

**ECBH ALERT 8-20-10
CRISIS/ACCESS NUMBER- 1-877-
685-2415**

CDW FAMILY INCOME/SIZE

IMPORTANT: Time sensitive information attached. Please review the attached documentation related to CDW family income/size. If you have any questions please contact Shirley Bennett at 332-4137, option 0.

**MEDICAID ALERT—PROVIDERS OF TCM FOR INDIVIDUALS
WITH I/DD**

Please see the Medicaid Alert below.

ECBH's billing system is ready to accept billing as noted in the provider enrollment information section.

As noted in the below Medicaid Alert, UNTIL PROVIDERS ARE DIRECTLY ENROLLED, providers may continue to bill TCM-IDD services through ECBH with T1017HI and T1017 HI SC at the current rate of \$17.67. Effective January 1, 2011, ECBH will no longer process TCM-IDD Claims.

For State funded TCM (case rate) effective 8/1/10 ECBH will authorize up to 2 units per month and the new Medicaid monthly case rate.

Medicaid Alert

References

- [ValueOptions TCM Provider Change Request Form](#)
- [Electronic Funds Transfer \(EFT\) Authorization Agreement for Automatic Deposit](#)

ATTENTION: PROVIDERS OF TARGETED CASE MANAGEMENT FOR INDIVIDUALS WITH INTELLECTUAL AND DEVELOPMENTAL DISABILITIES

DMA has received approval to implement a new procedure code and rate for Targeted Case Management-for Individuals with Intellectual and Developmental Disability (TCM-IDD) for direct enrolled providers. Effective with date of service August 1, 2010, or the date of enrollment, whichever is the later date, direct enrolled providers may be reimbursed for T1017HE at the new weekly rate of \$62.26. T1017HE may be billed only by the direct enrolled providers. HP will not process any systematic recoupment of T1017 HI and repayment for code of T1017 HE.

Medicaid cost containment initiatives will affect the reimbursement rate for TCM-MH/SA and TCM-IDD. All Medicaid services will have a 1.35% rate reduction effective with date of service September 1, 2010. The impact for TCM-IDD will be a reduction to \$61.42 per week for T1017 HE.

Provider Enrollment Information

The effective date of enrollment for direct enrolled providers will be the date requested by the provider but no earlier than August 1, 2010, or the date a complete enrollment package is received by CSC, if a date is not requested by the provider.

Until providers are directly enrolled, they may continue to bill TCM-IDD services through the Local Management Entities (LMEs) with T1017 HI and T1017 HI SC, at the current rate of \$17.67 per unit. Effective January 1, 2011, LMEs will no longer process TCM-IDD claims.

Service Authorization

This service must be prior authorized for non-CAP Waiver recipients prior to submitting claims. (TCM for CAP Wavier recipients does not require prior authorization.) Following enrollment, the provider will be able to request authorization for TCM-IDD for new non-CAP Waiver recipients in accordance with current procedures and documentation requirements. Providers may fax authorization requests to VO at 919-877-339-8754. For current recipients with an existing authorization, providers may request transfer of authorizations from T1017 HI to T1017 HE and transfer of the authorization from an LME to their TCM-IDD Medicaid Provider number through the ValueOptions' TCM Provider Change Request Form at http://www.valueoptions.com/providers/Network/North_Carolina_Medicaid.htm . ValueOptions (VO) will retroactively authorize the new code as requested starting August 1, 2010, or the actual provider enrollment date, whichever is later. There will be no charge to provider for this transfer of authorizations.

Additional Claims Processing Information

Claims Submission: The billing limit is one unit per week which runs from Sunday to Saturday. If the claim identifies a span of dates, (e.g. August 2-6, 2010), the claim will be denied. In order to bill, providers must provide at least 15 minutes of service per week. However, the expectation is that service will be provided and documented according to the needs of the recipient. Electronic claims submitted by Direct Enrolled Providers prior to the 8/19/2010 cutoff for procedure code T1017 HE will adjudicate on the 8/26/2010 check write. Claims processed after the 8/19/2010 cutoff will adjudicate according to the current check write schedule. **Please note:** System audits have been developed to deny claims billed with T1017 HE or T1017 HI if billed during the same calendar week. The first claim processed and paid for a recipient will result in the denial of any other claim for TCM during the same week.

Electronic Funds Transfer: Providers must submit to HP a completed EFT form specific to TCM –IDD. Claims will suspend if this EFT form is not on file. Although many providers have completed the enrollment process and been issued a Medicaid Provider Number, many have not completed an Electronic Funds Transfer (EFT) Authorization

Agreement for Automatic Deposit form needed for payment. You can access the form from DMA's website at <http://www.ncdhhs.gov/dma/provider/forms.htm>.

RECORD RETENTION DRAFT SCHEDULES FOR LME AND PROVIDERS

The draft schedules for LME and Providers are posted on the DCR webpage for review and input until 9/3/10. Please review and share any input you may have with Cynthia Allen Coe at the contact information listed below. Here is the link and they are located at the bottom of the page, in the section titled "For Comments".

<http://www.records.ncdcr.gov/local/default.htm>

"To love each other is truly the key to life"

Cynthia Allen Coe, RHA

Accountability Specialist

NC Div. MH/DD/SAS

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CLARIFICATION FROM DMH/DD/SAS

ECBH received clarification from DMH/DD/SAS on 8/9/10 regarding the Extended/Tripled Endorsement Timeframes (as outlined in Implementation Update #62, 10/8/09). Due to some reported variance amongst LMEs regarding the timeframes for which a provider can reapply for Endorsement after a services is denied OR involuntarily withdrawn, ECBH sought clarification from DMH/DD/SAS.

For an Endorsed service that is or has been denied OR involuntarily withdrawn, there is a **six (6) month** waiting period before the provider organization can reapply for site/service endorsement with the LME that denied or withdrew the endorsement.

If you have any questions, please contact Provider Operations Customer Services at 252-636-1510 or 252-332-4137.

MONTHLY PROVIDER FORUMS

ECBH has been conducting monthly (versus quarterly) Provider Forums since October 2009. The intent of the Provider Forums is to promote communication between the LME and Network Provider Agencies, as well as to provide technical assistance and training on a wide variety of issues and topics.

In addition, as a result of ECBH's previous management responsibilities of Albemarle Mental Health Center (AMHC) and current merger (effective 7/1/10) of ECBH and AMHC, the Provider Forums that were being held separately for ECBH and AMHC providers have now combined to 1 Monthly Provider Forum.

The Provider Forums occur the **2nd Tuesday of every month at 1:00 pm** at the Martin County Community College (1161 Kehukee Park Rd. Williamston, NC 27892) in Building #2.

If you or an appointed individual from your agency is unable to attend one of the Monthly Provider Forums, you can obtain a copy of the minutes and any attachments distributed at the forum at the ECBH website at the following link:

www.ecbhlme.org/Page_Provider.php?id=56

Please plan on attending these forums every month. Due to the never-ending changes we are facing in the current Mental Health, Substance Abuse, and Developmental Disabilities environment, these forums are our opportunity to try and make some sense of it all!

Thanks for your past and future participation.

SERVICE AUTHORIZATION CLARIFICATION:

In reference to IU#71, "Transition to Annual Authorization for Non-Waiver TCM/DD Services", we have had several calls from Providers regarding PCPs being valid for greater than 12 months. Though Value Options is in the process of providing annual authorizations for Targeted Case Management, the PCP still may not exceed 12 months. Per the 2010 PCP Instruction Manual, "A target date may never exceed 12 months from the "PCP Completed On" date, or the Effective Date {for CAP-MR/DD plans only}. For both Medicaid & State Funded Services, "The annual review of medical necessity is due upon the annual rewrite of the PCP, based on the "PCP Completed On" Date or, for CAP-MR/DD Plans only, the Effective Date." Thanks!

IMPORTANT INFORMATION REGARDING SUBSTANCE ABUSE TREATMENT

Attached is a letter from the Substance Abuse Professional Practice Board that clarifies the board's position pertaining to the need to register with the board for those individuals providing mental health or substance abuse treatment. Please feel free to redistribute this to anyone interested. See above attachment titled "distribution letter".

REPORTING PROVIDER FRAUD AND ABUSE

The N.C. Department of Health and Human Services (DHHS) has created a poster asking citizens to report Medicaid fraud and abuse. In a memo dated June 4, 2010, DHHS Secretary Lanier Cansler asked all health care agencies and private health care providers to print and prominently display the poster in their offices (see attached documents). We appreciate your participation in this important effort. For more information, please refer to the Division of Medical Assistance (DMA) website at <http://www.ncdhhs.gov/dma/provider/fraud.htm>

NC-TOPPS

Superusers – do not approve new users/clinicians for your agency unless they have a corporate email address. Take the time on a regular basis to view the QP list and remove users that are no longer employed with your agency. To complete this task go to the NC-TOPPS Profile Mgmt System under “Remove Users” and follow the prompts.

Superusers/Users - remember to view your agency’s Incomplete NC-TOPPS list and Updates Needed list weekly. Incomplete NC-TOPPS must be confirmed or deleted within 3 days.

NC-TOPPS LME Monthly Call Minutes are posted monthly on the NC-TOPPS Home Page, please click on “other info” on the NC-TOPPS homepage to view.

AMHC/ECBH Merger information went out through our network as an MCO Alert to all AMHC providers and is posted on the website www.ecbhlme.org. NC-TOPPS change requirements and instructions fall under #11 in the merger plan. All AMHC providers are required to read and follow these instructions.

For assistance with NC-TOPPS questions or concerns, please contact Susan Massey at 252-639-7740 or smassey@ecbhlme.org.

UPDATES FROM NC-TOPPS IN RALIEGH

NC-TOPPS Contacts and Superusers,

Beginning today, July 1, 2010, a few changes have been implemented to the NC-TOPPS web system and Guidelines. Please see below for the highlights.

Data Entry User

A new user status has been added to the online system called a Data Entry User (DEU). A DEU will have their own username and password and will have the ability to enter interviews for other QPs located in their provider agency. In order to become a DEU, the user will need to register using the online system. New users can register as they always have, but will be asked to select whether or not they are a DEU.

Existing users needing to become DEUs will need to go to the NC-TOPPS main website (<http://www.ncdhhs.gov/mhddsas/nc-topps/>), click on "User Enrollment", and then click on "If you already have an NC-TOPPS user login and password, click here." The DEU will enter their current username and password and under the Users tab, select Manage

Provider Agencies. They will need to scroll down to Step 3 and select that they are a Data Entry User. The DEU status will then need to be approved by the provider agency superuser.

When a DEU enters an interview online for a QP, a signature is required to be on the printable version of the interview by the QP responsible for the consumer's NC-TOPPS. The signature certifies that the QP conducted and completed the interview. The signed printable version must be placed in the consumer's record along with the summary page generated by the online system.

NOTE: It is not required for any existing users to re-register if they do not need to become a DEU.

Opioid Treatment Programs (OTPs)

All Opioid Treatment Programs (OTPs) are required to participate in NC-TOPPS. If an OTP serves only private-pay/self-pay consumers, the OTP will register directly with the NC-TOPPS Help Desk. The OTP will receive their own facility "LME" number and they can use their own consumer record numbers when entering consumer outcomes into NC-TOPPS (up to ten digits are allowed for the consumer record number in the system).

However, if an OTP also serves Medicaid/state-funded consumers, then the OTP must also register with the LME that is responsible for monitoring the agency (as the LME is responsible for the endorsement of the OTP in their catchment area). When entering the consumer outcomes in NC-TOPPS for Medicaid/state-funded consumers, the OTP must use the six-digit LME-assigned consumer record number. In the case of OTPs who are serving both private-pay/self-pay and Medicaid/state-funded consumers, QPs will need to sign up under both the private-pay/self-pay facility number and the LME associated with the OTP under one login. This will allow QPs to select the appropriate OTP association for each consumer when submitting an NC-TOPPS interview.

Change to Wording of Required Child and Adolescent Consumers All child and adolescent consumers under the supervision of the juvenile justice system who are receiving mental health and/or substance abuse treatment are required to be in NC-TOPPS if an LME enrolls them into CDW.

Please let us know if you have any questions.

Thank you,
NC-TOPPS Management Team

1ST LEVEL EDITS FOR CLAIMS PROCESSING-- EFFECTIVE 7-1-10

Effective 7/1/10 ECBH will implement new edits in claims processing at the 1st level of adjudication. These new edits will now deny claims which do not contain all required information for a clean claim at the 1st level of adjudication.

These claims were previously being approved at our 1st level of adjudication but denying on the state

level. ECBH claims processing staff were notifying the provider of these denials to obtain the needed information to correct

the claim. ECBH staff would then re-file the claim after the corrections were made. These new edits will be the **responsibility**

on the provider to submit a clean claim, which results in a more efficient turn around time for payment.

The additional edits that have been added are as follows:

INS - Invalid client ID

TDX - target pop/diagnosis mismatch (diagnosis does not fit target pop)

TPD - target pop does not cover date of service billed

TSV - service does not fit in target pop

TPM - client does not have a target pop at all

It will be the **PROVIDERS RESPONSIBILITY** to check provider folders (**weekly**) to insure all the claims that have been approved at the 1st level of adjudication. If you have denials, again, it is the **PROVIDERS RESPONSIBILITY** to correct and re-enter the claims.

REMEMBER, you have a 74 day window (time frame) to get a clean claim entered. (A clean claim is a claim that is approved at the 1st level of adjudication - one that states 1st level adjudication approved). Submitted claims approved at the 1st level of adjudication will be sent to the state for payment by ECBH. See updated claims entry manual for complete instructions.

The claims department will be glad to assist you with any questions. You may call 252-332-4137, choose option 4.

Thank You,
ECBH Claims
Department

ENTERING TARGET POPS

Entering a new target pop request (no other TPop in system, or only TPOps that have already ended before your start date)

Enter Agency Requesting Change

No need to enter anything in Old Target Pop slot

List the Target Pop code in New Target Pop slot

Enter start date of Target Pop

Enter end date of Target Pop:

If adult, add 10 years to start date UNLESS

- 1) AMCS, ADSC or ASCS code (only good 14 days at a time, and if ongoing will need new TPop request for each 14-day period)
- 2) AMAO, ASAO or ADAO code (only good for 30 days at a time – This is a screening/outreach code and is only for an initial visit. If client is receiving ongoing treatment, he/she should be in a regular TPop.)

If child, end date is day before 18th birthday UNLESS

- 1) CMCS, CDCS or CSCS code (only good 14 days at a time, and if ongoing will need new TPop request for each 14-day period)
- 2) CMAO, CDAO, CSAO code (only good for 30 days at a time – This is a screening/outreach code and is only for an initial visit. If client is receiving ongoing treatment, he/she should be in a regular TPop.)
- 3) CMECD code (this is only good from date of third birthday until the day before 6th birthday)

Enter name of Contact Person (person to be called if there is a problem with the request)

Enter Agency Phone Number (LME cannot contact you about any problem or question regarding the TPop request without this)

Entering a Change Target Pop request, without changing a previous TPop

To change a start date and/or end date of an existing TPop:

Enter Agency Requesting Change

No need to enter anything in Old Target Pop slot

List the Target Pop code in New Target Pop slot

Enter new start date of Target Pop (if only changing the end date, this will be the same as original entry)

Enter new end date of Target Pop (if only changing the start date, this will be the same as original entry)

Enter name of Contact Person (person to be called if there is a problem with the request)

Enter Agency Phone Number (LME cannot contact you about any problem or question regarding the TPop request without this)

Entering a Change Target Pop request, with resulting change or deletion of a current or previous Target Pop

If your request will require a change in the end date of current or previous TPop, or require the deletion of a current or previous TPop:

Enter Agency Requesting Change

Enter TPop code to be changed or deleted in Old Target Pop slot

List the new Target Pop code in New Target Pop slot

Enter start date of new Target Pop

NOTE: Do not use a start-date prior to date of YOUR agency's first service, as this would interfere with another agency's billing.

Enter end date of new Target Pop

Enter name of Contact Person (person to be called if there is a problem with the request)

Enter Agency Phone Number (LME cannot contact you about any problem or question regarding the TPop request without this)

NOTE: A TPop which must be ended early to allow the new TPop, will automatically be ended one day before the New Start Date. If a previous TPop falls entirely within the dates of the new request, the old TPop will be deleted.

Exercise caution when changing/deleting an existing Target Pop. Check the Updates Service Array on the right-hand side at:

<http://www.dhhs.state.nc.us/mhddsas/iprsmenu/index.htm> to see if services you bill are payable under the existing TPop. If so, do NOT request to change/delete the existing TPop, as this could cause payment problems for another provider.

If you have questions regarding Target Pops, please contact:

Bonnie D Harrison

Target Pop Specialist

East Carolina Behavioral Health (ECBH)

bharrison@ecbhime.org

Phone: 252-332-7453