psychological Consultants

Who is Eligible for START?

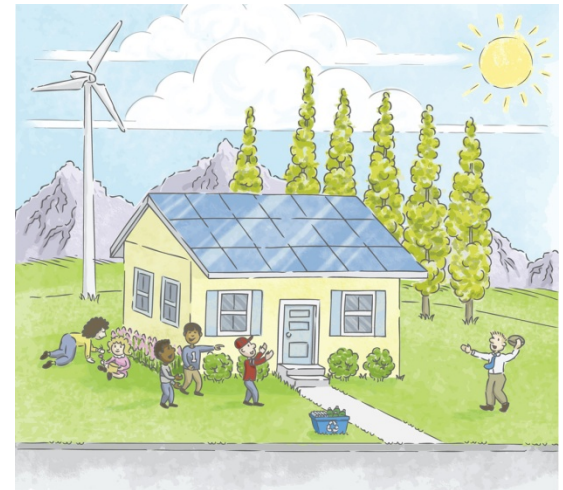
- At least 18 years of age
- Developmental Disability Diagnosis
- Co-occurring mental illness or significant challenging behaviors
- START services are provided based on the Clinical Team's review of the individual's needs, situation, and assessment information.

Program Elements

- I. Crisis Support Continuum
- II. Clinical Support – Assessment & Treatment (Cross-System Crisis Plan)
- III. Training and Consultation
- IV. Collaboration
- V. Emergent and Planned Respite

Respite Services

- **Respite Elements:**
 - Trained staff, many at QDDP Level
 - Symptom/behavior monitoring
 - Structured daily activities
 - Collaboration with individual's support team
 - Family support/education
- **Emergency Respite (up to 30 days)**
 - 2 beds per respite site
 - Behavior Stabilization
 - Hospital Diversion
- **Planned Respite (up to 72 hours)**
 - 2 beds per respite site
 - Targeting individuals who are not able to utilize traditional respite due to behavioral challenges





Referrals

Examples of how START can be accessed:

- **Crisis Response Consultation & Technical Assistance:**
 - First Responder acts in response to individual in crisis, utilizes Mobile Crisis Management, and/or initiates START involvement
 - Case Responsible Agency initiates START involvement as a preventative measure to aid in the reduction of future crises.
- **Training, Consultation & Community Collaboration:**
 - Through variety of sources: LME, provider, family, hospitals, social services, and community services
- **Emergency & Planned Respite:**
 - START Team facilitates respite based on individual assessment & situation in consultation with appropriate sources (first responder, family, LME, primary provider)

START

with the end in mind.

Quality Outcomes

Individual Outcomes

- Maintain stable community residence
- Access and engage resources
- Decrease behavioral challenges
- Decrease mental health symptoms
- Decrease state facility and hospital utilization
- Increase community involvement



Community Outcomes

- Increase crisis expertise in community
- Implement and maintain community collaboratives
- Utilization of community resources
- Decrease state facility and hospital utilization



Cross System Crisis Plan

- An **individualized, person-centered, written plan of response** that provides specific, clear, concrete, and realistic set of protective and supportive interventions that prevents crisis, and/or de-escalates and protects a consumer experiencing a MH or behavioral health crisis.
- The CSCP provides a coherent, coordinated plan that assures the First Responder's or Caregiver's ability to react effectively and to enlist the assistance of additional supportive resources.
- The CSCP preventative, protective, and supportive intervention procedures are **based on an understanding of systemic and environmental issues** as well as an individual consumer's escalating behaviors and/ or psychiatric de-compensation.

FAQs

- **Is NC START currently taking referrals?**
 - YES, YES, YES!! Don't leave today without your referral/ screening form.
- **How will the START Team respond to an emergent crisis (i.e. the 2 o'clock phone call scenario)?**
 - Although the START Team is not a First Responder, we will be available to assist the consumer, FR, and MCM coordinate any needed services in response to an emergent crisis.
- **Are RHA and ES-UCP going to take over case responsibility as a result of START involvement?**
 - No. RHA and ES-UCP are ambassadors of the START program and will collaborate with CRAs to coordinate services for your consumers.
- **Will the Cross System Crisis Plan replace the PCP Crisis Plan?**
 - No. The CSCP is intended to become part of the PCP and support the crisis interventions already in place.