



SMOKY MOUNTAIN LME/MCO

# Provider Operations Manual

© 2015 Smoky Mountain LME/MCO

# Helpful Contacts

DEPARTMENT OR TEAM	POINT OF CONTACT
<ul style="list-style-type: none"> <li>✓ <b>Provider Help Line</b> <ul style="list-style-type: none"> <li>○ General Questions/ Technical Assistance</li> <li>○ Requests to add a site or service</li> </ul> </li> </ul>	<p><b>1-866-990-9712</b>  <a href="mailto:ProviderInfo@smokymountaincenter.com">ProviderInfo@smokymountaincenter.com</a></p>
<ul style="list-style-type: none"> <li>✓ <b>Compliance Hotline (24/7/365)</b> <ul style="list-style-type: none"> <li>○ Report Fraud, Waste or Abuse</li> <li>○ Report Suspicious Billing</li> </ul> </li> </ul>	<p><b>1-866-916-4255</b>  <a href="mailto:LegalandCompliance@smokymountaincenter.com">LegalandCompliance@smokymountaincenter.com</a></p>
<ul style="list-style-type: none"> <li>✓ <b>Claims</b> <ul style="list-style-type: none"> <li>○ Billing and Reimbursement</li> <li>○ RAs, Credit Memos, Service Codes</li> </ul> </li> </ul>	<p><b>1-800-893-6246, Ext. 2455</b>  <a href="mailto:Claims@smokymountaincenter.com">Claims@smokymountaincenter.com</a></p>
<ul style="list-style-type: none"> <li>✓ <b>Eligibility and Enrollment</b> <ul style="list-style-type: none"> <li>○ Health plan eligibility &amp; enrollment</li> <li>○ Client updates</li> </ul> </li> </ul>	<p><b>1-800-893-6246, Ext. 2355</b>  <a href="mailto:EandE@smokymountaincenter.com">EandE@smokymountaincenter.com</a></p>
<ul style="list-style-type: none"> <li>✓ <b>Credentialing Hotline</b> <ul style="list-style-type: none"> <li>○ Credentialing and re-credentialing</li> <li>○ Update/ change information</li> <li>○ Add new practitioners to agency roster</li> </ul> </li> </ul>	<p><b>1-855-432-9139</b>  <a href="mailto:CredentialingTeam@smokymountaincenter.com">CredentialingTeam@smokymountaincenter.com</a></p>
<ul style="list-style-type: none"> <li>✓ <b>Care Management</b> <ul style="list-style-type: none"> <li>○ Authorizations and Service Definitions</li> <li>○ Clinical Practice Guidelines</li> </ul> </li> </ul>	<p><b>1-800-893-6246, Ext. 1513 (MH/SA), Ext. 1902 (IDD)</b>  <a href="mailto:UM@smokymountaincenter.com">UM@smokymountaincenter.com</a></p>
<ul style="list-style-type: none"> <li>✓ <b>Member Appeals</b> <ul style="list-style-type: none"> <li>○ Peer-to-Peer Discussions</li> <li>○ Reconsideration of Authorization Decisions</li> </ul> </li> </ul>	<p><b>1-800-893-6246, Ext. 1400</b></p>
<ul style="list-style-type: none"> <li>✓ <b>Help Desk/ Mgmt Info System (MIS)</b> <ul style="list-style-type: none"> <li>○ Alpha system issues</li> <li>○ Electronic billing (837/835)</li> </ul> </li> </ul>	<p><b>1-800-893-6246, Ext. 1500</b>  <a href="mailto:SMChelpdesk@smokymountaincenter.com">SMChelpdesk@smokymountaincenter.com</a></p>
<ul style="list-style-type: none"> <li>✓ <b>Access to Services Line (24/7/365)</b> <ul style="list-style-type: none"> <li>○ Help for appointments and referrals</li> <li>○ Link to Mobile Crisis Management</li> </ul> </li> </ul>	<p><b>1-800-849-6127</b></p>
<ul style="list-style-type: none"> <li>✓ <b>Consumer Relations Team</b> <ul style="list-style-type: none"> <li>○ Connect with a Smoky peer or family support specialist with lived MH/IDD/SA experience</li> </ul> </li> </ul>	<p><b>1-888-757-5724</b></p>
<ul style="list-style-type: none"> <li>✓ <b>Customer Services Line</b> <ul style="list-style-type: none"> <li>○ Report a compliment, complaint or concern</li> </ul> </li> </ul>	<p><b>1-888-757-5726</b>  <a href="mailto:Grievances@smokymountaincenter.com">Grievances@smokymountaincenter.com</a></p>

# Welcome to Smoky

On behalf of all of us at Smoky Mountain LME/MCO, whether you are a returning member or new to our system, I want to welcome you to our provider network. Smoky has grown significantly since becoming a public managed care organization under North Carolina's statewide expansion of the 1915(b)/(c) Medicaid waiver in 2012, and we now serve 23 counties in the foothills and western regions of the state. With this growth, Smoky has enjoyed collaborative relationships with our network of providers that has resulted in a strong system of care for individuals and their families in need of mental health, substance use/ addiction and intellectual/developmental disability services.



As you will see with this Manual, Smoky has worked to improve and standardize its business functions to effectively manage federal, state, local and Medicaid funds. One aspect that hasn't changed, however, is our commitment to a strong relationship with our provider network. That relationship is measured by the quality of services delivered to members, our ability to respond to the needs of community members and ultimately, our success as organizations. At Smoky, we value our work with our Provider Advisory Council and the input we receive to help us consistently improve our business functions and the service system. Together we have worked to build a stronger safety net with the expansion of community-based and specialty services throughout our catchment area. Moving forward, Smoky is focused on strengthening the service system by promoting integrated, collaborative care and the use of evidence-based practices that treat the "whole person" and have the best chance of positive outcomes for each individual.

As the CEO, my goal is twofold: first, to continue to push the organization toward meaningful improvements in our day-to-day operations that will provide real benefits to our provider and community partners, and second, to focus on the future as the N.C. Medicaid program and the healthcare system evolve. As always, Smoky's ability to adapt to General Assembly directives, Department policies and the demands of the health care marketplace will be crucial to our joint success. All of us at Smoky are committed to shaping that future by building on our strengths and those of our provider network, our healthcare partners and community stakeholders. We respect those relationships and grateful for your support. Thank you.

Brian Ingraham, CEO



*Meeting community needs, one person at a time.*

## **Mission, Vision and Values**

### **Mission Statement ("Who We Are")**

Smoky Mountain LME/MCO is a public manager of care for individuals facing challenges with mental illness, substance use, and/or intellectual/developmental disabilities. Our goal is to successfully evolve in the health care system by embracing innovation, adapting to a changing environment, and maximizing resources for the long term benefit of the people and communities we serve.

### **Vision Statement ("What We're Building")**

Communities where people get the help they need to live the life they choose.

### **Values ("What We Believe In")**

- **Person-Centeredness:** Interacting with compassion, cultural sensitivity, honesty and empathy.
- **Integration:** Caring for the Whole Person within the home and community of an individual's choice.
- **Commitment:** Partnering with consumers, families, providers and others to foster genuine, trusting, respectful relationships essential to creating the synergy and connections that make lives better.
- **Integrity:** Ensuring quality care and accountable financial stewardship through ethical, responsive, transparent and consistent leadership and business operations.

# Table of Contents

*[Final Table of Contents with page #s and clickable links to be inserted upon completion.]*

Section 1: About Smoky

Section 2: Network Participation

Section 3: Credentialing & Contracting

Section 4: Access to Care

Section 5: Billing & Reimbursement

Section 6: Benefit Plans & Authorization

Section 7: Member Rights & Empowerment

Section 8: Crisis Planning & After Hours Requirements

Section 9: Care Coordination

Section 10: Emergency Services & Hospital Requirements

Section 11: Involuntary Commitment

Section 12: Transition, Discharge and Provider Closures

Section 13: The N.C. Innovations Waiver

Section 14: Block Grant Requirements

Section 15: Compliance & Quality Management

Section 16: Audits, Monitoring & Investigations

Section 17: Dispute Resolution

Section 18: Community Collaboration

Appendix A: Code of Ethics

Appendix B: Comprehensive Care Center Model

Appendix C: Mixed Services Payment Protocol (Hospitals only)

Appendix D: Provider Resources

Appendix E: Commonly Used Acronyms and Glossary of Terms

Appendix F: Index

Appendix G: Change Log

# Section 1: About Smoky

Congratulations on joining the Smoky Provider Network! Smoky has developed this Provider Operations Manual and the companion Claims Manual and Billing Guide to provide detailed information and technical assistance to Smoky Network Providers on all aspects and requirements of network participation. (A Network Provider is an appropriately credentialed provider of mental health, intellectual and/or developmental disabilities, or substance use/addiction (MH/IDD/SA) services who signed a contract for participation in the Smoky Closed Provider Network.) Network participation means that you are listed in the Smoky Network Directory and are eligible for referrals from Smoky. This does not include providers who are serving a member under an Out of Network Agreement. Participation is based on selection and retention criteria outlined in Section 2 of this Manual.

**This Manual and all requirements outlined within it are a binding part of your contract with Smoky.** Please read it carefully and make sure that your employees and contractors are familiar with the requirements. Note that information or procedures which pertain only to a particular funding source (e.g. Medicaid, federal Block Grant, state funds) are identified as such. If unspecified, the information applies to all Smoky Network Providers regardless of funding source. Some information also applies to providers who signed an Out of Network Agreement.

All references to timeframes in this Manual refer to calendar days unless otherwise stated. A “business” or “working” day means Monday through Friday, 8:30 a.m. through 5:00 p.m. with the exception of any day recognized by Smoky as an official holiday, as well as any day Smoky is not open for administrative functions due to a weather-related event or other natural cause. If you have any questions or suggestions about the information in this Manual, please call Smoky’s Provider Network Department at 1-866-990-9712 or email us at [Manuals@smokymountaincenter.com](mailto:Manuals@smokymountaincenter.com). We look forward to hearing from you.

## What is Smoky Mountain LME/MCO?

Smoky is a local political subdivision of the State of North Carolina and a Local Management Entity/ Managed Care Organization (LME/MCO) as that term is defined at N.C.G.S. § 122C-3(20c). We operate a Medicaid Prepaid Inpatient Health Plan on a capitated per member per month (PMPM) basis pursuant to a contract with the NC Department of Health and Human Services (DHHS), Division of Medical Assistance (DMA) and in accordance with the NC 1915(b)/(c) combined Medicaid Waiver (the “Waiver”). North Carolina’s combined Medicaid Waiver includes a 1915(b) Service Delivery Waiver known as the “MH/DD/SA Health Plan,” and a 1915(c) Home and Community Based Services Waiver for persons with intellectual and/or developmental disabilities (I/DD) who meet institutional level of care criteria referred to as the “Innovations Waiver”.

Smoky also receives state and federal Block Grant funding pursuant to a contract with the DHHS Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS). Under our contracts with DMH and DMH/DD/SAS, we are responsible for the planning, development, implementation, management,

and monitoring/ oversight of all publicly-funded MH/IDD/SA services in a 23-county catchment area. Smoky's catchment area is comprised of Alleghany, Alexander, Ashe, Avery, Buncombe, Caldwell, Cherokee, Clay, Graham, Haywood, Henderson, Jackson, Macon, Madison, McDowell, Mitchell, Polk, Rutherford, Swain, Transylvania, Watauga, Wilkes and Yancey counties. This includes payment and reimbursement for services within available funding.

Essentially, Smoky operates three different health benefit plans: (1) the MH/DD/SA Health Plan for Medicaid beneficiaries residing in Smoky's catchment area who need MH/IDD/SA services; (2) the Innovations Waiver Health Plan for Innovations Waiver participants; and (3) a State-Funded Benefit Plan for persons who need MH/IDD/SA services and meet financial and other eligibility criteria. The State-Funded Benefit Plan includes federal Block Grant funding, state MH/DD/SA funding, and funding from counties in our catchment area. Each benefit plan has its own distinct set of services and eligibility criteria.

Smoky recently achieved 3-year re-accreditation from URAC through September 2018 in the areas of Health Call Center, Health Network, and Health Utilization Management. We are responsible for operating a 24/7/365 Call Center that provides screening, triage, and referral services as well as crisis intervention. We protect public funding through utilization management and utilization review that ensure requested services are medically necessary, as well as claims adjudication and data mining that guard against fraud, waste and abuse. We ensure accessibility, availability and quality of MH/IDD/SA services through our network development, credentialing, quality management, and monitoring and investigation efforts. We also offer care coordination services to eligible members. Your roles and responsibilities related to each of these functions is described in this Manual.

## **The 1915(b)/(c) Medicaid Waiver Model**

The N.C. Medicaid 1915(b)/(c) Waiver was approved by the federal Centers for Medicare & Medicaid Services (CMS) and is designed to:

- Better coordinate the system of care for individuals, families and providers
- Manage resources so that service dollars can be directed to those most in need
- Develop a more complete range of services and supports in the community so that more people can receive services in the home and community of their choice, with as little disruption to their lives as possible
- Create new services and programs by using the money generated from savings achieved by managing care and resources more effectively

## **About the 1915 (b) MH/DD/SA Health Plan Waiver**

The North Carolina MH/DD/SA Health Plan is a pre-paid inpatient health plan funded by Medicaid and authorized under Section 1915(b) of the Social Security Act. It allows North Carolina to manage mental health, substance use and I/DD services using alternatives to the traditional service delivery system. It is called a "waiver" because some requirements of the Social Security Act are waived:

- Waives state-wideness: Allows North Carolina to have behavioral health managed care plans in specific areas of the state, such as Smoky's 23-county region
- Waives comparability of services: Lets North Carolina provide different benefits to people enrolled in the managed care system
- Waives freedom of choice: Allows Smoky to operate a closed network of providers and require members to choose from providers within that network, with some limited exceptions

## **About the N.C. Innovations 1915 (c) Waiver**

The Innovations 1915(c) Waiver is a home and community-based services (HCBS) waiver for people with intellectual or developmental disabilities, regardless of age, who meet institutional level of care criteria. This waiver allows long-term care services to be provided in home and community-based settings instead of institutional settings such as Intermediate Care Facilities. The Innovations Waiver includes some non-medical services, for example home modification, that are not available under traditional Medicaid. HCBS waivers are designed to help keep people out of institutions and to promote independence, choice, community integration and the ability to realize life goals. To accomplish this, the Innovations Waiver incorporates self-direction, person centered planning, individual budgets, participant protections such as monthly health and safety visits, and quality assurance to support the development of a strong continuum of services.

The number of people who participate in the Innovations Waiver is limited by CMS and by the availability of slots funded by the State of North Carolina. People who are potentially eligible for the Innovations Waiver may have to wait for funding to become available. People who have not received a waiver slot can be placed on the Registry of Unmet Needs. The Registry is a first-come, first-serve list, so Network Providers must work with families of children who have an I/DD to place them on the Registry as soon as possible. For more information about the NC Innovations Waiver, please refer to Section 13 of this Manual.

## **Where is Smoky located?**

Smoky's administrative headquarters are centrally located in Buncombe County, with additional regional office locations accessible to providers, community stakeholders and members in Caldwell, Jackson, and Watauga counties. We also maintain a significant presence at two administrative offices in Haywood County. Smoky leases or shares other offices throughout the catchment area, including co-locations with county Health Departments, Departments of Social Services and Network Providers, as well as supporting a number of home-based employees. While maintaining these locations can be costly, we believe it is critical in order to provide a localized presence and support for members, providers and community stakeholders. Addresses and phone numbers for our regional offices are listed on the following page. Please note that you do not need to dial the local number – all Smoky offices and staff can be reached toll-free by calling **1-800-893-6246**.



<b>Buncombe County (Administrative Offices)</b> 200 Ridgefield Court, Suite 206, Asheville, NC 28806 Telephone: 828-225-2785 Facsimile: 828-252-9584	<b>Jackson County</b> 44 Bonnie Lane, Sylva, NC 28779 Telephone: 828-586-5501 Facsimile: 828-586-3965
<b>Caldwell County</b> 825 Wilkesboro Blvd. SE, Lenoir, NC 28645 Telephone: 828-759-2160 Facsimile: 828-759-2161	<b>Watauga County</b> 895 State Farm Road, Suite 507, Boone, NC 28607 Telephone: 828-265-5315 Facsimile: 828-262-1859

## Governance and Administration

Smoky is governed by a 21-member Board of Directors appointed under N.C.G.S. Chapter 122C. Our Board includes 6 individuals with specifically denominated expertise consistent with the nature of managed care operations, a County Commissioner representative, a member appointed by the DHHS Secretary, a hospital administrator, 3 members of our Consumer and Family Advisory Committee (CFAC), 8 at-large members, and the President of the Smoky Provider Advisory Council, who serves in a non-voting *ex officio* capacity. The Board provides broad oversight and policy direction for the organization and ensures that Smoky is accountable to community needs and local government. The Board actively and regularly reviews reports on finances, compliance, performance, quality, service utilization, customer service, unmet local service needs, access to services and provider capacity

Smoky’s administrative structure includes the Chief Executive Officer (CEO), Executive Leadership Team (ELT), numerous committees and cross functional teams (CFTs), and internal departments responsible for broad functional areas including Executive Administration, Care Coordination, Clinical Operations, Community Collaboration, Customer Services, Finance, Human Resources, Legal & Compliance, Management Information Systems, Public Affairs, Provider Network, and Quality & Project Operations.

## Information about Smoky Departments

Office of the CEO and Executive Administration: The CEO is responsible for overall management of the LME/MCO, including day-to-day leadership, oversight and administration, allocation of funding and resources and strategic planning. The CEO works directly with DHHS and other government and elected officials, provider executives and community leaders to negotiate strategic partnerships, develop innovative health care planning initiatives and respond to national and state healthcare policy changes. In addition to the CEO, Smoky’s Executive Leadership Team includes the Chief Operations Officer, Chief Marketing and Business Officer, Chief Medical Officer, Chief Information Officer, General Counsel/ Chief Compliance Officer and the Chief Financial Officer, all of whom report directly to the CEO.

Care Coordination (CC): Care coordination is a service offered by Smoky to eligible Medicaid enrollees, including

those who meet special needs population criteria in accordance with 42 CFR § 438.208, or to individuals eligible for state funds who are high risk/ high cost or at a critical treatment juncture as set forth at N.C.G.S. § 122C-115.4(5). This includes Innovations Waiver participants, persons with complex MH/SA needs or who are at high risk for institutional or residential placement, as well as individuals who are discharged from inpatient or residential facilities who are not linked to a Behavioral Health Clinical Home, under outpatient commitment, not receiving appropriate services and/or need assistance returning to the community. For more information about care coordination, see Section 9 of this Manual.

Clinical Operations (ClinOps): ClinOps is responsible for URAC-accredited Health Utilization Management functions, including prospective, concurrent and retrospective utilization review. Within ClinOps, Care Management (CM) evaluates the medical necessity, appropriateness and efficacy of requests for services against State Plan and Waiver requirements, benefit plan limitations and criteria, DMA Clinical Coverage Policies, DMH/DD/SAS Service Definitions, and established Clinical Practice Guidelines. The Clinical Support Team provides written notification of Care Management decisions and oversees the member reconsideration review process, which includes an impartial review by a clinical peer who was not involved in the original decision. Under the direction of Smoky's Chief Medical Officer, ClinOps also provides clinical support to other Smoky departments, conducts service utilization and trend analysis to guide organizational decision-making, and develops the organization's Clinical/ UM Plan and State-Funded Benefit Plan, which identifies the services that individuals in each target population are eligible to receive within available funding. For more information about the authorization process, see Section 6 of this Manual.

Community Collaboration (CoCo): The Community Collaboration department is divided into several teams who are responsible for community and member relations, including a process to protect member rights and support an effective CFAC in accordance with N.C.G.S. §122C-115.4(b)(6). The CoCo Consumer Relations Team is the chief liaison with CFAC and operates a toll-free number which gives individuals the opportunity to speak with a Peer or Family Support Specialist who has lived experience related to MH/IDD/SA issues. The CoCo Community Outreach and Education team works with community stakeholders to develop effective community partnerships and improve the system of care, and provides community education, training and outreach to decrease stigma around treatment services and increase access for high risk populations. The CoCo Specialized Transitions Unit employs in-house hospital liaisons who work with community hospitals and state-operated facilities to ensure effective discharge planning, manages Housing and Employment functions, and oversees the Transitions to Community Living Initiative (TCLI) resulting from the State's recent *Olmstead* settlement with the U.S. Department of Justice. The CoCo Crisis Coordination Team works to reduce or divert inappropriate emergency department (ED) utilization, and assists providers, members, families and stakeholders with crisis issues. CoCo also includes the state-funded Geriatric and Mental Health Specialty Team (GAMHST), which provides education and consultation for staff of long-term care facilities, as well as family members and caregivers of individuals 60 years and older with mental illness or other emotional or behavioral challenges, or who are experiencing early onset of dementia or other geriatric-type health illnesses. For more information about Smoky's Community Collaboration department, see Section 18 of this Manual.

Customer Services: Customer Services is responsible for URAC-accredited Health Call Center functions and operates a 24/7/ toll-free Access to Services Line 365 days a year for individuals who are in crisis or seeking

access to services. Customer Services also operates an 8:30 am – 5 pm Customer Services Line on regular business days. Customer Service Clinicians perform screening and triage using uniform clinical decision support tools that measure acuity, and make referrals to Network Providers in accordance with urgent, emergent and routine access and appointment standards established by DHHS, including referrals to mobile crisis management providers in order to appropriately divert from the ED. Customer Services Representatives (CSRs) perform initial screening and member satisfaction surveys, warm transfer calls to licensed clinicians when needed, answer general questions, provide information about MH/IDD/SA resources and services and the Smoky Health Plan(s), take down complaints and grievances and follow up on appointments and provider availability. For more information about Smoky’s Call Center, see Section 4 of this Manual.

Finance: The Finance Department is responsible for all finance and accounting functions, including but not limited to enrollment and eligibility, claims processing/ adjudication in compliance with DMA prompt pay requirements, and provider and vendor reimbursement. Finance is also responsible for the annual budget and participates in development and revision of the annual service management plan, which allocates the federal Block Grant, state and county funds received by Smoky.

Human Resources (HR): HR is responsible for recruitment and retention, employee relations, compensation and benefits, workplace safety, facility maintenance, office reception, wellness, and training and education for Smoky employees. This includes credentialing all Smoky licensed staff and performing criminal background, driver history, and exclusion checks for all new hires.

Legal and Compliance: Smoky’s team of legal and compliance professionals is responsible for procurement and contracting, litigation, risk management, records management, provider dispute resolution, regulatory compliance, government relations, support to the Board of Directors, review and approval of Smoky policies, procedures, manuals, forms and templates, and oversight of Smoky’s Compliance Committee and Privacy Officer functions. The General Counsel and other in-house attorneys provide daily advice and counsel to Smoky leadership and staff on a wide array of legal, compliance and risk issues confronting the organization. However, they do not represent, and cannot provide legal advice to, Smoky Network Providers.

Management Information Systems (MIS): The MIS Department is responsible for all aspects of research, development, operations, and support for Smoky’s network infrastructure, telecommunications, and computer systems, including the electronic authorization and claims processing system (AlphaMCS), which supports secure transmission of data via standard Electronic Data Interchange (EDI) formats. MIS also develops Smoky’s contingency plan for backup, disaster recovery and emergency operations and securely protects all sensitive electronic information, including Protected Health Information (PHI) maintained by Smoky. For questions related to AlphaMCS, please call 828-225-2785 Ext. 1500 or email [SMChelpdesk@smokymountaincenter.com](mailto:SMChelpdesk@smokymountaincenter.com).

Public Affairs: This department is responsible for oversight of external communications including provider communication bulletins, as well as press releases, marketing, website development and content management, health literacy, public event planning and coordination with broadcast, print, web-based and social media.

Provider Network: PN is responsible for URAC-accredited Health Network functions, including network

development, credentialing, network management, and routine and focused monitoring. The PN Department recruits, selects, credentials and monitors all participating providers to ensure quality services, fiscal sustainability, geographic accessibility and member choice, where required. PN helps negotiate provider contracts and offers technical assistance to participating providers through a dedicated toll-free number and email account. The Provider Accounts Team is chiefly responsible for the development of Smoky's annual Provider Capacity, Community Needs Assessment, and Gaps Analysis, designs innovative programs to create and enhance access to care and improve service availability, quality and efficiency, including capitated and outcome-based payment models, ensures that the Smoky Provider Search Tool and Provider Directory are accurate and up-to-date, and assists other departments in identifying available providers to meet member needs. The Credentialing Team is responsible for credentialing and re-credentialing of applicants and Network Providers on behalf of Smoky and two other LME/MCOs (Partners Behavioral Health Management and CenterPoint Human Services) and conducts Primary Source Verification of reported credentials to ensure quality. For more information about credentialing, see Section 3 of this Manual.

The Contract Performance Team is responsible for routine and focused monitoring, complaint investigations, and billing audits. The Special Investigations Team conducts data mining and trend analysis, identifies overpayments, responds to allegations of fraud, waste and abuse, and refers suspected fraud to DMA and the Medicaid Investigations Division of the NC Department of Justice for potential civil and/or criminal investigation. For more information about audits, monitoring and investigations, see Section 16 of this Manual.

Quality & Project Operations (QPO): QPO oversees the Smoky Quality Management Program, Project Management Office and Waiver Contract Management activities, which together encompass quality assurance, quality improvement, system performance, complaints, grievances and incidents, project management, and compliance with all DHHS reporting requirements. The Smoky QM program includes: (a) oversight of the collection, integration, analysis, and reporting of data necessary for the evaluation of system performance; (b) the application of quality management principles and techniques as a means of achieving organizational goals that further the mission of Smoky; and (c) review of system performance indicators and commissioning of organizational resources to address identified areas for remediation or improvement. Within the QM department, Grievance Specialists log, track, respond to, and refer for investigation or resolve complaints, grievances and quality of care concerns filed by members, relatives, staff, providers and other stakeholders, and the Incidents Team tracks, gathers follow-up information, and coordinates the review of incidents filed by providers in the State's Incident Response Improvement System (IRIS). For more information about Quality Management, see Section 15 of this Manual.

The Project Management Office (PMO) is responsible for oversight and management of Smoky's projects and initiatives to ensure appropriate prioritization and alignment with strategic goals. The Waiver Contract Manager is the chief liaison with DMA and is responsible for oversight of Smoky's adherence to the 1915(b)/(c) Waiver and the DMA Contract, including reporting requirements. Reports and the results of quality improvement projects are presented to DHHS, CFAC and the Board Performance & Quality Committee, and are used for planning, decision making, and system improvement. State reporting requirements include monthly and quarterly performance indicators and aggregate data and trends related to complaints, grievances, incidents, client rights, outcomes, use of state-operated facilities, crisis services and hospital emergency departments,

customer service/ call center performance, assessments of provider quality, results of audits and monitoring activities, management of state funds, financial indicators, and member and service trends, including service utilization rates, penetration rates, perceptions of care, member and provider satisfaction, service capacity, volume, cost of service per member, service authorization requests (SARs) and member appeals.

## **Advisory Boards**

Smoky has a number of advisory boards and subcommittees that provide input and recommendations to the governing board and executive leadership, including a Provider Advisory Council (PAC) discussed on the next page.

County Commissioner Advisory Board (CCAB): The CCAB serves as the chief advisory board to Smoky and the CEO on matters pertaining to the delivery of MH/IDD/SA services within the catchment area and provides input on appointments to the Smoky Board of Directors. In accordance with N.C.G.S. § 122C-118.2, the CCAB consists of one county commissioner from each of the 23 Smoky counties. Members are designated by the board of commissioners of each county. The individual who serves as the County Commissioner Board member in accordance with N.C.G.S. § 122C-118.1(b)(1) serves as Chair of the CCAB. The CCAB serves in an advisory capacity only, and its duties do not include authority over Smoky budgeting, personnel matters, governance, or policymaking.

Consumer and Family Advisory Committee (CFAC): The CFAC consists of individuals and family members of individuals who receive MH, I/DD and/or SA services funded by Smoky. CFAC is a self-governing committee that helps ensure that people receiving services are involved in Smoky's oversight, planning and operational committees. Under state law, CFAC is responsible for the following functions:

- Review, comment on, and monitor implementation of the local business plan;
- Identify service gaps and underserved populations;
- Make recommendations about the service array;
- Review and comment on the Smoky annual budget;
- Participate in Smoky's review of performance indicators and quality improvement measures; and
- Submit findings and recommendations to the state CFAC about ways to improve service delivery.

Smoky's CFAC meets at least six (6) times per year and fulfills the composition requirements of N.C.G.S. § 122C-170, with 56 members representing all 23 counties in Smoky's service area, as well as all three disability groups. CFAC also has four regional sub-groups, which facilitates local planning for members and families as well as cross regional planning and implementation. The Board and CFAC work cooperatively in accordance with a mutually established Relational Agreement that addresses their roles and responsibilities and a method for conflict resolution. The Smoky CFAC liaison(s) provide staff support and coordination of information between Smoky, CFAC and the Board. CFAC members serve on a number of Smoky committees, including Quality Improvement, and three CFAC members serve as governing Board members.

For more information about CFAC, please contact us via email at [CFAC@smokymountaincenter.com](mailto:CFAC@smokymountaincenter.com) or refer to the CFAC page on our website: <http://www.smokymountaincenter.com/consumers.asp?section=cfacmeet>

Human Rights Committee (HRC): The HRC is a subcommittee of the full governing Board and is responsible for monitoring Smoky's compliance with federal and state laws, rules and regulations regarding client rights and confidentiality, ensuring implementation of the Cultural Competency Plan and related issues, and reviewing and monitoring trends related to restrictive interventions, abuse, neglect and exploitation, and member deaths and medication errors. The HRC complies with N.C.G.S. § 122C-64 and 10A NCAC 27G .0504 and consists of a majority of people who receive services and their family members, along with expert advisors, community members and stakeholders, who meet at least quarterly. The HRC reports to the Board, which has ultimate responsibility for the assurance of client rights.

## **Provider Advisory Council**

As a Network Provider, you have the opportunity to participate in Smoky's Provider Advisory Council (PAC), which serves as a central advisory body to Smoky on issues affecting Network Providers. The PAC is a self-governing committee that operates pursuant to a set of Bylaws, and includes four Regional Advisory Councils who nominate members for the full Council in a manner that ensures representation from a broad cross-section of provider types serving all three service areas. Members of the PAC serve as fair and impartial representatives of all Network Providers for the purpose of advocacy, support and communication.

The PAC is designed to facilitate an open exchange of ideas, shared values, goals, and visions and bring forward concerns and solutions while promoting collaboration, ethical operations, mutual accountability, and quality services. The objectives for the PAC include but are not limited to:

1. Foster partnerships with Smoky to address issues affecting the MH/IDD/SA public service system.
2. Recommend and support the provision of best practices to empower members within Smoky's catchment area to achieve their personal goals.
3. Foster communication and collaboration between Network Providers in order to improve member care.
4. Provide input and recommendations to Smoky about clinical and provider payment policies, selection and retention criteria, dispute resolution mechanisms, the Provider Operations Manual, and other guidelines and requirements which directly impact Network Providers.
5. Assist in the dissemination of statewide Provider Satisfaction and Member Perception of Care surveys, provide input in the development of Smoky surveys, and make recommendations to improve survey participation and the perception of care in the community.
6. Review the results of surveys and the annual needs assessment and gap analysis, advise Smoky in the continued development of the Network Development Plan, and develop and make recommendations for service delivery models and gaps in services.
7. Address strategies regarding funding and financial issues, and provide feedback about network development initiatives, funding priorities and opportunities and Requests for Proposal (RFPs), Requests for Information (RFIs) and other procurement initiatives.

8. Assist in the development of global and individual provider performance outcomes, make recommendations for network quality management practices, and advise Smoky regarding service trends, quality improvement plans, utilization and performance measures, and provider quality and outcome indicators.
9. Provide feedback to Smoky about provider and community education, technical assistance and training needs.
10. Identify members to participate in designated Smoky committees and PAC subcommittees addressing initiatives such as quality improvement, credentialing, clinical practices, integrated care, training, bylaws, ethics, cultural competency, network development, provider manual, AlphaMCS, and finance/claims.

For more information about the Provider Advisory Council or Regional PAC meetings, please refer to the PAC section of Smoky's website: <http://www.smokymountaincenter.com/providers.asp?section=pac>.

## **Code of Ethics**

The Provider Advisory Council developed a Code of Ethics that is incorporated into this Manual as Appendix A, and all Network Providers are required to comply with the Code as a condition of network participation. Any alleged violation of this Code should first be discussed with the Network Provider. If the issue cannot be resolved informally, allegations of ethics violations may be presented to the PAC and considered in a closed session. The PAC may refer Network Providers alleged to be in violation of the Code of Ethics to Smoky for investigation and potential adverse action.

Smoky requires all employees and contractors to practice honesty, directness and integrity in dealings with one another, business partners, the public, the business community, internal and external stakeholders, "customers", suppliers, elected officials, and government authorities.

## **Stakeholder and Community Involvement**

Smoky hosts a variety of committees, open meetings and forums in order to ensure engagement of members, families, advocates, Network Providers, and community stakeholders. Network Providers participate as members of Smoky's internal Quality Improvement, Credentialing, and Clinical Advisory Committees, and provide important feedback to Smoky concerning performance and clinical practices. Please remember to regularly check the Smoky Calendar of Events on our website for upcoming forums, meetings, trainings and other events near you.

Smoky also maintains collaborative working relationships with a variety of community stakeholder and human service agencies within the catchment area to assess what services are working or needed and to ensure integration of care to support members who are involved with multiple agencies. These organizations include but are not limited to: county Departments of Social Services, local Health Departments, Federally Qualified Health Centers (FQHCs), community hospitals and regional health systems, public schools, law enforcement,

courts, Juvenile Court Counselors, NAMI, Community Care of North Carolina, Area Health Education Centers including MAHEC and NW AHEC, and primary care providers.

For more information about participating in a Smoky committee or providing feedback about Smoky's performance or policies, please contact the Provider Network Department at 1-866-990-9712 or via email at [providerinfo@smokymountaincenter.com](mailto:providerinfo@smokymountaincenter.com).

## **Provider Communications, Training and Technical Assistance**

Smoky is committed to ongoing communication with Network Providers through a variety of mechanisms in order to provide updates about network activities, training opportunities, request(s) for proposal and other procurement mechanisms, opportunities for collaboration, changes in the DMA fee schedule and/or Smoky reimbursement rates, provider dispute resolution mechanisms, information about Smoky benefit plans, changes to contracting provisions or this Manual, and any changes to federal or state laws, rules, regulations, policies or guidelines affecting service delivery.

We require all Network Providers to remain up-to-date on relevant information and changes communicated by the DMA and DMH/DD/SAS through the following links on the DHHS website:

- Joint DMA and DMH/DD/SAS Communication Bulletins: <http://itcommunicationbulletins.ncdhhs.gov/>. These Bulletins have superseded the previous joint DMA and DMH/DD/SAS Implementation Updates archived at <http://www2.ncdhhs.gov/mhddsas/implementationupdates/index.htm>, and the previous DMH/DD/SAS Communication Bulletins archived at <http://www2.ncdhhs.gov/mhddsas/communicationbulletins/archiveindex.htm>.
- Medicaid Bulletins available at: <http://www2.ncdhhs.gov/dma/bulletin/>.
- DMA Clinical Coverage Policies available at <http://www2.ncdhhs.gov/dma/mp/index.htm>.

Network Providers must keep abreast of changes in laws, rules, regulations or policies affecting the delivery of Medicaid and state-funded MH/DD/SA services, attend workshops and trainings to maintain clinical skills and/or licensure, be knowledgeable on evidence-based or emerging best practices, and be current on coding and reimbursement. Smoky will provide a number of resources to assist you in meeting this requirement. We will communicate information regarding workshops through a variety of mediums and will offer trainings or technical assistance as needed. You should regularly check our calendar for upcoming trainings: <http://www.smokymountaincenter.com/events/calendar.asp?cal=Provider%20Training>.

We can provide technical assistance related to contract requirements, claims, billing and reimbursement, the requirements of this Manual, requirements of DHHS and other oversight authorities, the development of appropriate clinical services, authorization processes and quality improvement initiatives. We can also link you to national or state resources for technical assistance. However, we are not required to provide technical assistance in areas that would normally be considered standard operational activities of a behavioral health



provider or to Network Providers that have demonstrated they are unable to assimilate previous technical assistance provided.

Smoky maintains a “Service Providers” section of our website that includes helpful information specifically targeted for Network Providers. Additionally, Smoky disseminates critical and/or time sensitive information, including changes in policy or requirements that impact Network Providers, through official Smoky Communication Bulletins delivered free of charge to your designated email through Constant Contact. All Network Providers are required to subscribe to Smoky’s Network Provider Bulletins. You are further required to adhere to any changes communicated in these Bulletins as of the effective dates indicated. If you have not already done so, please visit the Smoky website in order to join the Provider Bulletins email list:

<http://www.smokymountaincenter.com/providers.asp?section=commbulletins>.

In addition to Provider Bulletins, we also publish a monthly, system-level update called “News You Can Use.” An archive of these monthly bulletins is posted online at:

<http://archive.constantcontact.com/fs040/1109016511040/archive/1110690906517.html>.

We will strive to keep our communications meaningful, targeted and on point to avoid “information overload.” However, failing to read Smoky Provider Bulletins is not a valid excuse for non-compliance with requirements. Network Providers are required to be aware of changes that affect delivery of publicly-funded MH/IDD/SA services. There are several ways to do that:

- Read all written communications sent to you by Smoky.
- Keep apprised of current information regarding service provision through communication bulletins offered by Smoky, other LME/MCOs if applicable, DHHS, DMA and DMH/DD/SAS.
- Review the Smoky, DHHS, DMA, and DMH/DD/SAS websites for updates on a regular basis.
- Ensure that your employees and contractors are informed of new and/or changing information as it relates to their function.
- Join national and state provider advocacy organizations to learn more about best practices.
- Attend Smoky’s public Board or advisory committee meetings such as the CFAC or PAC.
- Attend and participate in Regional PAC meetings, and other provider meetings and forums hosted by Smoky in order to learn from and about other Network Providers, and share suggestions and guidance on how to improve the MH/IDD/SA system of care.
- Participate in provider trainings offered by Smoky, DHHS and other organizations.
- Get to know your assigned Provider Account Specialist in order to develop a personal working relationship with someone at Smoky.
- Invite Smoky staff to meet with you, your staff or your governing Board as needed to clarify issues or provide technical assistance.
- If you have questions or concerns, call the Provider Network Department at **1-866-990-9712** or contact us via email at [providerinfo@smokymountaincenter.com](mailto:providerinfo@smokymountaincenter.com). Our goal is to respond to all inquiries within 1 business day.

# Section 2: Network Participation

## Policy Statement

Smoky's policy is to develop and maintain a sufficient network of high quality service providers that meets member and community needs within available resources. However, participation in the Smoky Closed Provider Network is a privilege, not a right. Smoky has established a fair, impartial, objective and consistent process for the enrollment and re-enrollment of service providers in the Smoky Closed Network that complies with applicable federal and state laws, rules and regulations and the requirements of our DMA Waiver Contract.

## Background

When Smoky began 1915(b)/(c) Medicaid Waiver operations in July 2012, providers of MH/IDD/SA services who submitted a timely application, met Smoky credentialing criteria, were in good standing with DHHS, and had billed for services delivered to Smoky members in the sixty (60) days prior to their application were offered a contract for participation in the Smoky Closed Provider Network. On October 1, 2013, the Smoky and Western Highlands Network (WHN) catchment areas were consolidated and providers enrolled and in good standing with WHN were offered contracts with Smoky. Both of these are referred to as "open enrollment" periods. Subsequent provider contract extensions or renewals and new applications for participation in the Smoky Closed Network are subject to Smoky's selection and retention criteria and credentialing and re-credentialing requirements.

Federal regulations require Smoky to maintain a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of Medicaid enrollees in the Smoky catchment area. When the Waiver was approved, CMS exempted North Carolina from complying with the provider "freedom of choice" requirements under the Social Security Act. This waiver is balanced by Smoky's responsibility to ensure accessibility of services. DHHS monitors the adequacy of our network through the annual Provider Capacity, Community Needs Assessment, and Gaps Analysis ("capacity study"), which is also used to inform our Network Development Plan.

Most services will be available within 30-45 miles or 30-45 minutes driving time. There is a comprehensive care center location in every county. However, because of insufficient demand and economy of scale factors, some specialty providers may be located outside this radius or there may only be one provider available to deliver the needed service. The annual capacity study evaluates the ability of Network Providers to meet the needs of our members, and measures geographic access to service locations. We are not required to contract with providers beyond the number necessary to meet the needs of our members.

There is no right under federal or state law for any provider to participate in our Closed Provider Network. The only exceptions are for emergency services or when there is no network provider available to provide medically

necessary covered services to a particular individual. In fact, Section 7.6 of the DMA Waiver Contract explicitly states that Smoky “shall have the authority to operate a Closed Network and shall not be required to review the qualifications and credentials of Providers that wish to become Network Members if the Network has sufficient numbers of Providers with the same or similar qualifications and credentials to provide adequate access to all services covered under this Contract in accordance with 42 CFR 438.206.” The contract also states that we “have the sole discretion to determine provider participation in the PIHP Closed Network, including determinations regarding contract renewal and procurement, subject to the requirements of this Contract and federal regulations.”

This means that we have the ability to develop and implement our own provider network model. Smoky developed a Comprehensive Care Center model that is designed to promote quality services, maximize public resources, reduce fragmentation and ensure the clinical and financial viability of providers in the Closed Network. This model is embedded in our Network Development Plan and attached as Appendix B for reference. Ultimately, Smoky’s goal is to achieve integrated, collaborative care across our network, develop provider expertise in evidence-based and best practices, and establish data-driven outcome and performance measures to ensure that the system is meeting the needs of the individuals we serve.

Smoky department representatives meet at least annually to develop recommendations about renewals of existing contracts from a cross-functional perspective. Decisions about contract renewals are made in accordance with written selection and retention criteria as required by 42 CFR § 438.214. Our selection and retention criteria were initially vetted with the PAC in August 2014 and posted to our website for review and comments for 30 days in September 2014. The selection and retention criteria contained in this Manual have been slightly revised for clarity. Please read them carefully.

Smoky’s Closed Network is comprised of providers who demonstrate cultural competency, use of evidence-based and best practices, a commitment to high quality care and treatment that improves member outcomes, adherence to ethical and responsible practices, protection of member health, safety, welfare and member rights, and who meet Smoky’s business, operational and network development needs. Smoky is committed to the achievement of positive outcomes for members, as well as member satisfaction. We depend on our Network Providers to offer high quality services and demonstrate accountability for the well-being of Smoky Health Plan members.

## **Capacity Study and Network Development Plan**

The annual capacity study includes objective measures such as geo-mapping to help us analyze service access and availability throughout the catchment area, as well as input from consumer, family, provider and stakeholder surveys. Smoky has an ongoing Network Development Plan (NDP) that is informed by the capacity study and Clinical Plan and incorporated into our annual budget. At least annually, we review the NDP with the PAC. The NDP outlines our strategies for addressing the service and program development needs identified by Smoky staff and in the capacity study, and our required Local Business Plan. Feedback from Smoky Departments, committees and Senior and Executive leadership are incorporated into the development of the plan. Progress is

monitored through regular reports at the Executive and Board levels of the organization. Smoky's NDP will always reflect our commitment to flexible, accessible, family-centered services which honor the dignity, respect the rights, and maximize the potential of the individual.

## **Non-Discrimination Statement**

**Title VI of the Civil Rights Act of 1964 mandates that no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance. This includes the Medicaid program and programs funded with federal Block Grant dollars.**

Smoky does not discriminate on the basis of any protected classification or characteristic, including but not limited to race, color, creed, religion, ancestry, sex, gender, sexual orientation, ethnic or national origin, age, disability, genetic information, health status, marital status, parental status or other protected status. Smoky also does not discriminate against providers that serve high-risk populations or specialize in conditions that require costly treatment or based on practitioner or facility license or certification type. This applies to all aspects of network participation, including but not limited to selection and retention, credentialing and re-credentialing, contracting, audits, monitoring and investigations, adverse actions and dispute resolution.

Furthermore, Smoky does not permit Network Providers to discriminate on the basis of any protected classification or characteristic, including but not limited to race, color, creed, religion, ancestry, sex, gender, sexual orientation, ethnic or national origin, age, disability, genetic information, health status, marital status, parental status or other protected status. It is a violation of your contract to engage in unlawful discrimination or harassment of any kind related to hiring or employment practices or the provision of services. This includes your interactions with Smoky staff members.

## **Good Standing**

All applicants and providers must be in good standing to be considered for initial enrollment or contract renewal. Good standing will be verified as part of the credentialing, re-credentialing and/or contract renewal processes as described in Section 3 of this Manual. **We consider a provider to be in good standing if all of the following criteria are met:**

- The individual or entity and any owners, directors and managing employees are not excluded from participation in any federal health care program.
- The individual or entity and any owners, directors and managing employees have no relevant criminal history findings (see Section 3 of this Manual for more information about the types of offenses that are flagged for review).
- The individual or entity and any owners, directors and managing employees did not previously own, operate or manage any provider entity that had its participation in any State's Medicaid program, the Medicare program, or another Medicaid MCO network involuntarily terminated for any reason.

- The individual or entity and any owners, directors and managing employees did not previously own, operate or manage any provider entity that owes an outstanding overpayment to DHHS, Smoky or another LME/MCO.
- There are no current Medicare or Medicaid fines or sanction(s) in effect against the individual or entity by CMS or its contractors, or any State Medicaid agency, including but not limited to contract termination or suspension, referral suspension, payment suspension, moratorium, placement on prepayment review, or similar actions.
- The individual or entity has an acceptable professional liability history, defined as no history of liability claims for the last 5 years. An unacceptable liability history is defined as: within the 5 year period immediately preceding the date of application, one or more legal actions resulted in: (a) At least one judgment; (b) One settlement in an amount of \$50,000 or more; or (c) Two or more settlements in an aggregate amount of \$50,000 or more.
- The individual or entity does not owe any outstanding payments, fees, or documentation to any of the federal or state oversight authorities listed below, including but not limited to outstanding tax or payroll liabilities:
  - NC Department of Health and Human Services or any of its Divisions
  - NC Secretary of State (if organized as a corporation, partnership or limited liability company)
  - U.S. Internal Revenue Service
  - NC Department of Revenue
  - NC Department of Labor
- No negative or questionable findings are identified for the individual or entity in any of the following databases/ oversight authorities:
  - U.S. HHS Office of Inspector General (OIG) List of Excluded Individuals and Entities
  - U.S. System for Award Management (SAM) consolidated excluded parties list
  - NC Division of Health Service Regulation (DHSR) Health Care Personnel Registry (HCPR)
  - NC Tracks and/or National Plan & Provider Enumeration System (NPI numbers)
  - National Practitioner Data Bank (NPBD/HPDB)
  - National Technical Information Service for DEA certificates
  - Social Security Death Master File
  - DMA Program Integrity Database (pending)
  - National Accrediting Boards (e.g. CARF, Joint Commission on Accreditation of Hospitals)
  - Boards of Licensure or Certification for the applicable Scope of Practice
- The individual or entity is not currently subject to any of the following sanctions or administrative actions issued by state or local regulatory agencies, or has not been subject to any such sanctions or administrative actions within the twelve (12) months prior to the application or renewal decision:
  - Smoky or other MCO: Contract Termination or Suspension, Suspension of Referrals, Unresolved Plan of Correction (POC), Outstanding Overpayment, Prepayment Review, Payment Suspension
  - DMA: Contract Termination or Suspension, Payment Suspension Prepayment Review, Outstanding Final Overpayment
  - DMH/DD/SAS: Revocation of Authority to Receive Public Funds, Unresolved POC
  - DHSR: Unresolved Type A or B penalty under Article 3, Active Suspension of Admissions, Active

Summary Suspension, Active Notice of Revocation or Revocation in Effect

- N.C. Secretary of State: Administrative Dissolution, Revocation of Authority, Notice of Grounds for other reason, Revenue Suspension

For purposes of this Manual, “unresolved POC” means the provider has failed to submit or implement a POC in response to a Report of Findings within the designated timeframe identified in the DMH/DD/SAS Policy and Procedure for the Review, Approval and Follow-Up of Plans of Correction, effective December 2008. For purposes of this Manual, “outstanding” means the provider has failed to remit an identified overpayment or enter into an approved payment plan within the designated timeframe identified in the Notice of Overpayment.

Smoky considers an action of an LME/MCO to be final upon notification to the provider, unless the provider has timely requested a reconsideration review, in which case Smoky considers the action final upon issuance of a decision by the applicable LME/MCO reconsideration body. Smoky is not required to enroll an applicant in the Smoky Closed Network or renew a Network Contract if the individual or entity has an LME/MCO sanction pending at the Office of Administrative Hearings.

Smoky considers an action of DHHS or its Divisions to be final upon notification to the provider, unless the provider has timely requested a reconsideration review or administrative hearing, in which case Smoky considers the action final upon issuance of a decision by the DHHS Hearing Office or Office of Administrative Hearings as applicable. Smoky is not required to enroll an applicant in the Smoky Closed Network or renew a Network Contract if the individual or entity has a DHHS sanction pending in Superior Court.

Smoky reserves the right to make exceptions to the good standing criteria as needed to ensure appropriate availability and accessibility of services to members.

## **Cultural Competence**

An important prerequisite to network participation is the development of a Cultural Competency Plan. Smoky requires all Network Providers to develop and implement a Cultural Competency Plan that is respectful and supportive of the cultural and diverse needs of members, families, stakeholders, communities and other agencies. Cultural competency is a guiding principle that must be incorporated into your mission and values and reflected in your decisions, policies, clinical protocols, and established benchmarks and outcome measures. We require all Network Providers to practice person-centered thinking in every aspect of service delivery in order to achieve cultural competence. You will be successful in achieving a culturally competent organization when the skills and abilities needed for cultural competence become a priority at every level of the organization, including leadership and your Board of Directors (if applicable).

In order to develop cultural competence, individual practitioners, organizations and staff members must examine their own practices, potential barriers to services, and the importance of including family and community. Family is defined specifically by each culture but is typically the primary individual or group that provides a system of support to the member. Cultural competence, including person centered thinking, extends

to the community and includes natural and informal supports in the development of services. As reflected in person-centered thinking, members, families and natural supports should participate in decisions around the member's care, to the greatest extent possible and in accordance with clinical appropriateness and confidentiality requirements.

You must have an understanding of the social, linguistic, ethnic, and behavioral characteristics of the communities and populations you serve and the ability to systematically translate that knowledge into practices in the delivery of MH/IDD/SA services. Relationships should be collaborative in nature and should view communities as partners. You can demonstrate your cultural competence in the following ways:

#### Individually

- Examine one's own background and acknowledge cultural biases.
- Become educated about other cultural beliefs.
- Be open to and seek exposure to different cultural events.
- Be an active listener.
- Meet the individual where they are; do not judge.
- Acknowledge that discrimination is often a result of fear.

#### Organizationally

- Identify and adopt appropriate cultural diagnostic tools and train staff on their utilization.
- Advertise position openings in markets where minorities are exposed to the ads.
- Evaluate outreach and marketing strategies to ensure targeted communities and populations are reached.
- Practice inclusiveness.
- Acknowledge the interactive dynamics of cultural differences.
- Continuously expand cultural knowledge and resources with regard to populations served.
- Collaborate with the community regarding service provision and delivery
- Commit to cross-cultural training of staff and develop policies to provide relevant, effective programs for the diversity of people served.
- Earnestly participate in initiatives to achieve cultural competence.
- Pursue the acquisition of knowledge relative to cultural competence and the provision of services in a culturally competent manner.
- Recognize and Work to Reduce Potential Barriers to Treatment:
  - Stigma associated with receiving services
  - Distrust of the system
  - Perceived lack of confidentiality
  - Services not located in the community where they are needed
  - Lack of transportation
  - Poverty
  - Language
  - Fear, of discrimination or otherwise

- Family or community shame
- Lack of Providers with a culturally appropriate or diverse staffing base

In the future, Smoky may require Network Providers to complete a Cultural Competence Self-Assessment Tool annually in order to evaluate your level of Cultural Competence. Areas to be assessed will likely include:

- Staff Composition
- Physical Environment
- Written Materials
- Website
- Phone System
- Policies and Procedures
- Training Program
- Communication of the Program

## Identification of Service Needs

Smoky will not accept or review applications for new enrollment unless a service need has been identified. **This includes applications from currently credentialed practitioners who are interested in leaving their contracted employer and starting an independent practice.** If a specific service need is identified and approved as the result of the capacity study or based on an internal review, Smoky may seek to add providers through a variety of means, including but not limited to direct provider contact, solicitation of applications via the weekly bulletin or website posting, or development of a procurement process for selection of an appropriate provider. Smoky is committed to ensuring the fiscal stability of its contracted Network Providers, and will only consider applications from new applicants for MH/IDD/SA services if service capacity is not met, i.e. there is a demonstrated community or member service need. Providers seeking to enroll in the Smoky Closed Network for the first time, or Network Providers seeking to add a site or service to a Network Contract should check the Smoky website to determine if Smoky has identified a specific need for a provider type, specialty or location.

If we cannot identify existing Network Providers to meet an identified need, then we will seek to recruit new provider(s). If Smoky elects to pursue a formal procurement process, applicants must follow all steps identified in the applicable Request for Proposal (RFP) or Request for Information (RFI). Otherwise, the first step is for the applicant to complete and submit a Provider Nomination Form, available here:

<http://www.smokymountaincenter.com/providers.asp?section=enroll>. If the nomination is approved, the provider will be sent an application for credentialing and enrollment that will include detailed instructions and timelines for completion.

## Selection (Enrollment) Criteria

In order for a nomination to be approved, the applicant must meet all of the following criteria as determined by Smoky, as applicable to the provider type. We specifically reserve the right to conduct an on-site review at any



time to confirm provider compliance with these criteria and further reserve the right to reject any applicant or provider who does not meet these criteria as determined by Smoky.

1. There must be a need for the service the applicant is seeking to provide.
2. The applicant must meet all Smoky credentialing and/or re-credentialing requirements.
3. The applicant must be in good standing as outlined above.
4. The applicant must adhere to evidence-based or best practices where applicable and provide culturally competent services.
5. The applicant must demonstrate efforts to implement a customer service system that ensures good communication with members and families.
6. The applicant must have a “no-reject” policy for referrals.
7. The applicant must have a robust Compliance Plan and Quality Management Plan with evidence of implementation of strategies and goals.
8. The applicant must have adequate clinical leadership according to the disability and services being provided with a sufficient supervision structure.
9. The applicant must have a HIPAA compliant Electronic Medical Record (EMR) system which supports management of authorizations and billing functions and compliance with the Federal Meaningful Use Standards.
10. The applicant must demonstrate fiscal stability, based on the most recent annual audit or other financial indicators, and defined as having: (i) A minimum of one month’s working capital or line of credit equal to the applicant’s monthly gross income or revenue; and (ii) No tax liens.
11. The applicant must have the business operations and information technology infrastructure in place necessary to meet all clinical, quality improvement, billing, and confidentiality standards required for providers of publicly-funded healthcare services, including but not limited to infrastructure necessary to monitor all financial information of the company such as debt to income ratio.

## **Network Provider Enrollment and Change Requests**

Network Providers seeking to add a site or service to a Network Contract must be in good standing. The first step is to complete and submit a Provider Nomination Form, available here:

<http://www.smokymountaincenter.com/providers.asp?section=enroll>. If a need for the additional site or service has not been identified, Smoky may reject the request or may gather information related to service capacity and needs and present the request to leadership for consideration. If the nomination is approved, the Network Provider will be sent an application for credentialing and enrollment for the new site or service that will include detailed instructions and timelines for completion.

Network Providers may enroll additional licensed practitioners without submitting an application to add a new site or service so long as the additional licensed practitioners will be working out of existing site locations contracted with Smoky. All licensed practitioners are required to submit an application for credentialing as outlined in Section 3 of this Manual.

Existing Network Providers of Innovations Waiver services seeking to add an additional Innovations Waiver service to their Contract in order to serve a specific participant must be in good standing. The first step is to work with the assigned Care Coordinator to complete and submit the Provider Nomination Form. Requests will be reviewed and considered based on information from the Care Coordination department as to whether the additional Waiver service is necessary to meet a specific need. If the request is for a residential service that requires additional credentialing, it will be forwarded to the Credentialing Team to start the credentialing process.

## **Retention (Renewal) Criteria**

Smoky may choose to renew a contract in whole (all sites and services) or in part, and will strive to communicate renewal decisions to affected Network Providers at least 60 days prior to the Contract end date, unless non-renewal is recommended based on fraud, waste, abuse, or quality of care concerns, in which case the time frame may be reduced. If the Contract is not renewed, the Network Provider must cooperate with Smoky's efforts to safely and appropriately transition members to other providers in the Closed Network and must ensure that all medical records are stored, maintained and shared in accordance with federal and state laws, rules, regulations, policies, retention schedules and manuals, and this Manual.

In general, Smoky's policy is to renew Network Contracts unless one of the following applies: (1) renewal does not support the Comprehensive Care Center model as determined by Smoky; (2) renewal is not supported by the capacity study, Network Development Plan or a detailed Market Analysis as determined by Smoky; (3) public funds to support the service are not available (for example, reduction in state or local funding); (4) there is excess capacity for any of the services offered by the Network Provider as determined by Smoky; (5) Smoky has issued an RFP or RFI for the service(s) delivered by the Network Provider; or (6) the Network Provider meets any of the conditions outlined below, as determined by Smoky:

- The Network Provider is in breach of any provision of its current Contract with Smoky, including but not limited to a failure to comply with Controlling Authority and any applicable Scope of Work. Contract requirements reviewed may include but are not limited to:
  - Provision of services in accordance with all applicable state and federal laws, rules, regulations, the NC State Plan for Medical Assistance, the Waiver, State Service Definitions, and/or Clinical Coverage Policies;
  - Meeting all medical necessity and documentation requirements as set forth in Medicaid Clinical Coverage Policies, State Service Definitions, and/or the DMH/DD/SAS Records Management and Documentation Manual, APSM 45-2;
  - Cooperation and participation with all Smoky network integrity activities (including but not limited to audits, investigations and post-payment reviews), as well as Smoky process for utilization review/management, quality management, incident reporting, and member appeals and grievances.
- The Network Provider has not billed for services in the sixty (60) days prior to Smoky's review of the contract renewal, unless it concerns a provider of specialty or out-of-catchment area services that are

delivered infrequently.

- The Network Provider is not in good standing as defined in this Manual.
- Smoky has issued two or more Plans of Correction against the Network Provider for the same or substantially similar findings within the fiscal year covered by the Contract.
- Smoky has logged quality of care concerns, Level 2 or 3 incidents, or other serious grievances about the Network Provider that have not been satisfactorily resolved in required timelines.
- The Network Provider has a consistent and high volume of claim denials despite technical assistance or training offered and/or provided by Smoky.
- The Network Provider has not responded to requests for data or other information necessary for Smoky to respond to requests from the State or CMS.
- The Network provider fails to maintain and provide proof of insurance as required under the terms and conditions of the Contract.
- The Network Provider has failed to meet Routine Monitoring requirements.
- The Network Provider routinely fails to satisfactorily complete and upload Service Authorization Requests (SARs) that meet Smoky Care Management requirements (i.e. high percentage of administrative denials proportional to the numbers of members served - generally anything higher than 10% is unacceptable).
- The Network Provider routinely fails to submit requests for SARs for continuation of currently authorized services at least 14 days prior to end of existing authorization – at least 75% of SARs must meet this standard.
- The Network Provider has failed to implement an adequate emergency response system that complies with the requirements of contracted services, including the implementation of measures to respond to emergencies on weekends and evenings for members served by the Network Provider.
- The Network Provider routinely fails to meet DMH/DD/SAS access standards and appointment wait times or fails to comply with the no-reject policy for members referred by Smoky.
- The Network Provider is unable to meet re-credentialing criteria, including a failure to maintain any required facility or professional license.
- The Network Provider has failed to cooperate and comply with discharge and transfer requirements to ensure a smooth transfer for any member that desires to change providers, or because the Network Provider cannot meet his/her special needs.

Other factors that Smoky may consider as part of the retention and renewal process include:

- Efforts to satisfactorily implement an acceptable Cultural Competency Plan, including efforts to provide culturally competent services and ensure the cultural sensitivity of staff members.
- Efforts to achieve evidence-based or best practice in applicable areas of service, including the responsibilities associated with clinical and/or medical homes.
- Customer service and health literacy efforts to implement a system that ensures good communication with members and families.
- Evidence of cooperation with, and level of participation in, member and provider satisfaction surveys.
- Implementation of a robust Corporate Compliance Plan and Quality Management Plan with evidence of

strategies and goals being implemented by the Network Provider.

- Evidence of adequate clinical leadership according to the disability and services being provided by the Network Provider with a sufficient supervision structure.
- Efforts to implement a HIPAA compliant Electronic Medical Record (EMR) system which supports management of authorizations and billing functions and compliance with the Federal Meaningful Use Standards;
- Demonstrated financial stability defined as having: (i) A minimum of one month's working capital or line of credit equal to the Network Provider's monthly gross income; and (ii) No tax liens.
- Demonstrated operations and information technology infrastructure in place necessary to meet all clinical, quality improvement, billing, and confidentiality standards required for providers of publicly-funded healthcare services, including but not limited to infrastructure necessary to monitor all financial information of the company such as debt to income ratio.

**Smoky specifically reserves the right not to renew a contract with a Network Provider for any reason, or to reduce or limit the contracted services for a Network Provider in subsequent contract terms.**

# Section 3: Credentialing & Contracting

## Introduction

Credentialing is a process of primary and secondary source verification of licensure and other credentials to determine if a provider of MH/IDD/SA services meets minimum criteria for participation in our Closed Network. Our policy is to implement standardized credentialing, re-credentialing and contracting processes in a manner that ensures internal consistency, as well as security of sensitive information submitted by providers. The process includes a review of licensure, education, sanctions, exclusions, criminal and liability history, insurance and other relevant documents and information. New providers and licensed **independent** practitioners are only invited to submit a credentialing application if it has been determined they meet Smoky's selection criteria via the nomination process described in Section 2 of this Manual. Providers will not be added to the Provider Directory until they have been approved by the Credentialing Committee and executed a contract for network participation.

Smoky is responsible for performing delegated credentialing and re-credentialing functions for Partners Behavioral Health Management and CenterPoint Human Services. **This Manual is only applicable to Smoky Network Providers.** Providers in other MCO networks should consult the Partners and CenterPoint manuals, policies and websites for information about practices specific to those MCOs. Each MCO makes independent decisions about requests from providers seeking to apply for participation in the MCO Closed Network, nominates applicants for credentialing based on independent internal criteria, and makes independent decisions about applications for credentialing, re-credentialing and sanctions. For more information, please visit the Western Regional Partnership Credentialing page hosted by Smoky at: <http://www.smokymountaincenter.com/credentialing/>.

Please note that Smoky will electronically send all credentialing and contracting applications, forms and correspondence to the latest contact email address provided to Smoky. In the event the address provided is not accurate, Smoky will make only one attempt to obtain a corrected address.

## Overview of Provider Types

Comprehensive Care Center (CCC) providers serve as the cornerstone of our community-based system of recovery-oriented care. The CCC model is designed to avoid isolated delivery of enhanced services outside of a full continuum of care and enable increased access to Medicaid and State-funded safety net services, including basic outpatient therapy, medication management, screening, assessment, emergency triage, prevention, education, and consultation. CCCs must provide same-day walk-in capacity at approved sites for rapid access to assessment and treatment; deliver a full continuum of treatment services for adults and children with MH/SA conditions; provide IDD services or have the ability to coordinate services through formal or informal provider relationships; provide a continuum of crisis services for all disabilities, including 24/7 telephone crisis response

and first responder duties; maintain trained staff to conduct involuntary commitment first evaluations at all approved walk-in sites; have an established structure for providing or coordinating primary care services; maintain an electronic medical record that meets meaningful use standards; and accept a wide array of public and private funding, including Medicaid, Medicare, federal Block Grant, state and local funding and private insurance carriers.

Critical Access Behavioral Healthcare Agencies (CABHAs) have been certified by DMH/DD/SAS as clinically competent organizations with appropriate medical oversight necessary to deliver a designated continuum of mental health and/or substance use services, including the following core services: Comprehensive Clinical Assessment, Medication Management and Outpatient Therapy. Under the NC State Plan for Medical Assistance, only CABHAs can deliver the following enhanced services: Community Support Team, Day Treatment, and Intensive In-Home. All of Smoky's comprehensive providers are certified CABHAs.

Hospitals contract with Smoky to deliver psychiatric inpatient, outpatient and emergency services to our members. Smoky's provider network includes community hospitals, large medical centers, national and regional health systems, private psychiatric facilities, and state-operated facilities.

Licensed Practitioners are employed by a Comprehensive Care Center, CABHA, Agency, Hospital, or Group Practice that is fully contracted with Smoky to provide outpatient therapy. Licensed Independent Practitioners are directly contracted with Smoky to provide outpatient therapy to members. Whether working independently, in professional practice groups, or for large provider agencies or health systems, practitioners offer important access to outpatient care for members. The full list of practitioner types enrolled with Smoky is listed on page 28 of this Manual. All practitioners undergo rigorous credentialing to ensure the provision of high quality, evidence-based treatment. Associate practitioners must also provide proof of professional clinical supervision as evidenced by a current supervision contract including the name, contact information, and attestation from a clinical supervisor.

Integrated Care Providers offer behavioral health services from a primary care setting. This generally involves a Primary Care Physician employing or contracting with a Licensed Practitioner to provide outpatient treatment to individuals being served by the Primary Care Physician. Practice settings could include Federally Qualified Health Centers (FQHC), Rural Health Centers, County Health Departments, hospital outpatient practices, and general primary care practices.

Physician Practices may include Family Practices and Primary Care Practices. These practices may be independent or part of a larger health system. Practitioners at these offices include physicians, physician's assistants, family nurse practitioners, and registered nurses. These clinicians possess skills and knowledge which qualify them to provide continuing and comprehensive medical care, health maintenance, disease prevention and health education services to each member of the family regardless of sex, age or type of problem, be it biological, behavioral, or social. These practices are often the point of "first contact" for someone when a medical illness, issue or concern arises. Primary care involves the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of the family and community.

Specialty Providers concentrate on a specific disability, population or service such as vocational, residential services, dually diagnosed, veterans, eating disorders, or autism. Specialty Providers fill a critical role in the Smoky Network for Priority Populations and for those members with very specific service and support needs. Providers of Innovations Waiver services are specialty providers and are discussed more fully in Section 13 of this Manual.

Out of Area Providers are Network Providers who provide specialty services that are not available within the Smoky catchment area. These include specialized residential facilities that may be located out of the state.

Out of Network Providers are providers we contract with to meet the needs of specific Smoky members, either because of a specialty need that cannot be met by a Network Provider, or because the individual resides outside of our catchment area. These providers are not listed in the Provider Directory and are not eligible for referrals.

**NOTE:** Smoky will not pay for non-emergency services delivered by a provider who has not entered into a Network Participation Agreement or Out-of-Network Agreement with Smoky.

## **Credentialing Initiation**

The type of credentialing or re-credentialing application and verification process you must complete depends on your provider type and whether you are organized as an individual (sole proprietor) or a corporate entity, limited liability company (LLC), or partnership. Presently, we accept all credentialing forms, applications and other documentation via electronic, facsimile, U.S. mail, courier service or hand delivery with receipt. Submitted applications must include all requested and/or required information or other documentation, and must be signed by the applicant no more than 180 days prior to the initial review of the application by the Smoky Credentialing Committee.

Smoky's dedicated Credentialing Hotline can be reached at 1-855-432-9139, or you may contact us at [CredentialingTeam@smokymountaincenter.com](mailto:CredentialingTeam@smokymountaincenter.com). Our goal is to respond to all inquiries within 1 business day.

## **Credentialing Process for Entities**

Within 5 business days following a determination that Smoky has either: (a) approved the nomination of a new provider entity; or (b) approved the change request from a Network Provider seeking to add a new or additional site or service to their existing contract, we will send the applicant an email that includes electronic access to the applicable application, instructions and contact information for technical assistance. Within 60 days of receipt of this email, the applicant must submit a complete credentialing application packet that includes the following information:

- An attestation statement that attests the application is complete and accurate, authorizes Smoky to collect any information necessary to verify the information in the application (including consent to release social security numbers and dates of birth to verification entities and to consult with others who may have information bearing on the provider's competence and/or qualifications), signifies the

provider's willingness to abide by Smoky policies and procedures, releases Smoky from liability related to the credentialing process, affirms that the provider is able to send 837 HIPAA compliant transactions and to receive 835 Remittances or to participate in Smoky's AlphaMCS billing process, and attests that the provider has a "no-reject policy" for referrals within the capacity and parameters of their competencies and agrees to accept all referrals meeting criteria for services they provide when there is available capacity.

- Identification of ownership of the entity, to include a list of all persons with an ownership or control interest of 5% or more ("owners") and a list of all parent, sister, affiliate and subsidiary entities in the entire chain of ownership, including an organizational flow chart, up to the ultimate owner of the holding company. The ownership identification must include the name, title, address, contact information, date of birth, and Social Security Number of any owners, directors (including members of the Board of Directors) managing employee(s) and fiscal agent(s) of the entity.
- Copy of the current license for each facility that is applicable for the requested service(s). A copy of the actual license must be included unless it can be primary source verified via the appropriate licensing agency website.
- Completed and signed W-9 Form.
- Identification of taxation status that includes type of business (not-for-profit, profit, partnership, etc.) and tax identification (ID) number.
- List of any Accreditations held.
- History of sanctions, probation or loss of accreditation or certification and disclosure of any actions that could result in a sanction, probation, or loss of accreditation or certification.
- History of names the entity has done business under or if business is using a "doing business as" name.
- Written documentation of Source of Authority through Charter, constitution, bylaws and/or Articles of Incorporation unless it can be primary source verified **OR** a Certificate of Authority that shows eligibility to do business in North Carolina unless it can be primary source verified.
- Organizational chart that includes all departments, divisions, units, program heads/ supervisors, and staff titles, as well as staffing patterns for each service for which the agency has submitted an application.
- Certificate of Insurance or letter of intent from the agency's proposed insurance carrier that meets the minimum required amounts identified in the application.
- Professional liability claims history.
- Listing of Human Rights Committee members which include the names, title, and contact information (excluding Group Practices that only provide outpatient therapy services).
- Identification of any affiliation, by contract or otherwise, with any other NC Medicaid provider.

In order to decrease the administrative burden on hospitals/ health systems directly enrolled with DMA, we are permitted (but not required) to accept and rely upon DMA's credentialing of NC licensed hospitals. This may include all facilities and sites affiliated with the hospital/ health system seeking to be credentialed, to the extent such facilities and sites are enrolled with DMA and affiliated with the hospital/ health system in NC Tracks. Hospitals have the option of completing and submitting the full application described above, or submitting a copy of their DMA application. Smoky will review a hospital's completed DMA application against our



accreditation and Waiver Contract requirements. Any required information not submitted to or verified by DMA must be submitted to Smoky for verification in accordance with the process outlined above. This includes but is not limited to social security numbers and dates of birth for all owners, directors, members of the Board of Directors and managing employees.

However, under our DMA Waiver Contract, we remain directly responsible for credentialing of all practitioners billing through the hospital/ health system. Hospitals have the option of entering into a Delegated Credentialing Agreement (DCA) with Smoky for individual practitioner credentialing. In the absence of an executed DCA, all rostered hospital practitioners must complete the credentialing process described below prior to billing Smoky for services.

## **Credentialing Process for Practitioners**

### Practitioner Types

Smoky enrolls two different categories of practitioners: Licensed Independent Practitioners (LIPs) who directly contract with Smoky and are personally responsible for compliance with this Manual, and Licensed Practitioners (LPs) who work for, and bill through, another contracted provider such as an agency. LIPs must submit the Nomination form and meet selection criteria as outlined in Section 2 of this Manual. Network Providers may submit a Provider Change Form at any time to enroll new or additional LPs without going through the selection process, so long as the practitioners will be working out of a site that has already been credentialed.

Any of the following fully licensed or associate practitioners seeking to provide clinical services (including but not limited to psychiatric care, assessment or outpatient therapy) must undergo credentialing:

- Licensed Clinical Social Worker (LCSW)
- Licensed Professional Counselor (LPC)
- Licensed Marriage and Family Therapist (LMFT)
- Licensed Clinical Addiction Specialist (LCAS)
- Licensed Psychologists – (Health Service Provider-Psychologist (HSP-P))
- Licensed Psychological Associate (LPA) – (Health Service Provider-Psychological Associate (HSP-PA))
- Licensed Psychiatrist (MD, DO)
- Licensed Psychiatric Nurse (RN)
- Advanced Practice Psychiatric Clinical Nurse Specialist
- Licensed Psychiatric/Family Nurse Practitioner providing MH/SA services under the supervision of a licensed psychiatrist (PNP or FNP) – must have psychiatric experience or experience working with substance abuse population to apply as independent practitioner
- Licensed Physician Assistant (PA) providing MH/SA services under the supervision of a licensed psychiatrist
- Physician with substance use specialty or psychiatric training/experience (general physicians with no substance use or psychiatric training are not eligible to apply)

- Nurse Practitioners (providing team based services as part of an agency)
- Physical Therapist (providing Specialized Consultative Services)
- Occupational Therapist (providing Specialized Consultative Services)
- Speech Therapist (providing Specialized Consultative Services)
- Board Certified Behavioral Analyst (BCBA - providing Specialized Consultative Services)
- Certified Therapeutic Recreational Therapist (providing Specialized Consultative Services)

All practitioners must meet state licensure or certification requirements and hold a valid North Carolina license or certificate as listed above, unless the practitioner is seeking to provide services out of state, in which case he or she must meet all licensure or certification requirements of the State in which they are seeking to provide services.

### Step 1 – Credentialing Initiation Form (CIF) and Council on Affordable Quality Healthcare (CAQH) Process

If an LIP is determined to meet selection criteria or a Network Provider submits a Provider Change Form identifying a new LP, Smoky will send a Credentialing Initiation Form (CIF) with instructions to the practitioner. The CIF is used to initiate the process of engaging the practitioner in the Council on Affordable Quality Healthcare (CAQH) on-line application process.

Nurse Practitioners who are seeking to be credentialed as LIPs must also submit a collaborative practice agreement (CPA) as part of their CIF. The CPA must describe the arrangement for continuous availability between the nurse practitioner and the supervising physician. The CPA should also describe the patient population being served, prescribing authority, drugs and devices that may be prescribed by the nurse practitioner, minimum standards for consultation between the nurse practitioner and the primary supervising physician, and the process for the annual review/re-signing of the CPA. Psychiatrists must identify completion of an approved/ accredited residency, and sub-specialty fellowship training must be documented (if taken). Residency is the period of clinical education in a medical specialty that follows graduation from medical school and prepares physicians for the independent practice of medicine. For physicians, this is the highest level of education and/or training required to be primary source verified by Delegate. Board Certification is not required; however, practitioners who identify themselves as board certified must do so in accordance with the definition of board certification for that recognized specialty board (i.e., for psychiatrists – The American Board of Psychiatry and Neurology).

The CIF and supporting documentation must be completed and submitted to Smoky within 60 days of receipt. If a completed CIF is not received within 60 days, the application will not be processed. If the CIF information is incomplete, inaccurate or conflicting, Smoky will electronically notify the practitioner of the information that is missing or incorrect. The practitioner’s employer or a contact person with the employer may also be contacted to obtain additional information (if applicable). **For this reason, it is critical that the application contain accurate contact information.** If the practitioner does not return all necessary information within seven (7) business days of such notification, Smoky will provide a second electronic notification. If the practitioner does not return all necessary information within seven (7) business days of the second notification, Smoky will not

process the CIF and the practitioner will have to complete a new CIF.

Practitioners can request the status of their CIF at any time during the process by contacting Smoky at [CredentiaingTeam@smokymountaincenter.com](mailto:CredentiaingTeam@smokymountaincenter.com). If Smoky receives a timely, complete CIF, the prospective practitioner will be added to the Smoky CAQH roster. CAQH notifies practitioners already registered with CAQH of Smoky's interest in viewing their online application. Smoky must be able to view the completed on-line CAQH application before the credentialing process can proceed. For those not already registered, CAQH sends an initial registration packet with CAQH login information. The practitioner must complete the on-line CAQH application and add Smoky as an authorized entity. If the CAQH application is not available within 30 days from the date that the practitioner was added to the CAQH roster, the application will not be processed. The practitioner will then need to submit a new CIF to restart the process.

### Step 2 – Smoky Application Process

In order to complete the credentialing process, practitioners must submit a completed credentialing application packet which includes the following:

- Complete Council for Affordable Quality Healthcare (CAQH) Application.
- Name of Network Provider with whom LP is affiliated (does not apply to LIPs).
- Copy of initial and current license(s) renewal(s).
- Copy of initial and most recent board certification, if applicable.
- Copy of current DEA Certificate, if applicable.
- Certificate of Insurance or letter of intent from the practitioner's or agency's proposed insurance carrier that meets the minimum required amounts identified in the application.
- Professional liability claims history
- History of sanctions or pending actions that could result in sanctions
- History of loss or limitation of privileges or disciplinary activity.
- Identification of Hospital affiliations or privileges (if applicable) or name of practitioner to whom MD refers if lacking privileges.
- Past 5 years of relevant work history.
- Identification of languages spoken proficiently.
- Areas of specialized practice.
- Disclosure of any physical, mental, or substance abuse problems that could, without reasonable accommodation, impede the practitioner's ability to provide care according to accepted standards of professional performance or pose a threat to the health or safety of patients.
- Copy of Educational Commission for Foreign Medical Graduate Certificate (if applicable), unless it can be primary source verified;
- Identification of the practitioner's on-call designee, who must be a member of the network or otherwise approved by Smoky, and must have the same credentials or higher.
- An attestation statement that attests the application is complete and accurate, authorizes Smoky to collect any information necessary to verify the information in the application (including consent to

release social security numbers and dates of birth to verification entities and to consult with others who may have information bearing on the practitioner's competence and/or qualifications), signifies the practitioner's willingness to abide by Smoky policies and procedures, and releases Smoky from liability related to the credentialing process.

- LIP Only – (1) An attestation statement that the LIP is able to send 837 HIPAA compliant transactions and to receive 835 Remittances or to participate in Smoky's AlphaMCS billing process; and (2) a complete and signed W-9 form.

## Credentialing Verification Review

Verification must be performed no more than 180 days prior to the initial review of the application by the Credentialing Committee. You can request the status of your application at any time during the process by contacting us at [CredentialingTeam@smokymountaincenter.com](mailto:CredentialingTeam@smokymountaincenter.com). Applications are reviewed based on criteria specific to the provider type. Smoky's process is to verify the "primary source" of the submitted credential whenever possible. Our staff utilize the following databases to determine the accuracy of reported credentials and/or identify information that an applicant inadvertently or deliberately failed to disclose:

- Exclusions (OIG): <http://exclusions.oig.hhs.gov/>
- Exclusions (SAM): <https://www.sam.gov/portal/public/SAM/>
- National Practitioner Databank: <https://www.npdb-hipdb.hrsa.gov/Login.jsp>
- Social Security Death Master File: <https://www.ssdmf.com>
- NPPEs: <https://npiregistry.cms.hhs.gov/>
- NC Tracks: <http://ncmmis.ncdhhs.gov/taxonomy.asp>
- NC Department of Revenue: <http://www.dor.state.nc.us/collect/delinquent.html>
- NC Secretary of State: <http://www.secretary.state.nc.us/corporations/CSearch.aspx>
- DHSR Facility Licensure: <http://www.ncdhhs.gov/dhsr/mhlcs/facilities.html>
- DHSR Provider Penalty Tracking Database: <https://providertracking.dhhs.state.nc.us/>
- DHSR Healthcare Personnel Registry: [https://www.ncnar.org/verify\\_listings1.jsp](https://www.ncnar.org/verify_listings1.jsp)
- DEA Certificates: [www.deanumber.com](http://www.deanumber.com)
- NC Board of Licensed Professional Counselors (NCBLPC): <http://www.ncblpc.org/license-info/verification> (LPC).
- NC Marriage and Family Therapy Licensure Board: [http://www.nclmft.org/public\\_resources/verify\\_a\\_licensee/](http://www.nclmft.org/public_resources/verify_a_licensee/) (LMFT)
- NC Social Work Certification and Licensure Board (NCSWCLB): [www.ncswboard.org/](http://www.ncswboard.org/) (LCSW)
- NC Substance Abuse Professional Practice Board (NCSAPPB): <http://ncsappb.learningbuilder.com/Public/PractitionerLookup/Search> (LCAS)
- NC Medical Board: <http://wwwapps.ncmedboard.org/Clients/NCBOM/Public/LicenseeInformationSearch.aspx>
- NC Board of Psychology: <http://www.ncpsychologyboard.org/search.htm>
- NC Board of Nursing: <http://www.ncbon.com/>
- Criminal History: [www.accuratebackground.com](http://www.accuratebackground.com)

- Joint Commission: <http://www.qualitycheck.org/consumer/searchQCR.aspx>
- CARF: <http://www.carf.org/providerSearch.aspx>
- Council on Accreditation: <http://www.coanet.org/front3/page.cfm?sect=7&show=org&ctry>
- American Board of Medical Specialties: <http://www.abms.org/>
- Foreign Medical Graduates: [www.ecfm.org](http://www.ecfm.org)

Any documentation submitted that is older than 6 months (or 1 year for facility licenses) will be denied during the verification process. If additional or corrected information or documentation is required, Smoky will electronically notify you of the specific information that is needed to complete the application. **As stated above, it is critical that the application contain accurate provider contact information.** Smoky's experience has been that lapses in credentialing are primarily due to inaccurate contact information on file or failure to submit a complete application. If requested information is not returned within 7 business days of this notification, Smoky will provide a second electronic notification. If requested information is not returned within 7 business days of the second notification, the application will not be processed.

Once Smoky has received a complete application, the Credentialing Team will complete primary/ secondary source verification of information submitted, coordinate a Site Visit if required, and identify any "flags" that could impact the quality of care or services delivered to members.

## Site Visits

For initial credentialing applications (including new sites), a site visit is required prior to completion of credentialing. Stability of past operations is important. An assessment of the applicant's record of services, compliance with applicable laws, rules, regulations and standards, the qualifications and competency of any staff, the satisfaction of members and families served, systems of oversight, adequacy of staffing infrastructure, use of best practices, and quality management systems will be evaluated by the LME/MCO prior to enrollment to the extent possible and at regular intervals thereafter through Routine and Focused Monitoring. During this process, you may be asked to demonstrate your system of communication with members and how members and families are involved in treatment and services. Site visits are generally completed within 30 days of receipt of a complete application, and will be based on a standardized check sheet. In the event site visit criteria are not met, the applicant will be given 30 days in which to correct any deficiencies and undergo a final site visit. Failure to meet site visit criteria on the final visit shall result in the application not being presented to the Credentialing Committee.

## Credentialing Committee Review

The Credentialing Committee is tasked with assuring that all agency, facility and practitioner applicants meet standards for entrance into the Smoky Provider Network. The Committee is made up of Smoky staff and local practitioners who are already members of the Smoky Provider Network and represents various licensing guilds. Based on the credentialing verification, a roster is prepared that identifies all providers and practitioners ready for presentation to the Credentialing Committee, as well as any "flags" identified and the details related to such

flags that needs to be reviewed and discussed by the Credentialing Committee. All credentialing decisions are made by the Credentialing Committee, which is chaired by our Chief Medical Officer **and includes Network Provider representatives**. The Committee meets no less than monthly and has delegated the approval of unflagged applicants to the Chief Medical Officer. An unflagged application is one in which there are no negative actions disclosed in the application, no negative findings were identified on reviewed databases, and the applicant meets good standing criteria, to the extent good standing can be determined at time of credentialing verification review.

Flags that may prompt further investigation or review include but are not limited to:

- Any identified deficiency related to good standing, including certain criminal history findings:
  - All felony and misdemeanor convictions within the last 5 years.
  - All felony and misdemeanor convictions that involve violence, sexual offenses, fraud or financial impropriety, regardless of age or time elapsed since the offense.
  - All convictions and pending charges for driving under the influence/ driving while intoxicated, regardless of age or time elapsed since the offense.
  - Traffic violations are not flagged unless the applicant has 3 or more guilty records for events that occurred within the twelve (12) months prior to the date of application.
  - Misdemeanors, including traffic violations, are presented to the Credentialing Committee in every case when additional flags are present.
  - Any felonies or misdemeanors that were not disclosed in the application.
- Gaps in employment of more than 6 months if gap is due to incarceration, inpatient admission, or refusal to explain.

Smoky reserves the right to “flag” other issues as determined by the Chief Medical Officer in consultation with the Credentialing Team. If a flag is identified, the Credentialing Committee may decide to pend the application and request additional information from the applicant. Decisions about flagged applicants are within the sole discretion of the Credentialing Committee, subject to accreditation and Waiver Contract requirements.

In the event that third party verification databases are not available for timely processing, the affected applicant will be included on the monthly roster and presented to the Credentialing Committee based on the information available at the time of the meeting. The verification database will be monitored and verifications will be completed as soon as the database becomes available. If any flags are later discovered, Smoky will promptly notify the Credentialing Committee for the purpose of evaluating the new information. This exception does not apply to the OIG, SAM, NPDB, or licensing verifications.

Applicants will be notified in writing of Credentialing Committee decisions. Decisions are effective retroactive to the first day of the month in which Smoky received a complete application. Credentialing approval does not guarantee the issuance of a contract with Smoky. Any services delivered prior to the date of the Committee decision are delivered at your own risk. If credentialing or contracting is not approved, Smoky will not reimburse you for services delivered in the interim. Moreover, there is no right to appeal or contest a decision to deny an application for initial credentialing.

## Change Notifications

The data you provide during the credentialing process is used for referral purposes; therefore it is critical that you notify us as soon as possible if any of your information changes. All Network Providers must notify Smoky of any changes to the information presented in their most recent credentialing or re-credentialing application no later than 5 business days after the change using the Provider Change form available on Smoky's website: <http://www.smokymountaincenter.com/credentialing/>.

This includes but is not limited to changes to any of the following information:

- Legal name
- Business, mailing or billing address
- Contact information, especially your credentialing contact person
- NPI or Tax ID
- Licensure or privileging status
- Good standing status, including pending sanctions, citations, malpractice claims, investigations for Medicaid fraud, etc.
- Practitioner roster, but remember that new practitioners hired must be credentialed by Smoky prior to billing for services

In order to avoid any gaps in claim submission, Network Providers must notify Smoky of any changes in ownership or management, including but not limited to proposed acquisitions or mergers, as soon as practicable in advance of such change, but no later than 30 days prior to the planned change.

**Requests to add a new or additional site or service must go through the process described in Section 2 of this Manual.** Changes in capacity or inability to accept new referrals must be reported to [providerinfo@smokymountaincenter.com](mailto:providerinfo@smokymountaincenter.com) or the Provider Help Line at **1-866-9902-9712**. If you use the AlphaMCS slot scheduler, please notify Customer Services at 1-888-757-5726.

Independent Practitioners wishing to initiate a Leave of Absence from the Network must notify Smoky at least 60 days prior to their desired effective date, via email to [providerinfo@smokymountaincenter.com](mailto:providerinfo@smokymountaincenter.com). In the request, please identify the specific reason(s) for the request for a leave of absence (i.e. maternity leave, etc.). Smoky will generally approve requested leave for up to an initial 6 month period, with the option for an extension. An extension to the original leave should not exceed an additional 6 months and must be submitted no later than 60 days prior to the expiration of the original Leave of Absence.

The following chart identifies changes that require credentialing review and/or a contract amendment:

<b>Type of Change</b>	<b>Credentialing Verification Required?</b>	<b>Contract Amendment Required?</b>
Phone Number	No	No
Primary Contact Person	No	No
Other Cover Sheet Contacts	No	No
Email or Website	No	No
Mailing Address	No	Yes
Billing Address	No	No
Site Address	Yes	No
NPI Number	No	No
Tax ID Number	Yes	Yes
Additional (New) Site or Service	Yes	No
Remove Site or Service	No	No
Practitioner Name	Yes	Yes if LIP
Practitioner License/ Certification	Yes	No, unless services also changing
Facility License	Yes	No, unless services also changing
Add or remove practitioner from roster	No	No
Withdrawal from network	No	Requires written confirmation of contract termination
Entity Name Change	Yes	Yes
Merger/ acquisition	Yes	Yes if name change to entity
Business license/ Entity type (i.e. NCSOS change)	Yes	Yes if name change to entity
Change in ownership percentages or removal of owner(s)	Yes	No
Add or remove owner(s)/ managing employee(s)	Yes	No



## Emergent Change Requests

If needed in the event of a sudden and unexpected provider closure or to respond to a significant life, health or safety risk to a member, Smoky can process emergent change requests within 1 business day of the request. The applicable Provider Nomination or Provider Change form must be completed and submitted. In order to ensure timely processing, it is recommended that the requesting provider also call the Provider Helpline at 1-866-990-9712 or email [providerinfo@smokymountaincenter.com](mailto:providerinfo@smokymountaincenter.com) to notify PN staff of the request and reason for emergent processing.

## Re-Credentialing and Continuous Verification

All Network Providers, including practitioners, must be re-credentialed every 3 years. At least 180 days prior to the applicable re-credentialing expiration date, Smoky will provide you with electronic access to the applicable application, instructions (including deadline for submission) and contact information for technical assistance. **It is critical that you maintain accurate contact information with Smoky in order to avoid any lapse in credentialing.** If you do not submit a timely re-credentialing application or if your application contains errors or flags that require additional verification, your contract may be suspended on the date your credentialing with Smoky lapses, and may not be reinstated until your re-credentialing is approved. During the re-credentialing process, you must sign a release of information and liability that allows Smoky to make inquiries into your background, including questions regarding criminal history, physical and mental health status and lack of impairment due to chemical dependency/substance use, loss or limitation of privileges and/or disciplinary activity and current malpractice coverage.

The process for re-credentialing is virtually identical to initial credentialing. However, applications for re-credentialing must update any information that has changed since the previous credentialing. Providers who entered the network during the “Open Enrollment” process may have to provide additional information or meet higher standards during the re-credentialing process. Be aware that the following conditions can affect your credentialing status (this is not an exhaustive list):

- Loss of good standing status
- The Smoky Contract Performance Team, Special Investigations Unit, Quality Management Department or other Smoky staff report that you have breached a material term of your contract with Smoky
- The Credentialing Committee determines that your general area of practice or specialty involves experimental or unproved modalities of treatment, or therapy not widely accepted in the medical community
- Smoky receives a credible report of inappropriate contact with a patient of a sexual or amorous nature, or violation of other clinician/patient boundaries

Smoky maintains standards for practitioner participation that ensure competent, effective, and quality care to our members. Smoky reserves the right to suspend or terminate a practitioner’s credentials, or take other action as deemed necessary, for activity, actions, and/or non-actions which are contrary to accepted standards of

medical practice or the requirements of your contract. All practitioners are required to report disciplinary actions based on professional competency or conduct which would adversely affect your clinical privileges for a period longer than thirty (30) days or would require voluntary surrender or restriction of clinical privileges, while under, or to avoid, investigation, to the appropriate licensing bodies entity (i.e., State Medical Board, National Practitioner Data Bank, Federation of State Medical Boards, etc.). Failure to do so will be viewed as a breach of your contract with Smoky.

We continuously review available databases against our roster of credentialed providers, practitioners, owners and managing employees. Exclusion databases are monitored monthly on a monthly basis. State licensing boards, National Practitioner Data Bank (NPDB), National Technical Information Service and NC Department of Health and Human Services are monitored no less than quarterly. Smoky reserves the right to monitor more frequently and to monitor other databases not listed above. Any flags identified through such continuous verification will be brought to the Credentialing Committee for review and decision.

Disciplinary actions that can be taken by the Chief Medical Officer and/or full Credentialing Committee related to credentialing include but are not limited to a Letter of Censure, Site Visit, Probation/ Increased Monitoring, Plan of Correction, Contract Suspension, Suspension of Referrals, Revocation of Credentialing Status, and Exclusion. We also reserve the right to suspend a practitioner for up to 15 business days pending review by the Credentialing Committee/Credentialing Specialist where potential adverse medical outcome will affect a patient or the general patient population.

Any decisions or disciplinary actions to suspend, revoke or otherwise change a Network Provider's credentialed status resulting from re-credentialing or continuous verification will be in writing and will include notification of the process for dispute resolution. We may also notify appropriate licensure entities and the National Practitioner Data Bank of any disciplinary actions. This decision is made by the Chief Medical Officer.

## **Contracting**

All Network Providers must execute a written agreement with Smoky before any services can be authorized or reimbursed. These agreements must be in your official legal name, as identified on the NC Secretary of State database (for entities) or other legal form of identification (for independent practitioners). Smoky utilizes Medicaid and State-funded contract templates to ensure consistency across the Closed Network. This Manual is incorporated into your Contract with Smoky as a binding requirement. It is important that you review your Contract for accuracy and read it carefully before executing. If you don't understand something in your Contract, please let us know! We are available to answer questions about any of the Terms and Conditions.

Requests for changes, suggested language for future agreements, and any questions about operational or substantive requirements should be directed to [ProviderInfo@smokymountaincenter.com](mailto:ProviderInfo@smokymountaincenter.com). Questions about insurance requirements, legal terminology or the DocuSign® contract process should be sent to [Contracts@smokymountaincenter.com](mailto:Contracts@smokymountaincenter.com).

For FY15-16, several changes were implemented to improve Smoky's operational efficiency and eliminate the administrative burden for providers. First, Smoky no longer utilizes "evergreen" contracts with no end date. All provider contracts are now on the State FY cycle, from July 1 to June 30 of each year. Second, provider contracts no longer include an attachment with a specific list of approved sites, services and codes. This eliminates the need for a contract amendment every time a change is made. Instead, providers must verify that accurate sites, services and codes have been entered into Smoky's AlphaMCS system. Smoky's Contracts Team can generate a report upon request that lists all sites, services and codes associated with your Contract in AlphaMCS. Finally, we included a Cover Sheet and Contact Maintenance Log at the front of all contract packets this year. We hope this will help us improve the accuracy of contact information we have on file for Network Providers. However, it is your responsibility to let us know if any of your information changes after the contract is executed.

In FY14-15, we moved to a completely electronic process for contracting. We utilize DocuSign®, a web-based platform that provides electronic signature technology and Digital Transaction Management services for facilitating electronic exchanges of Smoky Contracts and signed documents. DocuSign® is legal, administratively efficient and automatically provides you with a scanned copy of your executed contract following execution. It has enabled Smoky to lower administrative costs, reduce contracting process timeframes, improve the tracking of executed contracts, and ensure that the vast majority of contracts are executed prior to their effective date.

**It is your responsibility to be familiar with, understand and adhere to all requirements of your contract(s) with Smoky. Lack of familiarity or understanding is not a valid excuse for non-compliance.**

**Note:** You must have a signed contract that includes the new site/service(s) in effect prior to the delivery of any new services or for services rendered from new sites. Providing new services and/or rendering services from a new site that is NOT incorporated into your contract will result in denied claims and/or adverse action.

## **Out-of-Network Agreements**

In situations where Smoky has determined that our Closed Network cannot meet the need for geographically accessible, appropriate and/or timely services for a specific member, we may identify a selected out of network provider to meet the need. Completing the abbreviated verification process described in this section does not mean the provider is a member of Smoky's Closed Network. The first step is to complete the Out of Network Agreement Request via DocuSign®, which is found on the provider enrollment page of Smoky's website at: <http://www.smokymountaincenter.com/providers.asp?section=enroll>. If the request is approved and all necessary information is submitted, Smoky will review and/or verify the following limited credentials necessary for successful claims adjudication and to ensure the health, safety and welfare of members, as applicable to the provider type:

- OIG and SAM exclusion databases
- National Practitioner Databank (NPDB)
- DHSR Healthcare Personnel Registry (HCPR)
- DHSR Facility License

- NCTracks for verification of National Provider Identifier(s) (NPIs)
- Criminal History

These verifications are not presented to the Credentialing Committee for review unless a flag is identified. If approved, the Agreement will proceed to final processing and execution. Providers who are serving multiple members under an Out of Network Agreement, or who have executed more than two Agreements in a fiscal year will be invited to apply for membership in the Closed Network.

# Section 4: Access to Care

Providing timely access to medically necessary services is a key function of our Closed Network. It is your responsibility to ensure that members are eligible and enrolled in a Smoky Health Plan before delivering services and/or submitting claims for reimbursement. It is also your responsibility to refer members for specialty care or to other contracted providers in response to a member request or change in level of care needed. Smoky's Eligibility and Enrollment team and Customer Services department can help you with enrollment, referrals and appointments to avoid delays in access to care.

## No Wrong Door

Smoky follows a "No Wrong Door" approach to eligibility, enrollment and access to care. This means that all Network Providers have the ability to complete eligibility determinations and request enrollment of an eligible individual into a Smoky Health Plan. It also means that members can access services through our Call Center or by contacting a Network Provider – there is no wrong door to access treatment. Smoky's Comprehensive Care Centers offer same day access for triage and/or assessment at offices located in each of our 23 counties. Network Providers may conduct screening, triage and referral following the process and criteria outlined below, or may link individuals requesting services to Smoky's Access to Services line at **1-800-849-6127**. **In either case, all Network Providers are required to meet the applicable DMH/DD/SAS access to care timeframe based on a classification of the request as Emergent, Urgent or Routine.**

## Eligibility

Individuals whose services are paid for in whole or in part by Smoky must meet eligibility criteria for a Smoky Health Plan. If you have any questions about whether someone is eligible for a Smoky Health Plan, please call the Enrollment and Eligibility (E&E) team at 828-225-2785 Ext. 2355. You can also email the E&E team at [EandE@smokymountaincenter.com](mailto:EandE@smokymountaincenter.com) or call Customer Services at 1-800-757-5726.

1915(b) Medicaid MH/DD/SA Health Plan: Individuals who receive a qualifying category of Medicaid from Alexander, Alleghany, Ashe, Avery, Buncombe, Caldwell, Cherokee, Clay, Graham, Haywood, Henderson, Jackson, Macon, Madison, McDowell, Mitchell, Polk, Rutherford, Swain, Transylvania, Watauga, Wilkes or Yancey counties are automatically a member of the MH/DD/SA Smoky Health Plan. In general, to be eligible for Medicaid coverage, the individual must:

- Be a U.S. citizen or provide proof of eligible immigration status; AND
- Be a resident of North Carolina and provide proof of residency; AND
- Have a Social Security number or have applied for one; AND
- Meet Category of Aid eligibility criteria as determined by the county Department of Social Services (DSS) office where the individual resides.
- NOTE: Individuals currently receiving Supplemental Security Income (SSI) benefits, Special Assistance

to the Blind, Work First Family Assistance or Special Assistance for the Aged or Disabled are automatically eligible for Medicaid and do not have to apply at DSS.

\*Some Medicaid Categories of Aid are not covered under the Smoky Health Plan and remain under the N.C. Division of Medical Assistance (DMA). Qualifying Categories of Aid are listed below:

- Individuals covered under Section 1931 of the Social Security Act (1931 Group, TANF/AFDC);
- Optional Categorically and Medically Needy Families and Children not in Medicaid deductible status (MAF);
- Blind and Disabled Children and Related Populations (SSI);
- Blind and Disabled Adults and Related Populations (SSI, Medicare);
- Aged and Related Populations (SSI, Medicare);
- Medicaid for the Aged (MAA);
- Medicaid for Pregnant Women (MPW);
- Medicaid for Infants and Children (MIC);
- Adult Care Home Residents (SAD, SAA);
- Foster Care Children;
- NC Innovations Waiver Participants
- Medicaid beneficiaries admitted to Intermediate Care Facilities for persons with I/DD

**Note that Smoky does not cover children under age 3 except for Innovations Waiver participants.**

1915(c) Innovations Waiver Health Plan: An individual must meet all of the following eligibility criteria and be enrolled in the Innovations Waiver in order to receive these services:

- The individual is eligible for Medicaid coverage, based on assets and income of the applicant (not including family resources) whether he/she is a child or an adult.
- The individual's residence, for purposes of Medicaid eligibility, is within one of Smoky's 23 catchment area counties.
- The individual has been assigned a Waiver "slot."
- The individual meets the requirements for ICF-IID level of care as approved by the Smoky Care Management Team.
- The individual lives in an ICF-IDD facility or is at high risk for placement in an ICF-IDD facility. High risk for ICF-IDD institutional placement is defined as a reasonable indication that individual may need such services in the near future (one month or less) in the absence of Home and Community Based Services.
- The individual's health, safety, and well-being can be maintained in the community through a combination of Waiver and natural supports.
- The individual qualifies for Innovations Waiver services, i.e. the services are medically necessary and appropriate for the individual. The individual must use at least one Waiver service per month for eligibility to be maintained.
- The individual, his/her family, or guardian desires participation in the Innovations Waiver program

rather than institutional services.

- New NC Innovations participants must live with private families or in a living arrangement with six or fewer persons unrelated to the owner of the facility.

State-Funded Health Plan: Individuals that do not have Medicaid or other insurance may be eligible for state-funded services. Some members that have Medicaid could also qualify for state-funded services, as long as an equivalent service is not available through Medicaid. Eligibility for state-funded services is based on citizenship, income and availability of other insurance. Some state-funded services, such as respite care for individuals with I/DD and the Adult Developmental Vocational Program (ADVP), are not based on income. Network Providers must interview all individuals seeking eligibility for state-funded services and document criteria as outlined below:

- Financial Eligibility – Household income for the individual must be 300% or less of the most current Federal Poverty Guidelines, based on family size. Please note that the guidelines are issued the first month of each calendar year in the Federal Register by the U.S. Department of Health and Human Services (HHS), and are a simplification of the U.S. Census Bureau poverty thresholds. Current 2015 guidelines are available here: <http://aspe.hhs.gov/2015-poverty-guidelines>.
- Other third party coverage – must be exhausted or not covered by the plan, and have proof of denial from insurer. State funds may not be used to pay for deductibles or co-payments.
- Citizenship – the individual must be a U.S. citizen or legal resident. Only exception is for emergency services as defined at 42 CFR § 438.114.

## **Enrollment**

Individuals whose services are paid for in whole or in part by Smoky must be enrolled in a Smoky Health Plan. If you have any questions about an individual's enrollment status, please call the E&E team at 828-225-2785 Ext. 2355. You can also email the E&E team at [EandE@smokymountaincenter.com](mailto:EandE@smokymountaincenter.com) or call Customer Services at 1-800-757-5726. It is your responsibility to make a complete and thorough investigation of an individual's ability to pay prior to requesting to enroll that person into a Smoky Health Plan. This means that you must check for the following:

- Determine if the individual has Medicaid or may be eligible for Medicaid. You are required to help individuals that may be eligible for Medicaid in applying through the applicable county Department of Social Services.
- Determine if the individual has Medicare or any other third party insurance coverage, including insurance through a non-custodial parent, an employer or the Patient Protection and Affordable Care Act Health Insurance Marketplace.
- Determine if there is any other payer involved – worker's compensation, disability insurance, Employee Assistance Program (EAP), court ordered services paid for by the court or another program, non-custodial parent pursuant to a custody order, liability judgment (e.g. vehicle accident), etc.
- Note that members who have third party coverage can be enrolled with Smoky established as the

secondary payor.

- Determine if the member is eligible for Smoky's State-Funded Health Plan as outlined above.

After eligibility is established, Network Providers are able to enroll individuals for services without prior screening, triage or referral by Smoky. If the individual has Medicaid or was previously enrolled in a Smoky Health Plan, he or she may be eligible for Medicaid or State-funded services through Smoky. If the individual was previously enrolled in a Smoky Health Plan, but claims for services have not been submitted for more than 90 days, you must complete a new enrollment. If the individual is not yet enrolled, then you must obtain and submit all data necessary to do so. Required data elements are identified in the Smoky Claims Manual & Billing Guide, and include Medicaid ID number if applicable, date of birth, and identification of any other third party payer, including Medicare. It is your responsibility to ensure that enrollment data is accurate and up-to-date. If enrollment data is not accurate or complete prior to service provision, your ability to successfully submit authorization requests and claims may be impacted.

Member enrollment can be performed electronically through AlphaMCS or by contacting the Access Center at 1-800-849-6127. Detailed instructions and timeframes for completing an enrollment request can be found in the Claims Manual & Billing Guide. You must complete the eligibility determination and enrollment request prior to service provision, except for crisis services provided in a documented emergency. Claims submitted for services provided prior to date of enrollment will be denied.

## Customer Services/ Call Center

The Customer Services department operates a toll-free Access to Services line 24 hours a day, 7 days a week, 365 days a year for telephonic screening, crisis intervention and appointment referrals for people seeking assistance with mental health, substance use, and intellectual/developmental disability issues. **This number is 1-800-849-6127.** The Access to Services line is answered by a live person, generally within 30 seconds. During times of heavy call volume, overflow calls may be automatically redirected to CenterPoint Human Services, Partners Behavioral Health Management or Cardinal Innovations for Call Center back-up.

Customer Services also provides our members and communities with general information via a separate toll-free Customer Services line that is available 8:30 am – 5:00 pm on regular business days. This number is 1-888-757-5726 and can be used to report a compliment, complaint or concern about Smoky or any of our Network Providers. The Customer Services department is staffed by Customer Services Representatives (CSRs) and Customer Services Clinicians:

- CSRs are bachelor level or non-licensed Qualified Professionals with at least two (2) years experience in the human services field. Their primary job responsibilities are to answer the telephone calls coming in to the Access to Services Line, collect demographic information, verify insurance eligibility, and complete a brief intake screening to determine the type and level of service/s most appropriate for callers. CSRs can also provide information about community resources, assist with placements to inpatient facilities, when appropriate, and follow up to assure members discharged from inpatient facilities are engaging in



the next level of care.

- Customer Services Clinicians are Master's Prepared Licensed Professionals who handle emergency and crisis intervention calls as well as regular CSR duties. The Customer Services Clinicians follow all requests for emergency services until it is established that contact with a mobile crisis management (MCM) provider, first responder or other provider has been made. Customer Services Clinicians are available to take over calls with members who are in distress.

Based on the caller's response to the greeting and questions from the CSR and/or Clinician, the call may address the following issues:

- Crisis intervention, including referral to Mobile Crisis Management
- Manage and provide referrals for Urgent and Emergent Calls
- Referrals for Diagnostic or Comprehensive Clinical Assessment
- Information about community (non-treatment) resources
- Enrollment of an individual into a Smoky Health Plan
- Eligibility questions
- Document complaints or grievances and route the information to the QM department for resolution
- General information about Smoky and the public MH/IDD/SA services available in our catchment area

## **Screening, Triage and Referral Process**

If the Member contacts Smoky's Call Center: If a caller does not request clinical assessment or treatment services, the CSR will offer suggestions for obtaining natural supports and/or community services. If a caller requests clinical assessment or treatment services, the CSR will gather demographic information and determine whether risk indicators are present that necessitate involvement of a Clinician. If the call involves no risk indicators, the CSR offers choice of available Network Providers and links the caller to the selected provider for an intake appointment. When risk indicators are identified, the CSR involves a Clinician to determine the most clinically appropriate referral and the clinical urgency with which the caller should be seen by the referred provider: Emergent, Urgent or Routine.

If the Member contacts a Network Provider: If a caller does not request clinical assessment or treatment services, you must offer suggestions for obtaining natural supports and/or community services. If a caller requests clinical assessment or treatment services, you must gather demographic information and determine whether risk indicators are present that necessitate involvement of an appropriately licensed practitioner. If the call involves no risk indicators, you must schedule an intake appointment. When risk indicators are identified, you must ensure involvement of an appropriately licensed practitioner to determine the most clinically appropriate referral and the clinical urgency with which the caller should be seen by the Network Provider: Emergent, Urgent or Routine.

Potential Risk indicators include but are not limited to the following:

- Report of harm to self or others or property destruction
- Statement of intent, threat or plan to harm self or others
- Report of inability to care for self or medical distress
- Substance use symptoms reported or observed, such as slurred speech or report of tactile sensations (itching, bugs crawling, etc.)
- Confusion about date, time, location, current events or recent history
- Report of hallucinations or hearing voices
- Signs of caller distress include crying, yelling, anger
- Report of feeling anxiety, panic, hopelessness, fear
- Lethargic, unresponsive, unable to comprehend questions
- Bizarre or unusual responses
- Significant inconsistencies in history as related by member and family
- Report of recent significant loss (e.g., death of loved one)

## **Screening, Triage and Referral Criteria**

Emergent Service Requests: If the member presents as an imminent danger to self or others, or has a moderate or severe risk related to safety or supervision, the request is classified as emergent. This determination is made based upon the member exhibiting one or more of the following indicators:

- The member has a current significant risk related to safety or supervision, as evidenced by:
  - Risk of harm without supervision, such as walking into traffic or wandering
  - Current harm without supervision
  - Impaired reality testing, such as delusions, hallucinations
  - Dangerous disruptive or bizarre behavior
- The member presents current significant risk of harm to self or others, as evidenced by:
  - Verbalized or implied threats to physically harm self or others
  - Verbalized or implied plan to physically harm self or others
  - Active cutting or burning self
  - Current self harm or of harm to others
- The member has severe incapacitation in one or more areas of physical, cognitive, or behavioral functioning related to MH/IDD/SA issue(s), such as:
  - Actively psychotic with impaired self-care functions, as in unable to care for self on a daily basis regarding food, hygiene, toileting, etc.
  - Bizarre thought processes
  - Recent physical, cognitive, or behavioral incapacitation related to MH/DD/SA issue(s)
- The member indicates multiple withdrawal symptoms or reports a history of severe withdrawal and current/recent heavy use, or recent referral for detoxification. Symptoms include tremors, paroxysmal sweats, anxiety, agitation, tactile disturbances (itching, bugs crawling, pins, burning sensations), auditory

disturbances, visual disturbances (e.g. light sensitivity, seeing things not there), headache, disorientation regarding date, and/or inability to do simple math (additions).

Emergent services may be provided by a Mobile Crisis Management Team or Facility-Based Crisis provider. If the individual is experiencing immediate life-threatening circumstances, he or she must be referred to the nearest hospital emergency department, or 911 may be called for emergency transportation to an ED.

Urgent Service Requests: If the member presents no imminent danger to self or others, but may become an emergency without prompt treatment, the request is classified as urgent. This is a level of clinical urgency in which the member presents with moderate risk of incapacitation in one or more areas of physical, cognitive, or behavioral functioning related to MH/IDD/SA issue(s). This determination is made based upon the member exhibiting one or more of the following indicators:

- The member has mild risk related to safety or supervision, as evidenced by significant distress due to mental illness, such as depression or anxiety, but no current plan for harm to self
- The member presents mild risk of harm to self or others, as evidenced by:
  - Superficial cutting
  - Significant distress due to mental illness, such as depression or anxiety, but no current plan for harm to self or others
- The member has mild to moderate incapacitation in one or more areas of physical, cognitive, or behavioral functioning related to MH/IDD/SA issue(s), such as recent history of hallucinations, delusions, bizarre thoughts, but none current
- The member is at mild risk for substance use withdrawal symptoms that could escalate if not addressed within 48 hours, as evidenced by:
  - Anxiety/depression, agitation, insomnia
  - History of severe withdrawal but no recent/current substance use

Urgent Services may be provided through an outpatient clinic or office, through a Walk-In Service, or by a Mobile Crisis Management Team.

Routine Service Requests: If the member presents with a need for services that is not an emergent or urgent, it is classified as routine. This is a level of clinical urgency in which the member presents with mild risk or incapacitation in one or more areas of physical, cognitive, or behavioral functioning related to MH/IDD/SA issue(s). This determination is made based upon the member exhibiting one or more of the following indicators:

- The member has mild to no risk related to safety or supervision, as evidenced by ability to care for self on a daily basis.
- The member presents no risk of harm to self or others, as evidenced by denying any thoughts or plan of harm to self or others.
- The member has mild to moderate incapacitation in one or more areas of physical, cognitive, or behavioral functioning related to MH/IDD/SA issue(s). An example is member's mental health symptoms cause distress but are not currently incapacitating.

- The member shows no indicators of significant risk for substance abuse withdrawal symptoms as evidenced by:
  - Mild agitation, anxiety, or depression
  - Member reports minimal recent use or no substance use within the past several days
  - No history of significant withdrawal
  - Member demonstrates motivation for treatment by agreeing to attend 12 step support during period prior to assessment

Routine Services may be provided through a variety of outpatient or clinic settings, or through a Walk-In center.

## **DMH/DD/SAS Access to Care Timeframes**

If you accept a referral for services from Smoky’s Call Center, you are required to meet the applicable DMH/DD/SAS access to care timeframe based on a classification of Emergent, Urgent or Routine.

- Emergent: This standard requires a face-to-face clinical assessment and intervention to be started within two hours of communication of the service request to the referred provider.
- Urgent: This standard requires a face-to-face clinical assessment and intervention to be started within 48 hours of communication of the service request to the referred provider.
- Routine: This standard requires a face-to-face clinical assessment and intervention to be started within 14 calendar days of communication of the service request to the referred provider.

Failure to meet these timeframes may result in referral for investigation and administrative action or sanction, up to and including termination of your contract with Smoky.

## **Referrals and Appointments**

You are responsible for making referrals to lower or higher levels of care if the needs of a member you are serving change. You are also responsible for facilitating transition to another Network Provider if the member requests to change providers or if your clinical relationship with the member has become detrimental to his or her treatment or recovery. Smoky Customer Services can assist you by providing current information on Network Providers accepting referrals. Please be as clear as possible in requests for information or services to enable our CSRs to help you in the most efficient and effective way possible.

If you wish to receive regular referrals for appointments from Customer Services, you must create appointment slots in the AlphaMCS system. For more information on how to complete that process and what to expect from a referral, please email [customer.services@smokymountaincenter.com](mailto:customer.services@smokymountaincenter.com). As a Network Provider, you are required to have a “no-reject” policy for referrals made by Smoky. This means that you cannot reject referrals unless you are at capacity or do not provide the most appropriate service for the member. If you reject a referral on any other basis, you must notify us of the reason for your decision not to accept the referral.

## **Medical Transportation Services**

Throughout Smoky's rural catchment area, members need transportation assistance in order to access services. As a Network Provider, you must assist members you serve in accessing available public transportation as well as medical transportation available through county Departments of Social Services. DSS transportation is for medical (including MH/IDD/SA) appointments or picking up prescriptions at a pharmacy. Riders have to call 2 to 4 days ahead to arrange a ride. There is no fee for Medicaid beneficiaries. For those who are not enrolled in Medicaid, transportation depends on available space, and there is a fee. Unfortunately, there are no publicly funded medical transportation services in the evening or on weekends.

# Section 5: Billing & Reimbursement

This section provides a high-level overview of the provider billing and reimbursement process. We recently created a Claims Manual & Billing Guide (“Claims Manual”) that provides more detailed information than what is contained in this Manual. Your staff or contractors who are responsible for billing should be familiar with the Claims Manual. For questions about claims or reimbursement issues, please contact us at 828-225-2785 Ext. 2455 or [Claims@smokymountaincenter.com](mailto:Claims@smokymountaincenter.com).

## Billing Prerequisites

Network Providers are responsible for ensuring that all billing prerequisites are met prior to submission of a claim.

- **Enrollment and Member ID:** As explained in Section 4 of this Manual, the individual must be eligible for and enrolled in a Smoky Health Plan in order for a claim to be processed. The Member ID Number identifies the specific individual receiving the service and is assigned by the AlphaMCS information system. In order for the Provider to obtain this number, the individual must have been successfully enrolled into a Smoky Health Plan. All claims submitted with incorrect Member ID numbers, or for members whose enrollment is no longer active, will be denied.
- **Medical Necessity:** All services paid with public funds must meet documented medical necessity criteria.
- **Prior Authorization:** As outlined in Section 6 of this Manual, certain services must be authorized by Smoky prior to service delivery and claims submission. Smoky’s claims adjudication system is specifically designed to verify authorization and other eligibility edits prior to reimbursement.
- **Coordination of Benefits:** Smoky is the payor of last resort. All other available first and third party payment must be exhausted prior to billing Smoky for services rendered. If the member is eligible, state funds must be exhausted prior to billing Medicaid.
- **NPI (National Provider Identifier) and Taxonomy:** All providers are required to obtain an NPI number to submit billing on the CMS1500 and UB04 forms. Best practice for successful claims submission is to obtain a separate NPI number for each site from which services are billed. Accurate NPI numbers and taxonomy codes are required for claims to be accepted and processed. Failure to comply with these guidelines will result in denied billing.
- **NC Tracks:** Network Providers are responsible for ensuring that provider names, billing addresses, site addresses, NPI numbers and taxonomy information submitted to Smoky are verified and accurate and exactly match the information in the State of North Carolina’s Medicaid Management Information System (MMIS), which is known as “NC Tracks.” Failure to adhere to this requirement may result in claims denial or recoupment.
- **Documentation and Service Delivery Requirements:** Network Providers are responsible for ensuring that services are delivered and documented in accordance with Controlling Authority outlined in your Contract, including but not limited to DMA Clinical Coverage Policies and the DMH/DD/SAS Records Management and Documentation Manual, APSM 45-2. Please be aware that Medicaid regulations do

not allow payment for services delivered to inmates of public correctional institutions or for people admitted to facilities with more than 16 beds that are classified as Institutions of Mental Diseases (IMDs). This may include some state facility, private hospital, Adult Care Home and Family Care Home settings. It is your responsibility to know whether a member is admitted to an IMD at the time of service delivery.

- **Clean Claims Requirement:** A clean claim is defined at 42 CFR § 447.45 as one that can be processed without obtaining additional information from the provider of the service or from a third party. It includes a claim with errors originating in Smoky's claims system. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity. It is your responsibility to ensure that all claims submitted to Smoky meet this definition.
- **Electronic Funds Transfers (EFTs):** All reimbursement is done through EFT. Smoky does not write paper checks to providers. It is your responsibility to ensure that Smoky has accurate EFT, tax ID and W-9 information on file prior to claims submission.

## Authorization Specifics

- **Date of Service:** Each authorization will have a unique number, a start date and an end date. Only claims with dates of service within these specific time frames will be paid. Dates and/or units outside these parameters will be denied.
- **Type or Code:** Each authorization will indicate the specific service or service code that is authorized. Each service will be validated against the authorization to make sure that the service billed matches the service authorized. Claims that fall outside of these parameters will be denied.
- **Units:** Each authorization will indicate the maximum number of units of service that is authorized for the time period in question. As each claim is being processed, the system will check to make sure that the units being claimed fall within the units of services authorized. The system will deny any claims that exceed the limits. Network Providers must establish internal procedures to monitor units of service against authorizations to avoid having claims denied due to exceeding units of service.
- **Exceptions:** There are certain services that do not require authorization at all, or do not require an authorization for an initial service period, referred to as the "pass-through" period. These services are limited in scope and the pass-through limits are applied per member, not per provider. Section 6 details services that do not require authorization or have a pass-through limit. Once the pass-through limit has been reached for a member, then all claims submitted without an authorization will be denied. Network Providers must be constantly aware of this issue in order to avoid denied claims.

## Claims Submission

Method: Network Providers (or your billing agents or clearinghouses) must submit all claims through the AlphaMCS Provider Portal or through a HIPAA-compliant 837 EDI file unless your contract specifically states an alternative method. Paper claims will not be accepted from Network Providers. When a specific service is rendered multiple times in a single day, the service must be "bundled," i.e. billed using multiple units rather than as separate line items. This will prevent a duplicate billing denial. Smoky will accept only HIPAA-compliant

transactions as required by law:

- Basic Benefit Services, Outpatient Therapy, Enhanced Services, Innovations Waiver Services, State-funded Residential and other daily and periodic services must be submitted using the ANSI 837P (Professional) format or the electronic CMS 1500 form if billing through the AlphaMCS Provider Portal.
- Inpatient, Therapeutic Leave, Medicaid-funded Residential Services, Outpatient Revenue Codes and ICF-IID Services must be submitted using the ANSI 837I (Institutional) format or the electronic UB04 form if billing through the AlphaMCS Provider Portal.
- Paper claims will only be accepted from Out of Network Hospitals or Physician Groups who submit claims for services delivered in an emergency department setting. These providers will be required to submit an accurate CMS1500 or UB04 billing form with the correct data elements.

Timeframes: In general, all claims must be submitted within 90 days of the date of service or discharge, unless otherwise specified in your contract. Claims where Smoky is the secondary payer must be submitted within 90 days of the primary payer's adjudication of the claim. Claims based on retroactive Medicaid eligibility must be submitted within 30 days of the date you knew or should have known of the eligibility determination. Claims submitted outside of these timeframes will be denied. Claims must be submitted no less than monthly. Network Providers are encouraged to produce routine billings on a weekly or bi-monthly schedule.

837 File Submission: Network Providers who wish to submit using an 837 file must complete training, successfully submit and receive test files, and execute a Trading Partner Agreement. The process is outlined at: [http://www.smokymountaincenter.com/documents/providers/billinfo/Steps\\_For\\_837p\\_And\\_837i\\_Testing\\_And\\_Approval\\_2015-04-02.pdf](http://www.smokymountaincenter.com/documents/providers/billinfo/Steps_For_837p_And_837i_Testing_And_Approval_2015-04-02.pdf). Training is available at <http://etraining.smokymountaincenter.com/>. Detailed instructions for 837 file submission are provided in the HIPAA Transaction Professional (837P) and Institutional (837I) Transaction Companion Guides, which explain entire testing and approval process. HIPAA compliant American National Standards Institute (ANSI) transactions are standardized; however each payer has the ability to exercise certain options and to require use of specific processes. The purpose of the Companion Guide is to clarify those choices and requirements so that Network Providers can submit accurate HIPAA transactions. Smoky provides the following HIPAA transaction files back to Providers: 999 (an acknowledgment receipt), 824 (a line by line acceptance/rejection response), and 835 (an electronic version of the remittance advice).

Rates: All Network Providers are reimbursed at the lesser of the Smoky published rates for the service being provided or your usual and customary charge for the services, unless otherwise stated in your Contract or identified in AlphaMCS. In general, Smoky follows the DMA fee schedule for Medicaid services. Rate changes will be announced at least 30 days in advance unless resulting from a change imposed by the General Assembly, DMA or DMH/DD/SAS. You can submit claims for more than the published rates, but only the published or contracted rate will be paid. If you submit a claim for less than the published or contracted rate, the lower rate will be paid. It is your responsibility to monitor the publishing of rates and to make the necessary changes to their billing systems.

Sites, Services and Codes: Sites, services and codes for which the Network Provider is approved are listed in AlphaMCS. Upon request, the Smoky Contracts Team can produce a report (previously called "Attachment A")



that identifies the sites, services and codes associated with your Contract in AlphaMCS. It is your responsibility to verify that AlphaMCS contains accurate information. You may only bill for sites, services and code listed in AlphaMCS or reimbursement will be denied as a non-contracted service. Standard codes for claims submission include the following:

- Current Procedure Terminology (CPT) codes and modifiers
- Healthcare Common Procedure Coding System (HCPCS) codes and modifiers
- CMS Uniform Billing Revenue codes and modifiers (UB04 submission)
- Place of Service Codes
- ICD-10 Diagnosis Codes: ICD-10 is the 10th revision of the International Statistical Classification of Diseases and Related Health Problems (ICD), a medical classification list by the World Health Organization (WHO). It contains codes for diseases, signs and symptoms, abnormal findings, complaints, social circumstances, and external causes of injury or diseases. Diagnosis codes from the ICD-10 Code Manual must be provided to the highest level of specificity and follow the classification and diagnostic tools found in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, 2013 (DSM-V). Implementation of the ICD-10 Code Manual by Smoky Network Providers was required effective October 1, 2015.

For more information about coding and ICD-10 implementation, please see <http://www.smokymountaincenter.com/claims.asp>.

## Coordination of Benefits

Smoky is the payor of last resort. Providers are required to collect all first and third party funds **prior** to submitting claims to Smoky for reimbursement. First party payers are the members or their guarantors. Third party payers are any other funding sources that can be billed to pay for the services provided to the member. This can include Medicare, third party (private) insurance coverage through a non-custodial parent, an employer, or the Patient Protection and Affordable Care Act Health Insurance Marketplace, worker's compensation, disability insurance, Employee Assistance Program (EAP), court ordered services paid for by the court or another program, non-custodial parent pursuant to a custody order, liability judgment (e.g. vehicle accident), etc.

As discussed in Section 4, Network Providers must conduct a comprehensive eligibility determination process whenever a member is enrolled. You must also regularly monitor and update eligibility information if circumstances change for a particular member. All first and third party payers must be added to the member's record by doing a Client Update in the AlphaMCS system.

You must bill all first and third party payers and make reasonable efforts to collect all first and third party funds prior to billing Smoky for services. You must wait a reasonable amount of time in order to obtain a response from the first or third party payer before billing Smoky. You are required to retain copies of the Electronic Remittance Advice (ERA), Explanation of Benefits (EOB) or other proof of payment or denial from the applicable

payer and record on the claim either the payment or denial information. Claims must identify the amounts collected from both first and third parties and only request payment for any remaining amount. If the member is eligible for state-funded services, those funds must be exhausted prior to billing Medicaid. The Smoky AlphaMCS System has the ability to validate third party payers and can deny or adjust the claim. For Out of Network hospitals and physician groups permitted to file paper claims with Smoky, the provider is required to submit copies of the ERA or EOB with the claim form to Smoky. If you receive reimbursement from a first or third party after a claim has been submitted to Smoky, you must notify us and submit reimbursement within 30 days of receipt of the first or third party funds.

Under the 1915(b) waiver, Network Providers are not permitted to charge a co-payment to Medicaid-eligible members for services. Once you accept referral of a Medicaid beneficiary from Smoky, you must accept Medicaid reimbursement as payment in full for the services (other than legitimate first and third party payments). You may not charge a Medicaid beneficiary for services delivered under your Contract with Smoky if we deny authorization or reimbursement. If you have collected funds from Medicaid beneficiaries for any services delivered under your Contract with Smoky, you must notify Smoky and return all funds received from the member or responsible party immediately.

Effective November 1, 2015, Smoky is implementing a sliding fee scale for **state-funded services only**, which means you must collect some percentage of the cost of services from members, as outlined below:

Household Income	Fee
Individuals whose household income falls under 100% of Federal Poverty Guidelines (FPG)	No co-payment or fee
Individuals whose household income falls between 100 and 200% of FPG	\$1.00 co-payment per service or visit
Individuals whose household income falls between 200 and 250% of FPG	\$2.00 co-payment per service or visit
Individuals whose household income falls between 250 and 300% of FPG	\$3.00 co-payment per service or visit

## Remittance Advice and Claims Inquiries

The Remittance Advice (RA) is the standard method of communicating back to providers exactly how each and every claim has been adjudicated. RAs will be available in the Download Option of the AlphaMCS system following each check write, and will report whether claims are approved or denied and the reason code for each denial. HIPAA regulations require Smoky to supply providers who submit 837 files with an electronic Remittance Advice known as the 835. The 835 will electronically report claims status and payment or denial information.

Inquiries regarding the status of claims should be directed to your assigned Smoky Claims Specialist or other Claims staff at 828-225-2785, Ext. 2455 or [Claims@smokymountaincenter.com](mailto:Claims@smokymountaincenter.com). The process for appealing Smoky's denial of any claims is outlined in Section 17 of this Manual.

Network Providers are directly responsible for management of accounts receivables. Smoky does not make advance payments or payments outside the posted check write schedule, except in documented situations

where a provider was not paid due to an error of Smoky or its vendors. We must comply with liens imposed by courts or government agencies such as the IRS or NC Department of Revenue.

## **Repayment of Funds Owed to Smoky**

You are required to pay back any overpayment identified through self audit or by Smoky. Encounter claim(s) submitted to NC Tracks that are rejected, denied or disallowed by DHHS shall be deemed an overpayment. The Finance Department works with legal counsel and SIU to collect any identified overpayments. We reserve the right to pursue collection of funds owed to Smoky through any legal means.

Under the Patient Protection and Affordable Care Act, it is your affirmative responsibility to notify us in writing of any claims reimbursed by Smoky that must be repaid, whether due to fraud, waste, abuse or error. You must either file a void claim or replacement claim, or you may choose to complete a Claims Adjustment Request Form. The form and instructions are posted at <http://www.smokymountaincenter.com/claims.asp>, under Forms and Templates. Upon receipt of the form, Smoky will make adjustments in the system and those adjustments will appear on your next RA.

If Smoky determines that you have been reimbursed for a claim or portion of a claim that should be disallowed as a result of an error or omission unrelated to fraud, waste or abuse, including encounter claims denied in NC Tracks, we will readjudicate such claims and recoup the overpayment from your claims payments. The RA will identify any such adjudication or recoupment, and you will have thirty (30) days from the date of the RA to request reconsideration.

If you receive a written Notice that Smoky has identified an overpayment based on fraud, waste, abuse, overutilization or non-compliance with your Contract, including Controlling Authority, you must remit the amount owed within 30 days of the Notice, unless you submit a timely request for reconsideration as outlined in Section 17 of this Manual, or request a payment plan. If you fail to do so, we may recoup the funds owed from your claims payments without further notification. We are not required to approve any request for a payment plan. All payment plans will require a signed agreement and may require a Promissory Note and security.

# Section 6: Benefit Plans & Authorization

## **Medicaid – The NC MH/DD/SAS Health Plan (1915(b) Waiver)**

Smoky's Medicaid MH/SA Benefit Package includes all behavioral health services required by the 1915(b) Waiver and the NC State Plan for Medical Assistance. Smoky's Medicaid 1915(b) Benefit Plan is available on our website at: <http://www.smokymountaincenter.com/authinfo.asp>. Smoky also offers (b)(3) services, which are Medicaid services funded through the savings achieved by Smoky and Network Providers through efficient management. Unlike regular Medicaid, (b)(3) services are not an entitlement, meaning they can only be authorized if funding is available to pay for these services. Denials based on lack of funding may not be appealed. A list of Smoky's available (b)(3) services is available at: <http://www.smokymountaincenter.com/authinfo.asp>.

## **Innovations – The NC Innovations Waiver Health Plan (1915(c) Waiver)**

NC Innovations is a 1915(c) home and community based services (HCBS) waiver. Smoky's Innovations Waiver Benefit Package includes all services required by the 1915(c) Waiver and NC DMA Clinical Coverage Policy No: 8P: <http://www.ncdhhs.gov/dma/mp/8P.pdf>. Smoky's Medicaid 1915(c) Benefit Plan is available on our website at: <http://www.smokymountaincenter.com/authinfo.asp>

## **State-Funded Benefit Plan**

Smoky's State-funded benefit plan includes services funded with state single stream, federal Block Grant and county dollars. The services managed by Smoky act as a public safety net. Smoky is committed to making sure our resources benefit people who need it most. Smoky targets its state and county funds toward people who meet priority population criteria based on screening, triage and referral information. Priority populations are groups of people with the most severe types of mental illness, severe emotional disturbances and substance use disorders with key complicating life circumstances, conditions and/or situations.

Unlike Medicaid, State-funded services are not an entitlement. Smoky can only fund services under this Benefit Plan within the resources allocated to us. Other than crisis or emergency services, state-funded services are generally not available to undocumented persons. Residential treatment is generally not covered under the state-funded benefit plan. When Smoky has funds available, exceptions may be made in limited circumstances where there is an identified, specific, significant health and safety risk to an individual, immediate family member or the community, when the requested service is designed to treat the individual's disorder, and no other funds are available.

Smoky's state-funded MH/SA and I/DD benefit plans are available on our website at: <http://www.smokymountaincenter.com/authinfo.asp>.

## Prior Authorization

Please note that not all services require prior authorization. Smoky does not require you to obtain prior authorization for the following services:

- Outpatient Therapy (including group). *This does not include Home-Based Therapy, which does require prior authorization.*
- Psychological Testing—no prior authorization is required for up to nine units. Prior authorization is required for more than nine units combined of these testing services for a Medicaid beneficiary in any 12 month period. *However, prior authorization is still required for psychological testing paid for with State funds.*
- Mobile Crisis Management Services – first 8 hours per episode of care do not require authorization
- Inpatient Services – first 72 hours per episode of care do not require prior authorization
- Facility Based Crisis Services – first seven (7) days per episode of care do not require prior authorization
- Substance Abuse Intensive Outpatient Program (SAIOP) – first 30 days per calendar year do not require prior authorization
- Supported Employment/Long Term Vocational Services – State-funded Long Term Vocational Support and Supported Employment services require no prior authorization for the first 64 units (16 hours) of SE/LTVS services for the initial engagement of the individual (for both SE and LTVS phases). These service are provided primarily through ADVP Programs contracted with Smoky and do not require an authorization unless the provider contract specifies otherwise. *Medicaid recipients must access Medicaid B3 Supported Employment rather than State-funded Supported Employment, which do require prior authorization.*
- Codes specifically agreed upon by Smoky and provider which are listed as “No Auth Required” under a Medicaid or State-Funded contract. Please see your contract for applicability.

**All other services require prior authorization.** Before requesting authorization for services, the first step is to complete a comprehensive clinical assessment addressing the elements required by DMA Clinical Coverage Policy No. 8C.

Please be aware that Smoky’s compensation structure for employees and contractors who perform utilization management activities does not provide incentives for the individual to deny, limit, or discontinue medically necessary services to any member.

Provider Responsibility: Requesting authorization, supporting the request with required documentation and demonstrating medical necessity is the responsibility of the provider who will be delivering the service. All providers must use the electronic AlphaMCS Service Authorization Request (SAR) form to request prior authorization. Smoky can only process a complete, valid request. If the form is not completed fully, including all required administrative and clinical information, the SAR may be returned, delayed or denied. Smoky staff may refer Network Providers who routinely fail to timely and fully complete SARs for investigation, as this directly impacts continuity of care for the members we serve. Requesting authorization is the responsibility of the provider who will be delivering the service. Please note that providers cannot request authorizations on behalf

of another provider. Behavioral Health Clinical Home providers generate and submit the service plan for all services for a given member, but may request authorization only for those services that they provide.

#### How do I complete and submit a Service Authorization Request (SAR)?

- A SAR must be submitted for each service requiring authorization.
- Except for requests based on retrospective Medicaid eligibility, all SARs must have a service start date that is on or after the date of SAR submission.
- To facilitate communication with Smoky about SARs, please include the name of the individual who is providing the service or who is most knowledgeable about the case, along with that person's telephone number, at the end of the Justification for Service Request field in AlphaMCS.
- All SARs must be submitted electronically via the AlphaMCS system. In documented instances where electronic transmittal is not possible, Smoky may accept transmittal via facsimile, U.S. mail or hand delivery. It is your responsibility to maintain documentation evidencing the date the request was submitted.
- **Network Providers can request specific technical assistance about SAR submission by contacting Smoky Care Management at (866) 990-9712, option 5.**

#### When do I submit a Service Authorization Request (SAR)?

- Initial Requests – SARs must be submitted at least fourteen (14) days prior to the requested start date of services, except for inpatient or other expedited requests.
- Periodic Services – For routine services, requests to renew an existing authorization must be submitted at least fourteen (14) days prior to the end of the previous authorization in order to avoid a gap in authorization or payment. It is your responsibility to submit a SAR for each subsequent service authorization request prior to the expiration of the current authorization, and to conduct a clinical review of the member's ongoing need for services.
- **All Network Providers are required to submit at least 75% of initial and continuing requests more than 14 days before requested start date or end of prior authorization, except for requests that meet criteria for expedited review and for emergent/ urgent services.**
- Inpatient and Facility Based Crisis Authorizations – if continued authorization is requested, the request and supporting documentation must be submitted to Smoky 24 hours prior to the lapse of the current authorization, unless the renewal date falls on a weekend or holiday when the request may be submitted the next business day for retrospective review.
- Retrospective Requests – In situations where the beneficiary did not have Medicaid at the time the service was provided but later obtains Medicaid eligibility with an effective date that encompasses the dates that the service was provided, the SAR and all associated documentation must be submitted no later than thirty (30) days following notification of the Medicaid eligibility determination. Any authorization information from a different vendor or LME that may have been applicable during the period of services to be reviewed should be included with the request.

### When can Smoky return a SAR as unable to process?

Smoky can only process SARs if we receive a complete, valid request. If any of the following information is missing, incomplete or incorrect, we will return the SAR as unable to process. Note that many of these elements are required fields in the electronic SAR.

- Member name, address, date of birth, identification number
- Identification of provider who is to perform the service
- Identification of service and/or procedure code requested
- Requested effective dates for service to be delivered
- Documentation or signatures required by federal or state laws, rules or regulation

Other reasons we may return a SAR as unable to process include but are not limited to:

- Identical or Duplicate request, i.e. the provider submits two requests for the same service/ same dates for a member OR two different providers submit the same request for the same member, in which case Smoky will process the first request received and return the second request as unable to process
- Member not enrolled in a Smoky Health Plan
- Inconsistent or conflicting information in the request and supporting documentation, i.e. name and MID do not match
- Diagnosis or service not covered by applicable Benefit Plan, i.e. you submit a request for a non-behavioral health service that is only covered by DMA (e.g. radiology)
- Requests submitted more than 30 days prior to the requested service start date, except for Innovations Waiver services which can be submitted up to forty-five 45 days prior to the start date
- Funding is not available for a non-Medicaid or (b)(3) service
- Service does not require prior authorization

An unable to process notification does not include appeal rights. Please note that Smoky will not retroactively review SARs that are re-submitted following an “unable to process” notice.

Supporting Documentation: You are responsible for understanding what documentation is required to be submitted with a SAR. This information can be found in the Medicaid Waiver, applicable DMA Clinical Coverage Policies and DMH/DD/SAS Service Definitions, and other references listed on the Authorization section of our website: <http://www.smokymountaincenter.com/authinfo.asp>. Requests that are missing required information may result in an administrative denial, which means there is no clinical review but the member receives a notice with appeal rights. In addition to required documentation, Network Providers are strongly encouraged to submit any and all information that will support a finding of medical necessity. We will consider all relevant information that is submitted. Our experience has been that many providers wait to submit required or helpful supporting information until after a denial has been issued. This delays care for members and creates more work for you and Smoky.

Service Plans: Some services require the development and submission of a service plan. Approved plan formats include the Person-Centered Plan (PCP) and Individual Support Plan (ISP), used with Innovations Waiver participants. For members receiving MH/SA services, plans must be submitted by the Behavioral Health Clinical Home Provider. If a member you are serving does not have a Behavioral Health Clinical Home, then you must collaborate with other providers in developing the service plan. For Innovations Waiver participants, the plan is submitted for approval by the assigned Smoky Care Coordinator. Service plans must be submitted to Smoky upon development of the initial plan following the initial assessment, at least annually thereafter, and whenever significant changes occur in the member's situation and/or plan of care, including all changes to recommended services.

Level of Care/ Placement Criteria: Smoky requires that all SARs include results from the following clinical decision support tools as applicable to the member or service being requested:

- LOCUS (Level of Care Utilization System) for individuals age 18 and older, and CALOCUS (Child & Adolescent Level of Care Utilization System) for children ages 5 to 17. The LOCUS<sup>®</sup> and CALOCUS<sup>®</sup> are assessments and placement instruments developed by the American Association of Community Psychiatrists (AACCP) with input from the American Academy of Child & Adolescent Psychiatry (AACAP). As of February 1, 2013 these assessment tools must be used to assess level of care for individuals with mental health, emotional or behavioral health needs and are required for all SARs submitted to Smoky. For more information about these tools, please see <http://www.locusonline.com/>.
- CANS-MH (Child & Adolescent Needs and Strengths) is used for children under age 5 with mental, emotional, behavioral health or intellectual/ developmental disability needs. For more information about the CANS tool, please see <http://praedfoundation.org/tools/the-child-and-adolescent-needs-and-strengths-cans/>.
- NC-SNAP (NC Support Needs Assessment Profile), which is a needs assessment tool that, when administered properly, measures an individual's level of intensity of need for I/DD supports and services. The NC-SNAP was developed by DHHS and officially adopted in 1999 as the requisite tool for determining an individual's intensity of need for I/DD services. Per guidance from DMA, Smoky and other MCOs are in the process of phasing out the use of NC-SNAP in favor of the SIS<sup>®</sup>.
- Supports Intensity Scale<sup>®</sup> (SIS) is a tool developed by the American Association on Intellectual and Developmental Disabilities that measures the individual's support needs in personal, work-related, and social activities in order to identify and describe the types and intensity of the supports an individual requires. The SIS<sup>®</sup> was designed to be part of person-centered planning processes that help all individuals identify their unique preferences, skills, and life goals. Smoky SIS<sup>®</sup> assessors have been trained by AAIDD in administration of the SIS<sup>®</sup>. Effective January 1, 2016 all Innovations Waiver participants must have a valid (performed within the last 3 years) SIS<sup>®</sup> score in place as part of the annual plan of care approval process. For more information about the SIS, please see Section 13 of this Manual or <http://aaid.org/sis#.Vgf895d5-OY>.
- ASAM (American Society of Addiction Medicine) Patient Placement Criteria (PPC), which are the most widely used and comprehensive set of guidelines for placement, continued stay and transfer/discharge of patients with substance use/ addiction and co-occurring conditions. For more information about



ASAM criteria, please see <http://www.asam.org/publications/the-asam-criteria>.

**Initial Review Process:** All requests are initially reviewed by Care Managers. The first step is to determine if the request is valid or should be returned as unable to process. If the request is valid, the next step is to determine if the request contains all required information. If information is missing, we will either contact you and request more information or issue an administrative denial. Administrative denials are not reviewed for medical necessity but will contain appeal rights. **Unable to process and administrative denials must not exceed 10% of your monthly SAR submissions.**

If we ask for more information, you will have 3 days to submit the additional information. If the request contains all required information, we will review to determine if medical necessity criteria are met. All requests for Medicaid members under age 21 are also reviewed against EPSDT criteria (discussed below). We will never ask you to withdraw or modify a request, although you may decide to do so at any time if you decide there is a different service that would be more clinically appropriate.

If we determine that the request meets medical necessity and/or EPSDT criteria, the Care Manager will approve the SAR, resulting in generation of an electronic authorization letter, available in AlphaMCS for your review. Please consult AlphaMCS training information or contact the Helpdesk for assistance in accessing authorization information. The authorization will contain provider and client identification, tracking numbers for reference (Authorization #), the name and total number of units of the service authorized, and effective dates. You are responsible for notifying the member when a service is approved. We do not send notifications to members unless the request is denied (in whole or in part). **Note that authorization does not guarantee payment. Payment by Smoky is subject to other requirements and limitations set forth in your Contract, this Manual and the Claims Manual & Billing Guide.**

**Peer Review:** If a Care Manager is unable to approve a request based on medical necessity or EPSDT, it will be referred to a licensed Ph.D. Psychologist, Psychiatrist or Physician for a Peer Review. Peer Reviewers review the SAR and all information submitted with it when making medical necessity determinations. Additionally the Peer Reviewer may contact you to obtain additional information or to better understand the information submitted.

When conducting peer-to-peer reviews, Peer Reviewers will call you and identify themselves as calling on behalf of Smoky to discuss an authorization request for a specific member. If unable to contact the appropriate provider representative on the first attempt, a Peer Reviewer may try again to make contact at a later time. However, because of the tight turn around time requirements for authorization decisions, the window to conduct peer-to-peer discussions is usually short. If the Peer Reviewer is unable to reach you or does not think that a peer-to-peer conversation is necessary, he or she will make a decision based on the information submitted with the SAR.

If Smoky issues a medical necessity denial without having conducted a peer-to-peer discussion, you may request one within 3 business days of the denial notice. This will ordinarily be with the clinical Peer Reviewer that made the initial decision but if that individual is not available, another equivalent Peer Reviewer will be made available to talk with you. This discussion is not an appeal of the adverse benefit determination but, rather, an

opportunity to discuss the decision and the reasons that Smoky could not approve the request. However, if based on the peer-to-peer discussion, the Peer Reviewer determines that a different decision should have been made, he or she may change the initial decision.

#### How much time does Smoky have to review the SAR?

- Routine Reviews: We will issue a decision within 14 days after we receive a complete SAR. We can extend the deadline up to 14 additional days under certain circumstances, but this is rare.
- Expedited Reviews: You can request an expedited review of a SAR if you believe that adherence to the standard timeframe could seriously jeopardize a member's life, health, or ability to attain, maintain, or regain maximum function. If we agree that it is necessary for the request to be expedited, we will complete the expedited review within 72 hours of the request and notify you and/or the member of our decision by phone. We will send a written decision no more than three (3) days after that. If we don't agree that expedited review is necessary, we will notify you and the member of our decision, and process it within the 14 day timeframe. Denial of expedited review cannot be appealed, but you or the member can file a grievance if you disagree with our decision.
- Inpatient Hospitalization and Facility Based Crisis Reviews: We will issue a decision within 24 hours of the initial request. If we receive a request to extend a current course of treatment at least 24 hours before the end of the current authorization, we will make every effort to issue a decision within 24 hours.

Medical Necessity: We use medical necessity criteria when making authorization decisions. Under our Waiver Contract, medical necessity is defined as treatment that is:

- Necessary and appropriate for the prevention, diagnosis, palliative, curative, or restorative treatment of a mental health or substance abuse condition; and
- Consistent with Medicaid policies and national or evidence based standards, NC DHHS defined standards, or verified by independent clinical experts at the time the procedures, products and the services are provided; and
- Provided in the most cost effective, least restrictive environment that is consistent with clinical standards of care; and
- Not provided solely for the convenience of the member, member's family, custodian or provider; and
- Not for experimental, investigational, unproven or solely cosmetic purposes; and
- 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 Title 42 of the Code of Federal Regulations, the Medicaid State Plan, the North Carolina Administrative Code, Medicaid medical coverage policies, and other applicable Federal and state directives; and
- Sufficient in amount, duration and scope to reasonably achieve its purpose; and
- Reasonably related to the diagnosis for which it is prescribed regarding type, intensity, duration of service and setting of treatment.
- Within the scope of the above guidelines, medically necessary treatment must 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.

Early Periodic Screening, Diagnosis and Treatment: EPSDT is a part of the federal Medicaid law that requires state Medicaid programs to pay for regular screenings and certain services for children under age 21, even if the services are not included in the N.C. State Plan for Medical Assistance or the 1915(b)/(c) Waiver. Services approved under EPSDT must be medically necessary to correct or ameliorate a defect, physical or mental illness or condition identified through the screening, and must meet all of the following criteria:

- Must fall within a category of services listed at Section 1905(a) of the Social Security Act. This means that most Innovations Waiver services are not covered under EPSDT.
- Must be medical in nature.
- Must be generally recognized as an accepted method of medical practice or treatment.
- Must not be experimental or investigational.
- Must be safe and effective.

We will review all requests submitted for Medicaid services for children under age 21 against these criteria. Please remember that all requirements for prior approval apply to EPSDT services. In addition to coverage of behavioral health services that are not traditionally covered by Smoky, the EPSDT benefit also means that Waiver and Clinical Coverage Policy limits on hours, units and visits that apply to adults may not apply to children under age 21 if the request meets EPSDT criteria. However, the Innovations Waiver annual budget limit cannot be exceeded under EPSDT. If you believe that a child you are serving would benefit from a behavioral health service that is not covered under the Waiver, you can submit an EPSDT Non-Covered Service request using the form available here: <http://www.smokymountaincenter.com/authinfo.asp>.

Decision Notices: Our review of the SAR may result in a full approval, partial approval, or a full administrative or clinical denial. If we issue a partial approval or denial of a SAR, the member will receive a written notice that includes appeal rights and a form to request reconsideration. All written notices are sent via certified mail to the address on file in our system. If a member has moved and failed to notify you or their county DSS, this will make it harder for them to receive the notice and file a timely appeal. Please help us make sure that members understand they need to keep their address current with DSS and accept certified mail from Smoky. The effective date of the decision is the date the notice is mailed, except that if a service is terminated or reduced before the current authorization has expired, the effective date of the change will be no sooner than 10 days after the date the notice is mailed. Please note that if you request services in excess of a Medicaid policy or Waiver limit for an adult member, we will not provide appeal rights for any portion of services requested over the limit for adult members.

Reconsideration and Appeal Process: As a Network Provider, it is your responsibility to understand and help members with the appeal process. However, you cannot file an appeal on behalf of a member without their written, signed permission. Smoky does not engage in retaliation of any kind against a member, Network Provider, family member or other person who requests a reconsideration, appeal or expedited review. More detailed information about the appeal process is included in the Handbook provided to all members and available on our website, but we have included an overview of the appeal process below for your reference. It is very important for members to follow exactly all procedures and timelines outlined in the notice. Members must go through the Smoky reconsideration process before filing a Medicaid appeal with the Office of Administrative Hearings (OAH) or state-funded appeal with DMH/DD/SAS.

The first step is to request a reconsideration review of the Smoky decision. Signed requests for reconsideration must be received by Smoky within 30 days of the notice (for Medicaid services) or 15 working days of the notice (for non-Medicaid services), as follows:

- By fax at 1-877-260-6517
- By mail to Smoky Mountain LME/MCO, Attn: Appeals Coordinator, P.O. Box 247, Waynesville, NC 28786
- By email to [appeals@smokymountaincenter.com](mailto:appeals@smokymountaincenter.com)
- In person at any of the offices listed on page 9 of this Manual.
- By phone at 1-800-893-6246, ext. 1400. If a request is made orally, we still need to receive a signed request for reconsideration within 30 days of the date of the notice.
- For assistance, please call the Clinical Support team at 1-800-893-6246, ext. 1400.

We always send an acknowledgement letter when we receive a reconsideration request. If the member does not receive an acknowledgement letter, please contact us right away to follow up. Reconsideration requests are reviewed by a healthcare professional with appropriate clinical expertise in treating the member's condition or disorder who was not involved in the original decision. As part of the process, members can request a copy of their records from Smoky, and new or additional information will be accepted and considered.

For Medicaid appeals, we will issue a written decision within 30 days of receipt of a timely request. For state-funded appeals, we will issue a decision within 7 business days of receipt of a timely request. The reconsideration can be expedited if you believe that adherence to the standard timeframe could seriously jeopardize a member's life, health, or ability to attain, maintain, or regain maximum function. If we agree that it is necessary for the request to be expedited, we will complete the expedited review within 72 hours of the request and notify you and/or the member of our decision by phone. We will send a written decision no more than three (3) days after that. If we don't agree that expedited review is necessary, we will notify you and the member of our decision, and process it within the applicable appeal timeframe. Denial of expedited review cannot be appealed, but you can file a grievance if you disagree with our decision.

If a member disagrees with our decision, he or she can either: (1) for Medicaid services, file an appeal with OAH within 30 days of the date of the Smoky reconsideration decision notice; or (2) for non-Medicaid services, file an appeal with DMH/DD/SAS within 11 calendar days of the Smoky appeal decision letter date. Instructions and an

appeal form are included with the decision notice. There is no “maintenance of service” under Medicaid managed care or for state-funded services. However, benefits will continue during the appeal through the end of the original authorization period if the member requests continuation of benefits within 10 days of the decision. If a member decides to appeal a Smoky decision and the decision is upheld, Smoky has the right to recover from the member, spouse or parent (if under 18) the cost of services furnished during the reconsideration and appeal process.

Second Opinion: Medicaid beneficiaries have the right to a second opinion if the person does not agree with the diagnosis, treatment, or the medication prescribed. Members are informed of this right in the Handbook sent to them when the individual is enrolled. If a second opinion is requested, you must refer the Member to Smoky’s Clinical Operations Department.

Smoky Clinical Plan and Clinical Practice Guidelines: The Clinical Plan defines the philosophical approach and creates the foundation for all of the “clinical operations” of Smoky including Customer Services, Care Management, Care Coordination and Network Development. The Clinical Plan is a living document that is reviewed and updated at least annually by the Chief Medical Officer and the Sr. Director of Clinical Operations with input from the Executive Leadership Team and the Consumer and Family Advisory Committee (CFAC). The goals of the Clinical Plan are to:

- Develop a more comprehensive continuum of care by developing and training a highly qualified and comprehensive Network of Providers;
- Encourage the development and provision of services based on cultural competence, recovery, self-determination, system of care principles and practices, and clinical evidence that have been demonstrated to lead to desired member outcomes;
- Apply the principles of cultural competence and person-centered care to ensure equitable access to, engagement with, and benefit from services for all persons served;
- Ensure timely access to care and service engagement consistent with Smoky and DHHS performance standards;
- Involve members and families in ways that ensure their ownership and satisfaction, and which engender a feeling of shared responsibility for services provided;
- Develop a sense of community ownership that comes from communication, collaboration and a commitment to people of the local communities, including providers; and
- Use data that can be translated into knowledge in order to demonstrate accountability, efficiency, need, quality, outcomes, and awareness of cultural and ethnic variations and to identify areas for change and improvement.

The Clinical Plan also includes a list of the Evidence Based Practices that Smoky endorses for delivery of services to our members. EBPs are an important tool for Network Providers because they describe best practices in various areas of treatment, help improve outcomes and update community practice models. You must be familiar with EBPs and best practices for the services you deliver, and incorporate them into service delivery to the best of your ability.

We have also adopted or endorsed specific Clinical Practice Guidelines for the treatment of certain conditions and disorders. These Guidelines are developed by national organizations such as the American Psychiatric Association (APA), the American Academy of Child Psychiatrists (AACAP), the Substance Abuse and Mental Health Services Administration (SAMHSA), the Veterans Administration (VA), the Center for Child and Family Health, the British National Institute for Health and Clinical Excellence, the Agency for Healthcare Research and Quality (AHRQ), the National Institute of Mental Health (NIMH), the National Center on Birth Defects and Developmental Disabilities, and other organizations. The Guidelines identify **required** standards for delivery of care and are based on valid and reliable clinical evidence, peer-reviewed studies, and consensus from wide surveys of expert opinions, including actively practicing physicians and other providers with current knowledge relevant to clinical decision making. **We use these Guidelines in making decisions about requests for authorization.** You and your staff must be familiar with them as they apply to the conditions and diagnoses you treat. The Guidelines are included in the Clinical Plan and are also available at:

[http://www.smokymountaincenter.com/documents/providers/SMC\\_Clinical\\_Practice\\_Guidelines\\_2013-05-31\\_2.pdf](http://www.smokymountaincenter.com/documents/providers/SMC_Clinical_Practice_Guidelines_2013-05-31_2.pdf).



# Section 7: Member Rights & Empowerment

The protection and promotion of member rights and empowerment is a crucial component of our service delivery system. Smoky Network Providers must respect member rights at all times, provide members with continuing education regarding their rights and support members in fully exercising their rights.

## Human Values

Smoky's management of services is based on a set of human values. These values were embedded in the vision of the North Carolina State Plan, called "Blueprint for Change," effective November 30, 2001, which stated that individuals with MH/IDD/SA service needs should have:

- A meaningful say in the design and planning of the service system
- Information about services and how to access them
- Easy, immediate access to appropriate services
- Services to prevent and resolve crises
- Satisfaction with the quality and quantity of services
- The opportunity to voice complaints
- An orderly, fair and timely system of arbitration and resolution
- Educational and employment opportunities
- Safe and humane living conditions in communities of their choice
- Reduced involvement with the criminal justice system
- Opportunities to participate in community life and make choices

## Member Rights

We believe that individuals have the following rights, which are based on the U.S. and N.C. Constitutions, N.C.G.S. Chapter 122C, Article 3, rules codified at Title 10A, Subchapters 27C, 27D, 27E and 27F of the North Carolina Administrative Code (published by DMH/DD/SAS as APSM 95-2), other applicable federal and state laws, rules and regulations, and the Blueprint for Change described above:

- The right to confidentiality and privacy
- The right to be treated with respect and dignity
- The right to humane care and freedom from mental and physical abuse, neglect, and exploitation
- The right to live as normally as possible while receiving care and treatment
- The right to be free from unwarranted searches or seizures
- The right to be free from unnecessary or excessive medication, which shall not be used for punishment, discipline, or staff convenience, and which shall be administered in accordance with accepted medical standards and only upon the order of a physician or other appropriately licensed practitioner



- The right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation
- The right to be free from any form of discrimination prohibited by federal and state laws, rules and regulations, whether based on race, color, religion, sex, gender, sexual orientation, ethnic or national origin, age, disability, genetic information, or parental status
- The right to freedom of speech and freedom of religious expression
- The right to exercise the same civil rights as any other citizen, including the right to vote, marry, divorce, procreate and raise children, make a will, sign a contract, sue others who have wronged them, and buy, sell, and own property, unless the exercise of such rights has been precluded by an unrevoked adjudication of incompetency (adults only)
- The right to be free from the threat of unwarranted suspension or expulsion from treatment
- The right to consent to or refuse treatment, except in a medical emergency or an involuntary commitment
- The right to receive treatment in the most natural, age-appropriate and least restrictive environment possible
- The right to participate with treating providers in making health care decisions
- The right to participate in the development and periodic review of a written person-centered treatment or habilitation plan that builds on individual needs, strengths and preferences
- The right to have an individualized treatment or habilitation plan implemented within thirty (30) days of admission to any inpatient or residential facility
- The right to ask questions of Smoky or treating providers at any point in the process and receive accurate information
- The right to participate in a candid discussion with treatment providers about medically necessary treatment options and alternatives for the relevant diagnosis or condition, regardless of benefit coverage limitation
- The right to be informed in advance of the benefits or risks of treatment choices, and to a second opinion at no cost
- The right to decide among relevant treatment options and express preferences about future treatment decisions regardless of benefit coverage limitation
- The right to be informed of the cost of services at the first visit, or during scheduling of the first appointment
- The right to have health information kept secure and confidential by Smoky and treating provider(s) in accordance with federal and state laws, rules and regulations
- The right to request and receive a copy of his or her medical record, subject to therapeutic privilege, and to request that his or her medical record be amended or corrected
- The right to voice complaint(s) or file a grievance about Smoky or the care and treatment received from Network Providers
- The right to receive written notification from Smoky about adverse decisions on requests for prior authorization

- The right to file an appeal with Smoky of the denial, reduction, suspension, or termination of a service, and to request a hearing with OAH (Medicaid services) or DMH/DD/SAS (State-funded services) if the member disagrees with Smoky's final decision
- The right to receive interpretation and translation services and other reasonable accommodations as needed for accessibility, free of charge
- The right to a current listing of Network Providers and access to a choice of providers from within the Closed Network to the extent possible or required by law
- The right to receive information about Smoky, its services, its providers/practitioners and member rights and responsibilities presented in a manner appropriate to the member's ability to understand

**Smoky strictly prohibits retaliation by Smoky staff or Network Providers against any member who exercises any of the rights described in this Section.**

## **Grievances, Complaints and Concerns**

All Network Providers are required to have an internal grievance process to address any grievances, complaints or concerns of the member or member's family related to services provided. This process must be in writing, well-publicized, and communicated to all members upon admission to treatment and upon request from any member. Any unresolved grievances, complaints or concerns should be referred to the Grievance Team at one of the contacts listed below. Smoky Health Plan members also have the right to file a grievance with Smoky about any matter other than authorization decisions, either verbally or in writing. You must publicize the process for contacting Smoky to report a grievance, complaint, concern, or potential rights violation:

- Telephone – Call the Customer Services Line at 1-888-757-5726
- Mail – Smoky Mountain LME/MCO, Quality & Project Operations Department, Attn: Complaints and Grievances, 1207 East Street, Waynesville, NC 28786-3438.
- Email – [Grievances@smokymountaincenter.com](mailto:Grievances@smokymountaincenter.com)

We frequently receive anonymous complaints. Occasionally we may receive a grievance about a Network Provider from one of your employees. We will not share the employee name with you unless ordered to do so by a court. **Retaliation by Network Providers or Smoky against individuals who report concerns or file grievances is strictly prohibited.** Regardless of the source, we take all grievances very seriously and strive to resolve them to the best of our ability. Examples of grievances we receive include concerns about:

- Provider or Smoky staff not keeping an appointment or being disrespectful
- Quality of care or access to services
- Failure to receive services identified in EOB
- Quality of a Network Provider's office or residential site
- Health, safety and welfare issues
- Confidentiality, Privacy and/or Security

- Provider non-compliance with billing or documentation
- Potential fraud, waste or abuse
- Concerns about Smoky's functions, management, activities, or employees

If we receive a grievance about a Network Provider, our first step is usually to call you, get more information, and try to resolve the issue, unless the grievance involves an allegation of fraud, in which case the SIU will be notified, or the grievance involves serious health and safety issues, in which case we will notify our Chief Medical Officer and take immediate action, if needed. You must keep documentation on all grievances received including date received, points of grievances, and resolution information, and must cooperate with grievance inquiries from Smoky. Network Providers are required to respond to Grievance Team members within 10 working days of a request for information. If you do not respond within this timeframe, a decision regarding the grievance will be made without your input and you may be reported to the Smoky Contract Performance Team for follow-up and potential sanction. Based on the nature of grievances we receive, Smoky may also choose to investigate a Network Provider in order to determine the validity of the grievance, or make a referral to another agency, such as the Division of Health Service Regulation (for licensed facilities). Investigations may be announced or unannounced. More information about those investigations can be found in Section 16 of this Manual.

Smoky makes every effort to resolve member grievance within 30 days. Under federal law, we have up to 90 days to resolve a member grievance. Members receive written notification about the resolution of the grievance but the resolution is final. There is no appeal of a grievance resolution.

## **Non-Discouragement**

Smoky staff and Network Providers are prohibited from discouraging a member from exercising his or her rights, including but not limited to the rights to request services, submit a plan of care the member agrees with, file reconsiderations or appeals, ask for expedited review, lodge complaints or grievances with DHHS or Smoky, or report suspicious billing or potential fraud, waste or abuse. Network Providers are specifically prohibited from discouraging a member from filing grievances or complaints with Smoky. Discouragement includes intentionally providing material misinformation to a member. However, Smoky staff and Network Providers can offer alternative services if appropriate, engage in clinical, treatment or educational discussions with members, explain that a request for services may be denied and suggest alternative services, and may explain the appeal process, including Smoky's right to recover the cost of services furnished during an appeal.

## **Informed Consent and Advocacy**

Smoky does not prohibit or otherwise restrict a health care professional acting within the lawful scope of practice from advising or advocating on behalf of a member. You should always:

- Advocate for medically necessary care or treatment options.
- Provide information the member needs in order to decide among all relevant treatment options.

- Encourage the member to participate in decisions regarding his or her healthcare and to express preferences about future treatment decisions through advance directives and crisis plans.

You must obtain informed consent from individuals prior to starting any service or course of treatment. This means that you must explain potential risks, benefits and consequences of treatment and non-treatment options, including any potential side effects of medication, as well as alternatives to the recommended treatment. You must also include individuals in treatment team meetings and development of their service plan. Members have the right to refuse any treatment, to refuse to take part in research studies, to stop or discontinue services at any time, or to discharge themselves from your care unless: (1) it is an emergency situation; (2) services are being provided under an inpatient or outpatient involuntary commitment order; (3) treatment is ordered by a court of law; or (4) the member is under 18, is not emancipated and the guardian or legally responsible person (LRP) gives permission.

## **Right to Privacy**

Smoky Network Providers must ensure the confidentiality, privacy and security of all member health records in accordance with the Health Insurance Portability and Accountability Act of 1996, the HIPAA Privacy Rule, HIPAA Security Rule, 42 C.F.R. Part 2, N.C.G.S. 122C, Article 3 and other federal and state laws, rules and regulations. You must also ensure that all employees and contractors maintain the confidentiality of persons receiving services and other information received in the course of providing services. This means that Network Providers and their employees and contractors must not discuss, transmit or narrate in any form any member information of a personal nature, medical or otherwise, except as authorized in writing by the member or his legally responsible person (LRP), or as permitted by applicable federal and state confidentiality laws, rules and regulations. It is your responsibility to know what information can be disclosed, to whom, and under what circumstances.

All electronic communications to or from members, or that contains protected health or other sensitive information about members, must be sent via a secure electronic mail system such as Zixmail. Please be aware that the HIPAA Privacy Rule requires all health care providers to develop and distribute a Notice of Privacy Practices that provides a clear, user friendly explanation of individuals' rights with respect to their health information and the privacy practices of the health care provider. More information and model notices are available at <http://www.hhs.gov/ocr/privacy/hipaa/modelnotices.html>. We may ask to see a copy of your Notice at an on-site review. Smoky's Notice of Privacy Practices is available on our website.

## **Rights of Minors**

Please be aware that under North Carolina law, a minor (person under age 18) has the right to agree to some treatments without the consent of his or her parent or guardian, including treatments for:

- Venereal (sexually transmitted) diseases

- Pregnancy (but not abortion, which requires consent of at least one parent)
- Use of alcohol or controlled substances
- Emotional disturbance

## 24-Hour Facilities

Network Providers who operate 24-hour treatment facilities must have a document that explains the specific rules for that facility, including rules that cover hygiene, grooming, living environment, personal funds and storage and protection of clothing and possessions. 24-hour facility providers must explain and provide a copy of these rules to individuals within 72 hours of admission. Please refer to Subchapter 27F of the 10A North Carolina Administrative Code, Section .0100 through .105 for more information about this requirement.

## Guardianship

Individuals who do not have the ability to make and communicate important decisions about their personal and financial affairs may be declared incompetent and be assigned a guardian to help them exercise their rights. If you are serving someone who may need a guardian, you should talk to their family members about options or file an adult protective services report with the county Department of Social Services. Guardianship does not necessarily mean the person loses all rights – it can be limited to protect those rights that are within the comprehension and judgment of the individual. For example, a guardian of the estate may be appointed to help the individual manage financial affairs, while the person retains the right to make decisions about healthcare, housing and other personal matters. Representative payees are another option to help someone who needs assistance managing their finances. A finding of incompetence is not permanent. Individual can have their rights restored if they can prove they are able to manage their own affairs and make and communicate important decisions. Partial restoration of some rights is also an option.

North Carolina’s guardianship laws are found at Chapter 35A of the General Statutes. You should be aware of the following provisions at minimum:

- N.C.G.S. § 35A-1201(5) states that “Guardianship should seek to preserve for the incompetent person the opportunity to exercise those rights that are within his comprehension and judgment, allowing for the possibility of error to the same degree as is allowed to persons who are not incompetent. To the maximum extent of his capabilities, an incompetent person should be permitted to participate as fully as possible in all decisions that will affect him.” This is the public policy of North Carolina. **This means that you must do your best to ensure that incompetent persons you are serving are included to the fullest extent possible in treatment team meetings and other venues where decisions about his or her care are made.**
- N.C.G.S. § 35A-1213(g) states that an employee of a treatment facility may not serve as guardian for a ward who is an inpatient in or resident of the facility in which the employee works. This means that

employees of psychiatric residential treatment facilities, group homes, Alternative Family Living homes, Family Care Homes, Adult Care Homes, halfway houses, and other community-based residential facilities licensed by DHSR cannot serve as the guardian for someone who resides at or is receiving inpatient treatment from the facility.

- N.C.G.S. § 35A-1213(f) states that an individual who contracts with, or is employed by an entity that contracts with, an LME/MCO for the delivery of MH/IDD/SA services may not serve as a guardian for a ward for whom the individual or entity is providing these services. **In general, this means that Smoky Network Providers cannot serve as guardians for Smoky Health Plan members being served by the provider, practitioner or staff member.** There are some limited exceptions:
  - A member of the ward's immediate family (meaning a spouse, child, sibling, parent, grandparent, or grandchild) who contracts with Smoky or works for a provider agency can still serve as guardian; or
  - A licensed family foster care provider or a licensed therapeutic foster care provider who was appointed to serve as a guardian on or before January 1, 2013; or
  - A biologically unrelated individual who was appointed to serve without compensation as a guardian on or before March 1, 2013.

## Firearms and Concealed Carry Permits

Under federal and state law, individuals with a history of substance use, involuntary commitment or certain criminal history may be denied the right to purchase a firearm or to carry a concealed weapon. Clerks of Court in North Carolina are required to report the following types of findings to the National Instant Criminal Background Check System (NICS):

- Involuntary commitment for inpatient or outpatient mental health or substance use treatment.
- A finding that an individual is not guilty by reason of insanity.
- A finding that an individual is mentally incompetent to proceed to criminal trial.
- A finding that an individual lacks the capacity to manage his or her affairs due to marked subnormal intelligence or mental illness, incompetency, condition, or disease.

In addition to the NICS check, persons who apply for a permit to carry a concealed weapon in North Carolina must give consent for the details of any mental health and substance use treatment and hospitalizations to be released to law enforcement. We process hundreds of authorization and release forms every year in order to check the health information in our care, custody and control for records that might disqualify someone for a concealed carry permit. Behavioral health providers also routinely receive signed authorization and release forms from local Sheriff's Departments asking for this information. Cooperating with mental health screening for gun permits is an important role in the public system, and another reason why records retention and maintenance is a critical function under your contract with Smoky.

## Restrictive Intervention

Smoky prohibits the use of restrictive interventions by Network Providers except as specifically permitted by each member's Person Centered Plan (PCP) or Individual Support Plan (ISP), as applicable, or on an emergency basis. "Prone" restraints or any techniques whereby the restrained individual will end up in a face-down position are entirely prohibited. If a restrictive intervention is used 3 or more times within a 30 day period or is used as a therapeutic treatment designed to reduce dangerous, aggressive, self-injurious, or undesirable behaviors to a level which will allow the use of less restrictive treatment or habilitation procedures, it must be included in the member's PCP or ISP, as applicable, as a planned restrictive intervention. Otherwise it must be reported to Smoky's HRC and/or in the state's Incident Response Improvement System (IRIS) as applicable. Any and all restrictive interventions or devices utilized must comply with Article 3 of N.C.G.S Chapter 122C.

## Client Rights Committee

Agencies contracted for participation in the Smoky Closed Network are required to establish and maintain a Client Rights Committee (also called a Human Rights Committee) in accordance with N.C.G.S. § 122C-164 and 10A NCAC 27G .0504. The Client Rights Committee must establish a process for the reporting of restrictive interventions used by the agency, including seclusion, restraint and isolation time out, as well as a review procedure for member grievances, alleged violations of the rights of individuals or groups, including cases of alleged abuse, neglect or exploitation; concerns regarding the use of restrictive interventions; and failure to provide needed services. Network Providers are required to submit the minutes of their Client Rights Committee meetings to Smoky on a quarterly basis. Prior to submission, you must de-identify any information that is not in relation to Smoky Health Plan members. The Smoky Human Rights Committee is responsible for the monitoring and oversight of Agency Client Rights Committee functions. The HRC receives routine reporting from Smoky staff on the use of restrictive interventions, rights violations and incidents of abuse, neglect and exploitation within the Smoky Closed Provider Network.

## Advance Directive for Mental Health Treatment

All states permit some form of legal advance directive for healthcare. Advance directives allow individuals to make decisions about end-of-life care and plan ahead with regard to health treatment, including psychiatric treatment. They are sometimes referred to as "living wills." In 1997, North Carolina developed a statutory process and specific form that can be used for individuals to create an advanced directive for mental health treatment, known as the Psychiatric Advanced Directive or PAD. The PAD enables individuals to plan ahead for mental health treatment they might want to receive if they experience a crisis and are unable to communicate for themselves or make voluntary decisions of their own free will. **You are responsible for educating members about the ability to create advance directives and assisting members who express the desire to create a PAD.** If you are assisting a member in completing a PAD, plan on several meetings to thoroughly think about crisis symptoms, medications, facility preferences, emergency contacts, and preferences for staff interactions, visitation permission, and other instructions. Below are some helpful tips and information:

- The statutory form can be found at N.C.G.S. § 122C-77.
- The PAD form was designed by Duke University. The form and other information are available electronically at <http://pad.duhs.duke.edu/>.
- The member must sign the PAD in the presence of two (2) qualified witnesses. The signatures must be acknowledged before a notary public. The witnesses may not be the attending physician, the mental health treatment provider, an employee of the physician or mental health treatment provider, the owner or employee of a health care facility in which the member is a resident, the member's spouse or someone related to the member.
- The PAD becomes effective upon its proper execution and remains valid unless revoked.
- The PAD is not designed for people who may be experiencing mental health problems associated with aging, such as Alzheimer's or dementia.
- A PAD can include a person's wishes about medications, electro-convulsive therapy (ECT), admission to a hospital, restraints, and whom to notify in case of hospitalization.
- The PAD may include instructions about paying rent or feeding pets while the member is in the hospital.
- The member can include the name of their treating psychiatrist or clinician with instructions for the ED to call him or her and follow their instructions if the member is unable to speak for him or herself or is confused.

Upon being presented with a valid PAD, the physician or other provider must make it a part of the person's medical record. The attending physician or other mental health treatment provider must act in accordance with the statements expressed in the PAD when the person is determined to be incapable, unless compliance is not consistent with generally accepted or best practice standards of treatment to benefit the member [see N.C.G.S. § 122C-74(g)], availability of the treatments or hospital requested, treatment in case of an emergency endangering life or health, or when the member is involuntarily committed to a 24 hour facility and undergoing treatment as provided by law. If the physician or provider is unwilling to comply with all or part of the advance directive, he or she must notify the member and record the reason for noncompliance in the patient's medical record.

The Handbook for Smoky Health Plan members includes more information about the PAD and other forms of advance directives, including the Health Care Power of Attorney and living wills.



# Section 8: After Hours Requirements & Crisis Planning/ Response

## Comprehensive Crisis Plan Development

All Network Providers are required to develop Comprehensive Crisis Plans (CCPs) as part of the person centered planning process and must follow the State's Comprehensive Crisis Intervention and Prevention Plan guidance as posted on [www.crisissolutionsnc.org](http://www.crisissolutionsnc.org) and in the following memo:

<http://crisissolutionsnc.org/wp-content/uploads/2014/01/crisis-crisisplnmemo8-20-14.pdf>. The CCP must be created with input and participation from the member and natural supports and include provider and support person contact information, prevention and early intervention strategies for the member to utilize, and member-identified strategies to be utilized by professionals if and when the member needs to access crisis services. It is designed to be one section of a Person Centered Plan (PCP) or Individual Support Plan (ISP) that can also be easily extracted as a stand-alone document for ease of distribution.

**Who is required to have a Comprehensive Crisis Plan?** Network Providers MUST ensure that ALL individuals who have Person Centered Plans also have completed Comprehensive Crisis Prevention and Intervention Plans. In addition, all members who are at significant risk of crisis events - including those receiving only basic benefit services, should have a CCP in place. This would include persons who have received inpatient psychiatric or substance use treatment, been arrested, attempted suicide, or used crisis services within the past year. Crisis services would include Mobile Crisis Management (MCM) team, Facility Based Crisis (FBC), non-hospital detoxification, walk-in crisis, NC START, or use of a hospital ED for reasons related to psychiatric illness or substance use.

A CCP is also required for all Innovations Waiver participants as well as individuals diagnosed with an I/DD who are not enrolled in the Innovations Waiver but meet one of the following conditions:

- The individual has been referred to or discharged from NCSTART; or
- The individual has been referred to or discharged from a State Developmental Center or ICF-IID; or
- The individual has received two unplanned restraints in one quarter.

**How and when is the CCP updated and shared?** Individuals receiving services must be provided with a copy of the plan and all pertinent crisis contact/ after hours numbers to utilize in an emergency. CCPs are "live documents," and must be reviewed and updated as needed. Plans are required to be updated whenever a member's medications or natural supports change or other significant change occurs that impacts crisis planning. Network Providers must upload all completed CCPs to the member's Alpha MCS profile labeled with member's initials\_CCP\_Date (YYMMDD), for example: JD\_CCP\_20151001. This enables it to be easily retrieved and shared in a crisis. In situations permitted under federal and state laws, rules and regulations governing

confidentiality, Smoky may share a member's CCP with an ED or a Mobile Crisis provider in order to help alleviate or respond to a crisis situation. For this reason, it is critical that CCPs be uploaded as soon as possible following completion or any updates to the plan.

## After Hours Coverage Requirements

All Network Providers are required to have appropriate after hours and emergency coverage, and to respond in a timely and appropriate manner to any member who is in crisis. **911 should never be the first line of contact for a behavioral health issue unless the emergency is life threatening.** The level of coverage required is based on the array of services you provide, as follows:

Providers of Basic Benefit Services (e.g., Outpatient Clinics or Licensed Independent Practitioners) and other services without first responder requirements must have capacity to provide 24/7 telephonic crisis intervention/response to members they serve.

- Basic Benefit Providers must have an answering service or voicemail with the provider's after hours contact number – the message must not direct members to 911 or the emergency department (ED) unless their emergency is life threatening. If the provider is using an answering service, the provider must return the call to the member within 15 minutes. All members must be provided with the mobile/pager/ answering service number of the provider on call. After hours recordings and voicemail messages must include the applicable emergency contact information.
- Crisis Plans must be developed with all members and include the provider's day time and after hours/emergency contact information along with helpful strategies to mitigate crisis. Members should have copies of the crisis plan and pertinent contact/crisis afterhours numbers for providers.
- Basic Benefit Providers responding to members in crisis must have 24/7 access to Crisis Plans and other information in the member's treatment record to guide crisis intervention.
- Basic Benefit Providers must have the ability to respond telephonically, but may access Mobile Crisis Services for the member if telephone contact cannot mitigate the crisis.

Behavioral Health Clinical Home (BHCH) and Providers of Enhanced Services are required to have "first responder" capability for their members, in accordance with DMA Clinical Coverage Policy No. 8C and the service definition for the enhanced service being provided.

- All of the above stipulations listed for Basic Benefit apply to BHCH and Enhanced Providers.
- In addition, these providers must be available 24/7 to respond to members receiving services from them both telephonically and face to face for crisis response as needed.
- BHCH and Enhanced Service Providers (IIH, MST, CST, ACTT, SAIOP, SACOT) must respond with a face to face contact if phone contact is not successful in mitigating the crisis.
- First responders are responsible for obtaining involuntary commitment (IVC) petitions if necessary. See Section 11 of this Manual for more information about the IVC process.

Who and What are Behavioral Health Clinical Home Providers? The philosophy behind the use of the term “clinical home” is based on the need for each member to have one provider who assumes overall responsibility for that person’s treatment and service coordination. The Behavioral Health Clinical Home is the cornerstone of the member’s treatment and fulfills key roles, including:

- Conduct and periodically update a Comprehensive Clinical Assessment
- Develop a treatment plan/ PCP with the member’s participation and input from natural supports that addresses the member as a whole person
- Develop a CCP as outlined above
- Make revisions to the treatment plan/ PCP and CCP when service needs, medication or other significant life circumstances change
- Coordinate service provision for the member, including management and monitoring of services and taking responsibility for a team approach to treatment and service provision
- Coordinate any support services that the member may need in addition to formal treatment services
- Submit all necessary paperwork to Smoky, including enrollment and authorization forms
- Provide crisis response and serve as a first responder

Providers of the enhanced services below assume the BHCH function and first responder functions for members immediately upon admission to these services.

- Intensive In-Home (IIH)
- Multisystemic Therapy (MST)
- Community Support Team (CST)
- Assertive Community Treatment Team (ACTT)
- Substance Abuse Intensive Outpatient Program (SAIOP)
- Substance Abuse Comprehensive Outpatient (SACOT)

Other BHCH Providers may include providers of Day Treatment and Psychosocial Rehabilitation as well as 24 hour residential treatment providers. Outpatient therapists assume clinical home functions in the event that outpatient services are being delivered and none of the above services are a part of the member’s Person Centered Plan (PCP). If the individual is not connected with another provider upon discharge from a BHCH, the Behavioral Health Clinical Home will retain emergency response duties for 60 days post discharge.

Relationship between First Responders and Mobile Crisis: Smoky has contracted with three Comprehensive Care Center providers to deliver Mobile Crisis Management (MCM) and other Crisis Services throughout our catchment area. Network Providers with first responder responsibilities, including the CCC providers, should not use MCM as the first responder, even if it is their own MCM team. **This does not meet the intent of a first responder.** The first responder function should be separate. MCM, which is a higher level service, should only be utilized once the First Responder has attempted telephonic intervention, face to face assessment and

implementation of the CCP without success. However, note that ACTT providers have more intensive crisis responsibilities under DMA Clinical Coverage Policy No. 8A-1, and should only call MCM if all other alternatives have been exhausted.

Innovations Waiver Providers of Direct Care Services: All Innovations Waiver providers are required to respond to emergencies/ crises on weekends and evenings as outlined in the applicable Innovations Waiver service definition. Under DMA Clinical Coverage Policy No. 8P, providers of the following services are required to have the capacity to offer Primary Crisis Services for emergencies that occur with participants in their care 24 hours per day 7 days per week, or have an arrangement (memorandum of agreement) with a Primary Crisis Services Provider:

- In-Home Intensive Supports
  - In Home Skill Building
  - Personal Care
  - Residential Support services
  - Respite
- 
- Providers of the above-listed services must train members and their paid/unpaid supports in how to access the designated crisis responder. The designated crisis responder's contact information must be clearly outlined in the participant's ISP and be accessible in the participant's home setting or settings where he or she receive services.
  - The minimum standard is that the provider must first assess by phone to determine if face to face support is needed. Assessment will include determining if Crisis Response Services are necessary. The Provider is responsible for knowing how to access Crisis Response Services and implement them to fit the nature of the crisis.
  - MCM is not considered a primary crisis responder for individuals receiving the above-listed services unless, after an initial assessment, the responsible provider feels that MCM is needed to assist with ED diversion.
  - Members have the right to select another Crisis Services provider from within the Closed Network.
  - ISP crisis plans must be inclusive of mental health or medical health supports and their contact information. All providers listed on a crisis plan must know and understand their role in a crisis for that participant, including MCM. Crisis can occur in the form of mental health, behavioral or medical needs.

Direct Care Providers of State Funded I/DD Services such as Personal care/Personal Assistance must also develop appropriate crisis plans for persons they serve. Members and their support persons must be trained in implementing the plan, and all individuals/ providers included in the crisis plan must be know and understand their role in crisis response.

Individuals with an I/DD who are not receiving services or linked to a provider should utilize MCM in a behavioral health crisis situation. Any eligible individual who is linked to MCM for emergency response will be connected with a provider for follow-up services as needed.

## Frequently Asked Questions

**Who is the first responder in situations where several providers are involved?** This should be clearly outlined in the crisis plan. There are times when several providers are serving the same member. During the crisis planning process, roles and contacts should be clearly defined and detailed in collaboration with the individual and his or her family, friends or other natural supports identified in the plan.

**What if the case has been closed or transferred? Or the member has not been seen in a long time?** This is a complicated and often frustrating concern. The spirit and intent of first responder is that the professional with the most knowledge and established relationship is best prepared to assist in crisis. As a general rule, Smoky requires all providers to respond for a member who was seen or treated by the provider in the previous 60 days. Until the case is accepted by a new provider and the member is seen there, it is not officially transferred and the original provider would be in the best position to act as first responder. If a case is closed without referral to another service, and the member experiences a crisis within 60 days, the provider must respond and use the crisis opportunity as a means of evaluating and re-engaging the member.

**When should a Mobile Crisis Management (MCM) team be called to handle a member who is in crisis?**

Smoky will contact and refer to MCM if the first responder is not accessible, to assure the member receives timely engagement in crisis services. Providers may consult and refer directly to MCM after their first responder intervention has failed to safely manage the crisis and /or divert from the hospital. Providers are not required to go through Smoky Customer Services to make a referral to MCM.

**Should first responders go to the Emergency Departments? When is this appropriate?** The provider must be available to consult by phone with the ED, and often this is all that is needed. However, first responders/providers of enhanced services who have assessed that their member is in need of a higher level of care and have exhausted other alternatives (MCM, Facility Based Crisis, detox, crisis bed, etc.) must accompany the individual to the ED and provide a warm hand-off, sharing clinical and resource information to assist in the evaluation process. The first responder must stay in contact with the ED behavioral health clinicians/ case managers to actively participate in treatment planning and work toward appropriate disposition. The availability of the first responder will often play an important role in the decision about whether to hospitalize some members. A hospital MD may be more willing to consider diversion if the first responder is there and able to make specific arrangements for prompt and aggressive follow-up if the member is not hospitalized.

**Does Smoky need copies of the crisis plans every time they are updated?** Yes. Smoky Network Providers must upload CCPs and PCPs into AlphaMCS to support continuity of care, both at time of first signature and whenever revisions are made. Crisis plans must be updated when the PCP is updated or when there is any significant change in functioning. As with any revision to the PCP, a signature is required.

## The Crisis Continuum

There is a strong continuum of services available to help support and stabilize members in crisis. As a Network Provider, you must be aware of the resources available, how to access Crisis Response services and implement them to fit the nature of the member's crisis, and your role and responsibilities within the crisis continuum. Smoky contracts with three contracted MCM teams to cover the entire 23 county region. There are walk-in centers in each county, operated by Smoky's contracted Comprehensive Care Centers, where members can go to receive same-day assessment and treatment. There are also Facility Based Crisis (FBC) centers in three counties that serve the region. As discussed above, basic benefit providers may utilize MCM for face to face assessment and intervention if the provider's phone response does not reduce the crisis. First responders/enhanced services providers must assess members in crisis face to face and consider all other alternatives to hospitalization such as use of family or community resources, initiation of medication or medication adjustments, safety planning, arranging follow-up, etc., prior to contacting MCM or the Smoky Call Center. Interventions should focus on the least restrictive options, starting with the CCC walk-in centers, MCM, FBC or detoxification facility, before considering inpatient hospitalization. If the first responder's assessment is that the member needs inpatient level of care, some hospitals will consider direct referrals from the community provider. All alternatives should be attempted prior to going to the ED. Options become more limited when a person enters the ED. Regional walk in facilities, MCM providers, and FBC centers for detox or crisis stabilization are listed below.

### Central Region - Alexander, Caldwell, and McDowell Counties

**RHA Mobile Crisis Services 1-888-573-1006**

#### Regional Walk-In Centers

- RHA - Alexander Center 393 3rd Avenue, SW—**Taylorsville**, NC 28681 (828) 848-2515
- RHA - Caldwell Center 2415 Morganton Blvd., SW—**Lenoir**, NC 28645 (828) 394-5563
- RHA - McDowell Center 486 Spaulding Road, Suite B—**Marion**, NC 28752 (828) 652-2919

**Facility Based Crisis Center in Caldwell County is under development with a July 2016 planned opening**

### Northern Region - Alleghany, Ashe, Avery, Watauga and Wilkes Counties

**Daymark Mobile Crisis Services 1-877-492-2785**

#### Regional Walk-In Centers

- Daymark - Alleghany Center 1650 N. Carolina Highway 18 South— **Sparta**, NC 28675 (336) 372-4095
- Daymark - Ashe Center 101 Colvern Street—**Jefferson**, NC 28640 (336) 246-4542
- Daymark - Avery Center 360 Beech Street—**Newland**, NC 28657 (828) 733-5889
- Daymark - Watauga Center 132 Poplar Grove Connector—**Boone**, NC 28607 (828) 264-8759
- Daymark - Wilkes Center 1400 Willow Lane, West Park C61-2 — **N Wilkesboro**, NC 28659 (336) 667-5151

**Facility Based Crisis Center:** Synergy Recovery Center- Phone- 1-866-667-7191, 118 Peace St. North, Wilkesboro NC 28659 14 bed non-hospital detoxification and crisis stabilization unit. 24/7.

## **Southern Region - Buncombe, Henderson, Madison, Mitchell, Polk, Rutherford, Transylvania and Yancey Counties**

**RHA Mobile Crisis Services 1-888-573-1006**

### **Regional Walk-In Centers**

- Family Preservation Services, Phone: (828) 225-3100 1314F Patton Avenue - **Asheville**, NC 28806
- RHA Health Services, Phone: (828) 254-2700 356 Biltmore Ave. -**Asheville**, NC 28801
- Family Preservation Services, Phone: (828) 697-4187 1430 Asheville Hwy - **Hendersonville**, NC 28791
- RHA Health Services, Phone: (828) 649-9174 13 South Main Street - **Marshall**, NC 28753
- RHA Health Services, Phone: (828) 765-0894 129 Skyview Circle - **Spruce Pine**, NC 28777
- Family Preservation Services, Phone: (828) 894-2290 94 White Drive – **Columbus**, NC 28722
- Family Preservation Services, Phone: (828) 287-7945 190 N. Main Street - **Rutherfordton**, NC 28139
- Blue Ridge Community Health, Phone: (828) 883-5550 89 Hospital Drive, Suite B - **Brevard**, NC 28712
- RHA Health Services, Phone: (828) 682-2111 72 Blue Ridge Lane - **Burnsville**, NC 28714

**Facility Based Crisis Center:** Neil Dobbins Center - Phone 828-253-5306, 277 Biltmore Avenue, Asheville NC 28801- 16 bed non-hospital detoxification and crisis stabilization unit. Designated Involuntary Commitment Facility. 24/7.

## **Western Region - Cherokee, Clay, Graham, Haywood, Jackson, Macon and Swain Counties**

**ACS Mobile Crisis Services 1-888-315-2880**

### **Regional Walk-In Centers**

- ACS, Cherokee Center— Phone: (828) 837-0071 750 US Hwy. 64 West—**Murphy**, NC 28906
- ACS, Clay Center—Phone: (828) 389-1494 254 Church Street—**Hayesville**, NC 28904
- ACS, Graham Center—Phone: (828) 479-6466 217 South Main Street—**Robbinsville**, NC 28771
- ACS, Haywood Center—Phone: (828) 452-1395 1482 Russ Avenue—**Waynesville**, NC 28786
- Meridian, Jackson Center—Phone: (828) 631-3973 154 Medical Park Loop—**Sylva**, NC 28779
- ACS, Macon Center—Phone: (828) 524-9385 100 Thomas Heights, # 206—**Franklin**, NC 28734
- ACS, Swain Center—Phone: (828) 488-3294 100 Teptal Terrace—**Bryson City**, NC 28713

**Facility Based Crisis Center:** The Balsam Center—Phone: 1-888-315-2880 91 Timberlane Road—**Waynesville**, NC 28786 –12 bed non-hospital detoxification and crisis stabilization unit. 24/7

# Section 9: Care Coordination

Smoky provides integrated, whole person care coordination through community based MH/SA and I/DD teams. The Care Coordination (CC) department also includes Supports Intensity Scale (SIS®) Assessors for Innovations Waiver eligible and potentially-eligible participants. **Not all members will qualify for care coordination**, which is a federally defined managed care function. Instead, care coordination is provided to members based on criteria set by DMA and DMH/DD/SAS. CC functions and activities include the identification, assessment, coordination, monitoring and linkage to behavioral health treatment/ rehabilitative services, community supports, medical, dental health treatment, primary care and specialists. These activities are dependent on the member's individual needs and funding source.

## Admission Criteria and Covered Populations

Under the DMA Waiver Contract, we provide care coordination for the following Medicaid populations:

- Members who fall under Special Health Care Needs designation as defined below;
- Members engaged with Community Care of North Carolina (CCNC) networks;
- Innovations Waiver participants;
- Members admitting and discharging from hospital and institutional settings receiving a behavioral health inpatient service;
- Members designated as High Risk/High Cost as defined below;
- Members who are on Outpatient Commitment;
- Individuals who have transitioned into the community through the Transitions to Community Living initiative;
- Youth (under age 18) being admitted to or discharged from mental health or substance use residential level III or IV group homes or a Psychiatric Residential Treatment Facility (PRTF); and
- Individuals who currently reside in an Intermediate Care Facility for Individuals with I/DD (ICF-IID) who could be successfully transitioned to a community setting.

**Medicaid members who do not fall into one of the categories listed above are not eligible for Smoky care coordination.** Please note that lack of housing or diagnosis of Traumatic Brain Injury by itself DOES NOT qualify a person for care coordination regardless of disability group or funding source. Under N.C.G.S. Chapter 122C and our DMH/DD/SAS contract, we also provide care coordination for the following populations enrolled in our State-Funded Health Plan:

- Members without a Behavioral Health Clinical Home being discharged from an inpatient setting;
- Members designated as High Risk/High Cost as defined below; and
- Members who are on Outpatient Commitment.



## Special Health Care Needs Populations

DMA defines populations with special health care needs as the following:

### Intellectual and/or Developmental Disabilities

- Individuals who are functionally eligible for, but not enrolled in, the Innovations Waiver and not living in an ICF-IID; or
- Individuals with an I/DD diagnosis who are currently, or have been within the past 30 days, in a facility operated by the Department of Correction (DOC) or the Department of Public Safety (DPS), Division of Juvenile Justice (DJJ) for whom Smoky has received notification of discharge.
- Although individuals in ICF-IIDs are not eligible for care coordination, Smoky staff participate in the annual Plan of Care meetings for members who reside in ICF-IIDs and are appropriate for community placement.

### Child Mental Health

- Children under age 18 who have a current CALOCUS<sup>®</sup> level of VI and a diagnosis within the following DMS-V diagnostic ranges:
  - 293-297.99
  - 298.8-298.9
  - 300-300.99
  - 302-302.6
  - 302.8-302.9
  - 307-307.99
  - 308.3
  - 309.81
  - 311-312.99
  - 313.81
  - 313.89
  - 995.5-995.59
  - V61.21
- Children who are currently, or have been within the past 30 days, in a facility (including a Youth Development Center or Youth Detention Center) operated by DOC or DJJ for whom Smoky has received notification of discharge. This target group includes children who are in Level III and Level IV residential group home settings as well as PRTF or inpatient settings but may also include children who are at imminent risk for entering these levels of care. CC partners with DSS and DJJ to identify and engage high risk children and their families in services to reduce out of home placements and connect to appropriate services.
- Children who have more complex diagnostic patterns including dual MH/SA or co-occurring IDD and receiving enhanced services, are also eligible for care coordination based on criteria listed in the Substance Dependent, Opioid Dependent and Co-Occurring Diagnoses sections below.

### Adult Mental Health

- Adults ages 18 and over who have a current LOCUS<sup>®</sup> level of VI and a diagnosis within the following DMS-V diagnostic ranges:
  - 295-295.99
  - 296-296.99
  - 298.9
  - 309.81
- Adults who have more complex diagnostic patterns including Substance Dependent, Opioid Dependent or co-occurring I/DD are also eligible for care coordination, as set forth below.

Substance Dependent: Individuals are considered substance dependent with a substance dependence diagnosis and current ASAM PPC Level of III.7 or II.2-D or higher.

Opioid Dependent: Individuals are considered opioid dependent with an Opioid Dependence diagnosis and have reported to have used drugs by injection within the past 30 days.

Co-occurring Diagnoses: Individuals with co-occurring diagnoses may be a combination of mental health, substance use and/or I/DD. The following criteria are required to be considered eligible for care coordination under the Special Health Care Needs criteria for co-occurring diagnoses:

- Individuals with both a mental health diagnosis and a substance use diagnosis and a current LOCUS<sup>®</sup>/CALOCUS<sup>®</sup> of V or higher, or current ASAM PPC Level of III.5 or higher; or
- Individuals with both a mental health diagnosis and an I/DD diagnosis and current LOCUS<sup>®</sup>/CALOCUS<sup>®</sup> of IV or higher; or
- Individuals with both a substance use diagnosis and an I/DD diagnosis and current ASAM PPC Level of III.3 or higher.

### **Other Medicaid-Only Care Coordination Admission Criteria**

Community Care of North Carolina (CCNC): Members who are enrolled with a CCNC network may be eligible for care coordination through Smoky. Smoky and CCNC operate under what is called a Four Quadrant model to determine whether CCNC or Smoky has primary responsibility for care coordination. Essentially, Smoky is responsible for all individuals enrolled with a CCNC network who experience high MH/IDD/SA health complexity or risk and low physical health complexity or risk. Smoky and CCNC work together to determine who should be primarily responsible for individuals with high levels of both MH/IDD/SA and physical health complexity or risk. The CC department staff complex cases with CCNC and collaborates with them to ensure that members are linked to necessary services. All members assigned to Smoky Care Coordination are required to be referred and linked to both medical homes as well as Behavioral Health Clinical Homes. In situations where members choose to not engage in behavioral health or medical home services, continued attempts will be made to link the member to care for the duration of the CC intervention.

Innovations Waiver Participants: Innovations Waiver slots are allocated by DMA to each MCO. Smoky approves Waiver slot enrollment on a first come, first serve basis. Individuals who have an Innovations slot receive care coordination services as part of the Waiver. This includes ISP development and monthly health and safety monitoring. Smoky maintains a list of individuals wishing to be considered for participation in the Innovations Waiver, called the Registry of Unmet Needs. If a slot becomes available, CC will notify individuals who meet criteria in order to process the eligibility determination request and begin development of a plan of care.

## **Medicaid & State-Funded Care Coordination Admission Criteria**

The following categories of individuals are eligible for care coordination through Smoky regardless of funding source (i.e., whether they are Medicaid or State-funds eligible):

High Risk/ High Cost Members: In accordance with N.C.G.S. § 122C-115.4(f), a high risk individual is someone who has been assessed as needed emergent crisis services 3 or more times in the previous 12 months. For purposes of high risk eligibility, “emergent crisis services” means Mobile Crisis Management (MCM) team intervention, FBC admission, or ED primary behavioral health intervention. In accordance with N.C.G.S. § 122C-115.4(f), a high cost individual is someone whose treatment plan is expected to incur costs in the top 20% of all members in a specific disability group (MH, SA or I/DD).

Members Discharged from Inpatient or Crisis Settings: Individuals who are not engaged with a community-based behavioral health provider or do not have a Behavioral Health Clinical Home **and** are being discharged from state facilities, hospital EDs, inpatient psychiatric services, detoxification facilities or FBC centers, are also considered high risk, and may receive care coordination services until such time as they are linked to a behavioral health provider for ongoing follow-up and intervention. Smoky works to ensure that these individuals are seen by a community-based Network Provider within 7 days of discharge. Network Providers must make every effort to ensure that appointments are available for these high risk individuals. If a member fails to show up at a scheduled appointment, Smoky staff will contact them within 5 days to reschedule services.

Outpatient Commitments: Smoky provides care coordination services for all members who are under a valid Outpatient Commitment (OPC) order. This includes maintaining up-to-date records on each member in the catchment area with an OPC order, including the name or names of their treatment provider(s) and documentation of CC contacts to verify the member compliance with the outpatient commitment order. If the assigned care coordinator determines that the member has failed to comply or clearly refuses to comply with all or part of the prescribed treatment, the CC must report such failure as required by law. More information about inpatient, substance use and outpatient commitments is included in Section 11 of this Manual.

## **Referral Process for Care Coordination**

If a Network Provider wishes to refer a member for care coordination, you must complete the CC Referral form and send it to the Smoky MH/SA or IDD CC Manager for the region where the individual resides. The form is

available at:

[http://www.smokymountaincenter.com/documents/consumers/carecoord/SMC\\_CareCoordination\\_Referral\\_Intake\\_Form\\_2013-12.doc](http://www.smokymountaincenter.com/documents/consumers/carecoord/SMC_CareCoordination_Referral_Intake_Form_2013-12.doc). Referrals can also be made through the Customer Services department, by other

Smoky staff members, community stakeholders, members and their natural supports. The Referral form must be transmitted through secure email or via fax, mail or hand delivery. Instructions can be found directly on the referral form. The referral request will be reviewed for eligibility for care coordination services within 5 business days of receipt:

- If eligible, the applicable CC Manager assigns the individual to a care coordinator and contacts the member and/or legally responsible person (LRP) to initiate services within a reasonable timeframe. Assignments are made based on county of residence and CC caseload diversity. In general, Smoky will not process requests for a change in the assigned care coordinator absent a compelling reason, such as a documented instance of inappropriate behavior or interaction by the care coordinator. Smoky will not re-assign care coordinators in response to requests based on discriminatory reasons such as race, color, religion, sex, gender, sexual orientation, ethnic or national origin, age, disability, genetic information, or parental status.
- If not eligible, the CC Manager will electronically notify the requestor of the determination and reason(s) for ineligibility of CC services. **This decision is not an “action” that is subject to appeal.** Individuals who are dissatisfied with the decision may file a grievance or complaint or contact the CC Manager to discuss.

## Care Coordination Role

Care Coordination staff will be available at times reasonably convenient to the member and their family for telephonic consultation and face to face meetings. This means that we are willing to schedule meetings after hours and on the weekends if necessary to meet the unique needs of the member and his or her family. This does not mean that we will agree to meet at unreasonable times such as late at night or Sunday morning. If the member or natural support’s behavior or home environment presents a risk to the health, safety or well-being of the assigned care coordinator, we reserve the right to hold meetings in a neutral location such as the Network Provider’s office and/or include a care coordination manager in the meeting. Dangerous home environments include locations where unsecured or illegal weapons, illegal substances or dangerous animals are present. We will not tolerate physical or verbal abuse of our CC staff by members, natural supports, Network Providers or their staff. This includes but is not limited to profanity, yelling, gross disrespect, inappropriate physical interactions or violations of personal space. In such cases, we reserve the right to immediately terminate the meeting or telephone call and report such behavior to the Network Provider.

If the member has a Behavioral Health Clinical Home and receives services that include certain care coordination or case management activities per the applicable DMA Clinical Coverage Policy, DMH/DD/SAS state services definition or the Network Provider’s contract with Smoky, CC staff will ensure that the member’s care coordination needs are met via the Network Provider. A failure to provide required care coordination services or cooperate with assigned care coordinators will result in a referral for investigation and may lead to

administrative action or sanction, up to and including termination of contract. In cases where there is not an identified Behavioral Health Clinical Home, CC staff will provide the following CC activities:

- **Assessment:** Coordination and linkage to appropriate healthcare professionals for assessment and reduction of redundancy in assessment of treatment needs. CC staff may provide assessment and or screenings within the scope of their experience, training and licensure typically in a context where there is a specific benefit to the member. Examples of screening might include health screening or depression screening. A member may also be referred for medication reconciliation. Assessments and screenings conducted by CC staff are covered as administrative duties and are therefore not billed. Care coordinators continually assess member's clinical needs, strengths, and challenges and the services being delivered to ensure that members are getting the right service, at the right time and in the right amount and help determine if additional assessment, evaluation or referral to specialists need to occur.
- **Treatment planning:** CC staff ensure that a treatment plan is developed for members with special health care needs that includes participation of the member, any natural supports, the member's primary care provider, and any specialists caring for the member. This helps ensure that the individual has access to specialists as appropriate for the member's condition and identified needs.
- **Individual Support Plan (ISP) Development:** I/DD care coordinators, in collaboration with the member/LRP, natural supports and Network Provider(s), will develop an annual ISP for each Innovations Waiver participant, and will submit the plan for approval. Network Providers are responsible for the development of short term goals.
- **Person Centered Plan (PCP) role:** Network Providers are responsible for completing a comprehensive clinical assessment and gathering relevant clinical information in order to complete a PCP. Clinical information includes behavioral health information, current medical conditions and linkage to a primary care provider (if the person does not have a current PCP). Smoky will provide technical assistance and participate in the process, but we do not create PCPs for our members.
- Provide linkage, referral and monitoring of identified service needs.
- Participate in and provide clinical and case information to the Child & Family Team or Adult Team regarding options for care that reflect the member's needs for treatment or habilitation.
- Upon request, provide clinical and case information regarding a member's presentation or progress to Utilization Management staff and contractors, including Peer Reviewers, to support medically necessary services for each individual. **Smoky care coordinators do not make authorization decisions and there is a "firewall" in place at Smoky to ensure that authorization decisions are made independently without inappropriate influence from a care coordinator or other Smoky staff member.**
- Coordinate and monitor institutional (e.g. state facilities, inpatient psychiatric facility) admissions and discharges, including assistance with discharge planning. This may include participating in on-site inpatient discharge planning and continuing to work with the member until he or she is connected to a Behavioral Health Clinical Home. Please note that discharge planning is the primary responsibility of the discharging facility, but we will provide assistance and input to the best of our ability. We will not write the discharge plan for you.
- Ensure the coordination of care with member's primary care practices, CCNC physician and other medical providers as needed.

- Provide follow-up activities to high risk members who do not appear for scheduled appointments; to individuals for whom a crisis service has been provided as the first service, in order to facilitate engagement with ongoing care; and to individuals discharged from 24/7 facilities.
- Participate in Health & Safety Wellness Checks. I/DD care coordinators conduct no less than monthly monitoring visits of all Innovations Waiver participants to verify the participant's health, safety and well-being, confirm appropriate service provisions and ensure the individual's needs are being met. These meetings generally occur face to face but can also include telephonic contact with the participant, family/LRP, and Network Provider as well as documentation review to ensure services are being provided as outlined in the ISP.
- For Intellectual and Developmental Disability Care Coordination specifically, the I/DD Care Coordinator will follow internal policy regarding eligibility for Reserved Capacity or Non- Reserved capacity slots for a potentially eligible NC Innovations participant.

## **Discharge from Care Coordination**

A member is discharged from the MH/SA Care Coordination Team when the services have been determined to be effective and the member is stable or stabilizing as evidenced by:

- No psychiatric or behavioral health inpatient or crisis admissions or placements within the previous 90 days;
- Has not required MCM or other crisis service within the previous 90 days;
- Is engaged with a BHCH or other community-based behavioral health provider, as evidenced by the fact that the member can identify his or her provider(s), has participated in their plan development and has attended 4 appointments within the previous 45 days;
- If applicable, all Outpatient Commitment requirements have been met; or
- Despite multiple attempts to engage, the member or LRP continues to refuse CC services.

Innovations Waiver participants will not be discharged from the I/DD Care Coordination Team unless their Innovations Waiver slot is terminated. Other members with I/DD who do not meet ICF-IID level of care will be discharged from care coordination when:

- The member has had no psychiatric or behavioral health inpatient or crisis admissions or placements within the previous 90 days;
- The member has not required a crisis service from NC START or MCM team within the previous 90 days;
- The member is engaged with a behavioral health, residential or habilitative service provider or has service needs being met, as evidenced by the fact that the member/ LRP can identify his or her provider(s), has participated in their plan development and has attended 4 appointments or received 4 service visits within the previous 45 days
- If applicable, all Outpatient Commitment requirements have been met; or
- Despite multiple attempts to engage, the member or LRP continues to refuse CC services.



## Network Provider Care Coordination Responsibilities

As a Network Provider, you must fully cooperate with Smoky's care coordination and integrated care activities, including but not limited to the following:

- Actively participate in interdisciplinary team meetings convened or arranged by the care coordinator and/or include the care coordinator in team meetings convened or arranged by you.
- Provide at least 24 hours prior notice to the care coordinator of the date, time and place of any treatment team or discharge planning meeting involving a member with an assigned care coordinator.
- Provide accurate and timely information to the care coordinator regarding the member's participation in treatment and clinical progress.
- Work with the CC and the Child and Family or Adult planning team in developing an appropriate, whole person plan of care (ISP or PCP), including crisis planning for individuals regardless of disability type. Treatment plans must address mental health, substance use/ addiction, I/DD, medical, dental and specialty needs, evidence of medication reconciliation across all care providers and include a detailed, cross system comprehensive crisis plan using evaluations, assessments and collateral information.
- Develop and implement treatment and/or supports strategies to address assigned areas of responsibility from the PCP or ISP.
- Develop step down and discharge plans within the first month of admission.
- Take the primary role in transitions to other levels of care.
- Notify the assigned care coordinator whenever a member receiving CC services has been admitted to an ED/ FBC or inpatient unit.
- Provide accurate information to members and their families regarding clinical coverage policies and levels of care that are typically most effective at treating or supporting a member's treatment or rehabilitative need and helping a member and his or her family plan for multiple treatment options.
- Timely and accurately completing all appropriate or required level of care/ clinical decision support tools identified in Section 6 of this Manual, including but not limited to the LOCUS<sup>®</sup>, CALOCUS<sup>®</sup>, CANS-MH, NC-SNAP, SIS<sup>®</sup>, and ASAM placement criteria
- Follow the process for admissions to a State Developmental Center. Any application for a State Developmental Center must be coordinated with the MCO. The member/ family/ LRP or Network Provider must provide us with all information necessary for a complete admission packet to be submitted. Our *Olmstead* Care Coordinator will review the application to ensure that all other reasonable lower levels of care have been exhausted first. We must provide a letter of support in order for the application to be accepted. For individuals who are accepted into a State Developmental Center, the *Olmstead* CC will follow the individual through discharge. **State Developmental Centers are not considered lifetime residential placements** and individuals must be reviewed quarterly for discharge consideration.



# Section 10: Emergency Services & Hospital Requirements

Smoky contracts with a large number of licensed hospitals across the State of North Carolina, as well as neighboring states. These may include large health systems with multiple hospital facilities and physician practices, as well as county hospitals, state facilities, private psychiatric hospitals and psychiatric residential treatment facilities (PRTFs) for children and adolescents. We routinely enter into Out of Network Agreements with hospitals and facilities to cover medically necessary inpatient psychiatric treatment for our members. We also reimburse hospitals and facilities for medically necessary emergency department and crisis services provided to our members, even if the hospital or facility is not contracted to participate in our Closed Network. **This Section of the Manual is applicable to all hospitals and 24-hour inpatient facilities who receive reimbursement from Smoky.** The requirements of this Section are designed to help reduce inpatient admissions and length of stay so that members can be connected with a community-based provider and resume recovery as soon as possible.

## Emergency and Crisis Stabilization Services

Smoky will provide reimbursement for emergency and crisis stabilization services for eligible Medicaid beneficiaries at any time without regard to prior authorization or whether the provider has a contract with Smoky. However, the treatment must fall within the scope of services covered under the 1915(b)/(c) Waiver. In other words, we will not reimburse you for cancer treatment just because the member has a behavioral health diagnosis. Medical treatment provided in the ED that is unrelated to behavioral health is the responsibility of DMA. If you are unsure about whether a service should be billed to Smoky or to DMA, please refer to the Mixed Services Payment Protocol attached as Appendix C to this Manual. The Protocol is included in our DMA Waiver Contract and in all contracts between Smoky and hospitals.

Emergency services means covered inpatient and outpatient services that are needed to evaluate or stabilize an emergency medical condition as defined at 42 CFR § 438.114(a). We do not limit what is considered an emergency medical condition on the basis of lists of diagnoses or symptoms. We consider Facility Based Crisis (FBC) services to fall within this definition. Crisis stabilization or “poststabilization care” services generally means covered inpatient and outpatient services that are provided in order to maintain the stabilized emergency medical condition. Requests for reimbursement for emergency services must be presented to Smoky within 90 days of treatment or discharge. We will not require you to enter into a contract for reimbursement but we will ask you to complete a billing enrollment form so that we have information required for our financial records. **You may not bill Medicaid members (or otherwise hold them liable for payment) for screening and treatment that was needed to diagnose an emergency medical condition or stabilize the individual.**

If the individual was not enrolled with Smoky at the time of service delivery, Smoky will enroll them as soon as

possible. The date of enrollment will be the date the emergency or poststabilization care services were provided. Individuals must be enrolled in our system, however, before they can receive additional, non-crisis services.

## **Emergency Department Admission Notification**

If a member of a Smoky Health Plan, or someone who you believe may be eligible for a Smoky Health Plan, presents at an emergency department (ED) or Facility Based Crisis (FBC) in a behavioral health crisis, the facility must inform Smoky of the admission via a daily report to Smoky's Crisis Coordination team and/or by calling the Smoky Customer Services department at **1-800-849-6127**. The hospital ED or facility where the individual is receiving treatment is ultimately responsible for assessment and disposition of individuals in their care. However, Smoky employs crisis staff and hospital liaisons who are available to provide ED and FBC staff with consultation, coordination with the individual's Behavioral Health Clinical Home (BHCH), and education on possible resources for appropriate treatment. If the member is not engaged with a BHCH or other provider and meets criteria for Care Coordination, the Crisis Coordinator will refer to the Care Coordination Department for follow-up by a Care Coordinator.

You must allow Smoky care coordinators and hospital liaisons access to Smoky Health Plan members while in the ED or FBC to participate in diversion from inpatient admission, discharge planning, bridging to outpatient service engagement, crisis planning, etc. Likewise, if the member has a treatment relationship with a Smoky Network Provider, you must allow that provider access to the member while in the ED or FBC to help facilitate diversion from inpatient care.

You must notify Smoky whenever a Smoky Health Plan member is discharged from the ED or FBC within 24 hours of discharge. If a member who presented to the ED or FBC with a behavioral health issue is discharged, you must arrange for a follow-up appointment with the individual's BHCH, or if there is no BHCH, with an appropriate outpatient or other behavioral health provider within 5 business days of discharge. Smoky Customer Services staff can assist with arranging the follow-up appointment for members who are not yet connected with services. Please call the 24/7 Access to Services line at **1-800-849-6127** for assistance with appointments.

## **Inpatient Admission Notification and Authorization of Stay**

Smoky generally honors a 72 hour "pass through" for inpatient psychiatric treatment. This means that we do not require prior authorization for the first 72 hours of an inpatient stay. However, we reserve the right at any time to conduct post-payment review to verify the medical necessity of any inpatient stay, and may identify an overpayment if it is determined that inpatient treatment was not medically necessary or delivered in accordance with all requirements of the Controlling Authority listed in your Contract or Out of Network Agreement, including but not limited to DMA Clinical Coverage Policy No. 8B.

Regardless of this 72 hour pass through period, you must notify Smoky within 24 hours of any inpatient

admission of a Smoky Health Plan member in order for us to immediately link the member to a community-based provider or work with the member's existing provider on discharge planning. Effective discharge planning is critical to reduce the cycle of readmission for some of our members with serious and persistent mental illness. **You must notify us of an inpatient admission by calling the Smoky Customer Services department at 1-800-849-6127 within 24 hours of admission.** We reserve the right to deny authorization and reimbursement of the initial 72 hour pass through period if you fail to notify us of the individual's admission within this timeframe.

Certification for continued hospitalization or services include the number of extended days or units or service, the next anticipated review point, the new total number of days or services approved, and the date of admission or onset of services. Requests for continued stay must be submitted electronically via AlphaMCS. The following information must be included in SARs: original admission information including category of disability and diagnostic profile, reasons for requesting continued stay including current risk factors, current medications, name of attending physician, anticipated discharge date and plan that notes step-down services and discharge living arrangement. For members with primary diagnoses of substance use Smoky requires the following: current vital signs, Clinical Institute Withdrawal Assessment for Alcohol (CIWA or CIWA-Ar) score and/or Clinical Opiate Withdrawal Scale (COWS) score as applicable, current withdrawal symptoms, and results of UDS. You must also attach the Regional Assessment and Referral Form (RARF) or other demographic and clinical information on which the admission decision was made. Requests must be received by **noon** of the last authorized service day. Failure to submit timely SARS may result in non-covered service days.

There may be times when Care Managers need to contact inpatient staff for additional information in order to make a medical necessity decision. Failure to respond in a timely manner to these requests may result in longer request processing times and/or referral to peer review.

## **Criterion V Reviews**

In the event that not all of the criteria for continued acute state in an inpatient psychiatric facility as specified in 10A NCAC 25C. 0302 are met for beneficiaries through the age of 17, we may authorize continued stay in an inpatient psychiatric facility at a post-acute level of care to be paid at an established residential rate if the facility and program services are appropriate for the beneficiary's treatment needs and provided that all of the Criterion V conditions are met. Criterion V is approved only when the beneficiary has a history of sudden de-compensation or measurable regression, and experiences weakness in his or her environmental support system which is likely to trigger a de-compensation or regression.

## **Retrospective Authorization**

In the event that you admit a patient who was not Medicaid eligible on or before admission and the patient received retroactive Medicaid eligibility that would cover the inpatient stay, you can request a retrospective authorization review as follows. You must submit **a cover letter, a print screen from NC Tracks showing the**

**date of Medicaid eligibility determination** and a **paper copy of the full closed medical record** (discs are not accepted) to the following address within 30 days of the eligibility determination (or longer time if specified in your contract – you are responsible for being familiar with the requirements of your contract with Smoky):

Smoky Mountain LME/MCO  
Attn: Inpatient Review Team  
P.O. Box 247  
Waynesville, NC 28786

It is your responsibility to routinely check NC Tracks for the eligibility status of Medicaid beneficiaries. We will not process requests for retrospective authorization received outside of this timeframe.

## **Treatment Coordination and Discharge Planning Requirements**

Discharge planning begins at the time of the initial assessment and is an integral part of every member's treatment plan regardless of the level of care being delivered. The discharge planning process includes use of the member's strengths and support systems, the provision of treatment in the least restrictive environment possible, the planned use of treatment at varying levels of intensity, and the selected use of community services and support when appropriate to assist the member with functioning in the community. Involvement of family members and other identified supports, including primary care doctors or community behavioral health providers, require the member's written consent.

Hospitals and facilities contracted with us must cooperate fully with our care coordination and discharge planning efforts, including but not limited to coordination with the member's primary care provider, BHCH or other community-based behavioral health provider, and participation in interdisciplinary team meetings facilitated by Smoky. Specific requirements include the following:

- You must regularly schedule treatment and discharge planning meetings for members in 24 hour inpatient care.
- You must provide Smoky and the member's BHCH or other designated community behavioral health provider with at least 24 hours prior notice of the date, time and place of any treatment team or discharge planning meeting regarding a Smoky Health Plan member. If a member declines to permit notice to Smoky or the provider, this must be documented in the medical record.
- You must allow any assigned Smoky care coordinator, hospital liaison, crisis coordinator, BHCH or designated community behavioral health provider to attend and actively participate in treatment team and discharge planning meetings regarding members. If a member declines to permit access to Smoky or the provider, this must be documented in the medical record.
- You must notify Smoky, the BHCH and/or the designated community behavioral health service provider at least 24 hours prior to the intended date and time of any discharge of a member from inpatient care. If a member declines to permit notice to Smoky or the provider, this must be documented in the

medical record.

- In those instances where formulary medication has been used previously and proven ineffective for a member, you must request a pharmacology consultation by contacting Smoky's Chief Medical Officer prior to discharge. The consultation process will include review of available treatment alternatives that can facilitate ongoing medication adherence and effective treatment. **Medicaid members should not be discharged with prescriptions for medication that is not covered by Medicaid.**
- Once the discharge date has been determined, you must schedule a follow-up appointment with the BHCH or designated community behavioral health service provider (if the member has an active treatment relationship pre-dating admission) or request that Smoky's Customer Services department do so. The follow-up appointment must be scheduled to occur within five (5) days of discharge.
- At the time of discharge, you must complete the discharge module in AlphaMCS and upload documentation of reconciliation and depart summary into the Patient Module in AlphaMCS.
- At the time of discharge, you must provide the member, Smoky, and the assigned community behavioral health provider with the following critical patient discharge information:
  - Reason for hospitalization;
  - Significant findings;
  - Procedures and treatment provided;
  - Admission and discharge diagnoses;
  - Member's demographic information;
  - Member's discharge condition (including level of risk to self/others);
  - Discharge medications and Medication Reconciliation Form (dosage and amounts, when refills needed);
  - Recommended follow up care (both medical and psychiatric);
  - Recommended revisions to Comprehensive Crisis Plan (if any);
  - Name of discharging physician with contact information; and
  - Any other information requested by Smoky at the time of discharge.

Smoky staff will review the status of the discharge plans at each review to assure that a discharge plan exists, was developed with member input and includes individualized goals and language specific to the member. Goals in a discharge plan must be specific, realistic, comprehensive, timely, objective and measurable.

# Section 11: Involuntary Commitment

In North Carolina, courts can issue involuntary commitment orders when a person is dangerous to self or others and a psychiatrist or psychologist determines that the individual meets commitment criteria set forth at N.C.G.S. Chapter 122C, Article 6. Courts also have the option to order that an individual who meets criteria be placed under an outpatient commitment, which would require the person to obtain treatment on a regular basis while living in the community. This Section describes the involuntary commitment process for inpatient, substance use or outpatient treatment and your role as a Network Provider in that process.

## Involuntary Commitment Process

If the Behavioral Health Clinical Home or First Responder is unable to mitigate a member's crisis and the individual is a danger to self or others, yet is not willing to seek stabilization voluntarily, you are responsible for initiating an involuntary commitment (IVC) petition. The affidavit and petition form is available on the website of the Administrative Office of the Courts: <http://www.nccourts.org/Forms/Documents/661.pdf>.

**Who can file a petition for involuntary commitment?** A petition can be filed by **any person** who has knowledge that a person meets criteria. However, if the petitioner is a physician, psychiatrist or eligible psychologist, it can be notarized.

**What are the criteria for involuntary commitment?** In order to file a petition for involuntary commitment, the petitioner must have knowledge that the person is mentally ill and dangerous to self or others OR is a substance abuser and is a danger to self or others. Please note that an intellectual/ developmental disability (what used to be referred to as "mental retardation") in and of itself is no longer considered sufficient criteria for commitment.

**What should the petition include?** The petition must contain facts to support the petitioner's belief that the individual (referred to as the "respondent") meets criteria for commitment, including evidence of significant history of harm to self or others when unstable if available. Best practice is to avoid conclusory statements and to specifically designate the facility where law enforcement is to transport the member once located (i.e. hospital ED, Facility Based Crisis center, other IVC designated facility, etc.).

**Where, how and when is the petition filed?** Every county has its own procedure, so it is important to check with the Clerk of Court's office where the petition is to be filed before initiating the process. The petition must be filed in the county where the individual resides. IVC petitions are generally taken out with the Clerk of Court or local Magistrate. In some counties only the Magistrate can accept an IVC petition. The petition can be filed at any time, including after regular business hours. After hours petitions are always taken out with the local Magistrate. Contact information for Clerks of Court and Magistrate's offices are available on county websites and through the Administrative Office of the Courts: <http://www.nccourts.org/> (click on "Courts" → "Court

Information by County” → “Court Telephone Directory”).

**What happens if the IVC petition is accepted?** If the Magistrate or Clerk of Court agrees that the petition meets criteria for involuntary commitment, he or she will issue a custody order to have law enforcement transport the individual to an area facility – typically an ED or other IVC designated facility, which can include an FBC – for evaluation, or to any physician locally available. The custody order must be served within 24 hours of issuance. This means that if the individual cannot be located within 24 hours, a new petition must be filed.

**What happens after the individual is picked up by law enforcement?** The individual must receive an evaluation from a physician, psychiatrist or eligible psychologist (called the “first evaluator”) within 24 hours of presentation to the facility. The first evaluator can do one of the following: (a) stop the process and release the respondent if the evaluator determines the individual does not meet IVC; (b) recommend inpatient mental health or substance use commitment; or (c) recommend outpatient mental health or substance use commitment and release pending a hearing for outpatient commitment. The decision to release or recommend outpatient MH or SA commitment must be documented and reported to the Clerk of Court using the DMH/DD/SAS Notice of Commitment Change form, currently available on the archived DHHS website: <http://www2.ncdhhs.gov/mhddsas/statspublications/Forms/formsforfacilities/form-5-79-01commitchge.pdf>.

**What happens if the first evaluator recommends inpatient commitment?** If the evaluator recommends inpatient commitment, law enforcement must transport the respondent to a 24 hour facility (inpatient unit) for care and treatment. If a 24 hour facility is not immediately available OR appropriate to the respondent’s medical condition, the respondent can be temporarily detained under appropriate supervision at the site of the first evaluation for up to 7 days from issuance of custody order **OR** released upon further examination by a physician, psychiatrist or eligible psychologist:

- If 7 days pass, the commitment process is terminated at that time or can be restarted with new petition. If doctor or eligible psychologist is new petitioner, the doctor or psychologist must conduct a new examination and may not rely upon prior examination.
- The interim evaluation cannot be performed by other mental health professionals who perform initial examinations under the waiver. The decision to release or recommend outpatient MH or SA commitment must be documented and reported to the Clerk of Court using a change of commitment form.

**What happens when a 24 hour facility is located?** The 24 hour facility must accept the respondent for admission. Once that occurs and the respondent is transported, an MD evaluator must complete a second evaluation within 24 hours of presentation to the 24 hour facility. The second evaluator can stop the process and release the respondent if the evaluator determines the individual does not meet IVC, recommend inpatient mental health or substance use commitment, or recommend outpatient mental health or substance use commitment and release pending a hearing for outpatient commitment. The individual may also be given the option to sign in voluntarily. The decision to release or recommend outpatient MH or SA commitment must be documented and reported to the Clerk of Court using a change of commitment form. If the respondent is

released, he or she is returned home via law enforcement, or may arrange their own transportation. **Network Providers may not decline inpatient admission based on an individual's transportation options post-discharge.**

**What happens after the respondent is admitted to an inpatient unit on IVC?** The 24 hour facility sends the petition and paper work to the Clerk of Court in the county where the facility is located. A District Court hearing must be held within 10 days of being taken into custody by law enforcement. If the court finds by clear, cogent and convincing evidence that the individual meets inpatient commitment criteria, it may order inpatient commitment for up to 90 days (MH) or 180 days (SA). Commitment can be inpatient, outpatient (MH or SA), or a combination of the two. If the respondent needs to be committed for longer than the initial time period ordered by the court, a Request for Hearing must be completed and submitted to the Clerk of Court that issued the initial IVC. This form is currently available on the DHHS archived website at:

<http://www2.ncdhhs.gov/mhddsas/statspublications/Forms/formsforfacilities/form-dmh5-76-01reqhearing.pdf>.

If continued IVC criteria are met, a second commitment order can be issued for an additional period of up to 180 days. Re-hearings must be held at the end of this second commitment and at least annually thereafter.

**Can an OPC be initiated without first requiring the respondent to be committed for an inpatient stay?** Yes. An OPC can be initiated during the involuntary commitment process by an MD/ Licensed Psychologist on the first evaluation after the initial petition and not as part of any facility discharge. In such cases:

- The first evaluator must complete an Examination and Recommendation to Determine Necessity for Involuntary Commitment form, check all appropriate Outpatient Commitment boxes in all sections, and identify the name and address of the proposed outpatient treatment provider. This form is currently available on the archived DHHS website at:  
<http://www2.ncdhhs.gov/mhddsas/statspublications/Forms/index.htm>.
- The first evaluator must also give the member an appointment time and date for the follow up examination with the outpatient treatment provider.
- The Initial Petition and the First Evaluation must be returned to the Clerk of Court prior to the follow-up appointment with the proposed provider.
- The Clerk of Court will schedule a hearing and notify the respondent and the proposed outpatient treatment center of the hearing date.
- If the member fails to show for the follow-up OPC appointment, the proposed provider must attempt follow-up and, if that fails, may have the member picked up for evaluation using the Request for Transportation Order and Order (Outpatient Fails to Appear for Pre-hearing Examination AOC-SP-224), available here: <http://www.nccourts.org/Forms/Documents/853.pdf>.
- The proposed provider's MD/Licensed Psychologist must complete another Examination to determine if the individual continues to meet the criteria for OPC.
- If the member is still in need of an OPC, the proposed provider MD, Licensed Psychologist or designated clinician will attend the OPC hearing where the judge decides whether or not to continue the OPC. In some instances, the judge may order the examining MD or Licensed Psychologist to provide face to face testimony at the OPC hearing. This OPC hearing is held within ten days of the initial MD's evaluation.
- If the member shows up for the follow up examination appointment and no longer meets the criteria for



OPC, the MD/Licensed Psychologist should complete the Notice of Commitment Change form and send to the Clerk of Court, with a copy to the assigned Smoky care coordinator. This form is currently available on the archived DHHS website at:

<http://www2.ncdhhs.gov/mhddsas/statspublications/Forms/formsforfacilities/form-5-79-01commitchge.pdf>.

## Outpatient Commitment Responsibilities

Outpatient Commitment (OPC) can be ordered for persons who are deemed mentally ill, capable of surviving safely in the community with available supervision from family, friends, or others, in need of treatment in order to prevent further deterioration, and whose current mental illness limits or negates the ability of the ability to make an informed decision to seek voluntary treatment or comply with recommended treatment. Failure to comply with an OPC order may result in an order to law enforcement to take the individual into custody and present them to an inpatient facility for an evaluation.

Members placed on OPC are likely to be individuals with high-risk behaviors about whom there is also a concern regarding treatment compliance. The goal is to assure that a strong effort is made to provide appropriate follow-up for these individuals. Smoky requires Network Providers to meet the following requirements for members who are on OPC. However, please be aware that some counties, specific Magistrates and Clerks of Court have developed specific procedures and workflows for working with OPCs. Network Providers are responsible for adhering to established procedures and workflows applicable to the county where the OPC was issued.

You must perform a face-to-face assessment within 5 working days of notification that a member you are serving is under OPC order, followed by ongoing outpatient face-to-face assessment and follow-up treatment at the level clinically appropriate to the member's needs and condition. Some members may need daily contact while others may need weekly contact. No member shall be seen less than once every two weeks unless they are in a 24 hour supervised (Family Care Home, Group Home) setting and are stable. If you determine that the member can be seen less than bi-weekly (2x per month), then a MD/Licensed Psychologist/FNP/PA must assess the need to continue the OPC and document the contact.

**What is the process if a Network Provider is considering discharging a member on OPC?** If you determine that the member no longer meets criteria to continue the OPC, then the MD/ Licensed Psychologist/ FNP/ PA must complete a DMH/DD/SAS Notice of Commitment Change form, currently available on the archived DHHS website:

<http://www2.ncdhhs.gov/mhddsas/statspublications/Forms/formsforfacilities/form-5-79-01commitchge.pdf>.

Once completed, you must send one copy to the Clerk of Court in the county the Court Order dictates (which is the county of supervision) and one to the assigned Smoky care coordinator who will log the termination of commitment. If the member was initially committed as a result of conduct resulting in the individual being charged with a violent crime, including a crime involving an assault with a deadly weapon, and was found

Incapable To Proceed (ITP), a hearing must be scheduled to make any changes in the commitment. If you are unsure about the reason for the initial commitment, you must contact the Clerk of Court for clarification.

**What if the member clearly refuses and fails to comply with treatment?** If the individual clearly refuses and fails to comply with all or part of the prescribed treatment, and continues to meet commitment criteria, you should make all reasonable efforts to engage the member's compliance, and document those efforts in a letter prepared by the treating clinician. The clinician's letter should be sent to the Clerk of Court where the commitment is being supervised along with a Request for Supplemental Hearing (Outpatient Clearly Refuses to Comply with Treatment AOC-SP-221) available here: <http://nccourts.org/Forms/Documents/856.pdf>. A copy must also be sent to the assigned Smoky care coordinator.

**What if the member fails to comply but does not clearly REFUSE to comply with treatment?** If the member fails to comply but does not clearly refuse to comply, i.e., the individual has a pattern of scheduling appointments but does not show up, you may request the court to order the member taken into custody for the purpose of a face to face evaluation. This option is only available if you know where the member can be located. To do this, you must complete a Request for Transportation Order and Order (Outpatient Fails but Does Not Clearly Refuse to Comply with Treatment AOC-SP-220) available here: <http://nccourts.org/Forms/Documents/857.pdf>. It must be sent to the Clerk of Court where the commitment is being supervised, with a copy to the assigned Smoky care coordinator.

**What if the member does not comply with treatment and cannot be located?** If the member is non-compliant and cannot be located for a pick up order, then you must attempt the following reasonable professional efforts:

- First, you must be able to demonstrate supporting documentation and/or billing for at least one of the following **within 72 hours (not including holidays/weekends)** of the initial missed appointment:
  - a face-to-face visit in the member's home
  - a rescheduled office appointment with the clinician that the member keeps
  - a phone conversation with the member about the services being offered
  - at least one face to face attempt to contact the member at his or her last known address
  - a follow-up letter sent to the member at his or her last known address
- Second, assuming the above-listed attempts to locate the member are unsuccessful, you must attempt face-to-face contacts once per week the first two weeks, then one more attempt two weeks later (4<sup>th</sup> week).
  - If the member's last known address is a homeless shelter or someone else who resides at the last known address states that the member does not reside at the last known address, the above three face-to-face attempts should be made at local homeless shelters. Any information provided to you by a family member or another person regarding the member's location must also be pursued).

**What if these reasonable professional efforts are unsuccessful?** You must document the efforts made, including three attempts at face-to-face contact over a 4-week period, in a letter to the Clerk of Court in the

supervising county, complete a Notice of Commitment Change, and send to the Clerk of Court, with a copy to the assigned Smoky care coordinator. Remember that if the member is initially committed as a result of conduct resulting in the individual being charged with a violent crime, including a crime involving an assault with a deadly weapon, and the member was found Incapable To Proceed (ITP), a hearing must be scheduled to make any changes in the commitment. If you are unsure about the reason for the initial commitment, you must contact the Clerk of Court for clarification. If the member's case is active in AlphaMCS, you must keep the case open for 60 days from last contact. If the member cannot be located within 60 days from last contact, you may discharge the member from services and notify Smoky using the normal discharge documentation and procedures.

**What is the review process for continuation of OPC?** At least days prior to the expiration of the OPC, the Network Provider clinician must review the case with an MD/Licensed Psychologist/ FNP/ PA and determine if the member still meets the criteria for OPC and whether it needs to be extended. If the member has been compliant and no longer meets the criteria, then the duration of the OPC will naturally expire. If you determine that the member continues to meet the criteria for the OPC and a rehearing is needed, then the MD/Licensed Psychologist will need to complete an Examination and Recommendation to Determine Necessity for Involuntary Commitment, form 5-72-09, available at <http://www2.ncdhhs.gov/mhddsas/statspublications/Forms/index.htm>. This form, along with a completed Request for Hearing form, must be submitted to the Clerk of Court, with a copy to the assigned Smoky care coordinator.

**What if the member moves to another state while under OPC?** If the member moves to another state, you must document this change in the medical record, complete a Notice of Commitment Change and send to the Clerk of Court, with a copy to the assigned Smoky care coordinator. Remember that if the member is initially committed as a result of conduct resulting in the individual being charged with a violent crime, including a crime involving an assault with a deadly weapon, and the member was found Incapable To Proceed (ITP), a hearing must be scheduled to make any changes in the commitment. If you are unsure about the reason for the initial commitment, you must contact the Clerk of Court for clarification.

**What if the member moves to another MCO catchment area?** If the member plans to relocate to another county within the state that is outside of Smoky's 23-county catchment area, you must request the Clerk of Court in the county where the OPC is supervised to schedule a hearing prior to the move. The MD/ Licensed Psychologist must complete a new Examination and Recommendation to Determine Necessity for Involuntary Commitment and send it to the Clerk of Court with a completed Request for Hearing, with a copy to the assigned Smoky care coordinator.

**What if the member relocates to another county within Smoky's catchment area?** If the member is moving to a new county and wants to receive services from a new provider, the original provider must connect the member to a new provider. The original provider's OPC responsibilities do not end until the new provider has accepted the member for services. If the member is moving to a new county but staying with the same provider organization, the current provider must arrange for all necessary transition of paperwork and contact information. As outlined above, the law requires **any** move from one county to another to be done through the

court and a hearing must be requested for OPC transfer to the new county.

**What if the member wants to change providers?** If the member wants to receive services from a different Network Provider, the original provider must connect the member to a new provider. The original provider's OPC responsibilities do not end until the new provider has accepted the member for services.

## **Substance Use Commitment**

Involuntary Substance Abuse (SA) commitments generally take a great deal of coordination between community-based outpatient providers (SAIOP, SACOT, etc.) and potential inpatient treating facilities (state Alcohol and Drug Abuse Treatment Facilities, local Facility Based Crisis or detoxification facilities). An SA commitment order is a hybrid of inpatient and outpatient care. SA commitments are for 180 days, of which 45 consecutive days can be inpatient. If longer inpatient time is needed inpatient, a re-hearing must be held. At this hearing, 90 days can be ordered inpatient. Members under SA commitment who do not comply with treatment can be picked up by law enforcement, evaluated in the community and then admitted to a 24 hour treatment facility if inpatient criteria are met (without a new petition). In such cases, the Network Provider must complete Request for Transportation Order and Order (Committed Substance Abuser Fails to Comply with Treatment or is Discharged from 24-Hour Facility AOC-SP-223), available here: <http://www.nccourts.org/Forms/Documents/854.pdf>, and submit to the Clerk of Court, with a copy to the assigned Smoky care coordinator.

Once the pick up order is issued, the member will be located by law enforcement and brought to you for evaluation. Please remember to file this request early in the day to allow for sufficient time for the individual to be presented for a face-to-face evaluation. If, upon evaluation, you determine that the member meets inpatient criteria, you can arrange for the individual to be admitted to an inpatient SA treatment facility. Similar to the OPC process, each county may have a different process for SA commitments and pick up orders. As a Smoky Network Provider, it is your responsibility to understand and follow the applicable county process.

# Section 12: Transition, Discharge and Provider Closures

Network Providers are required to refer members for specialty care or to other contracted providers in response to a member request, change in member's level of care, or change in the Network Provider's status within the Closed Network. You must ensure continuity of care for members in such circumstances, limit potential disruption in services and cooperate with all transition and discharge activities, including but not limited to complying with all referral and documentation requirements. In the event of a provider closure (voluntary or involuntary), the same requirements apply. **Network Providers are required to notify Smoky 60 days in advance of a voluntary closure of a site, service, or regional or state-wide business operations.** Upon receipt of such notice, we will send you a written confirmation of withdrawal from the network, confirming the effective date of your contract termination.

## Member Request

In the event that a member requests to change providers, you must assist the individual in transitioning to the new provider of his or her choice. This includes providing them with a list of alternate providers, making the new appointment or working with the Call Center to get an appointment with the new provider, and ensuring that all health records necessary to ensure continuity of care are shared with the new provider as soon as possible. It is not acceptable to discourage a member from selecting a new provider or practitioner, or charge a fee for the transfer of medical records.

## Change in Level of Care

In the event that you determine a member's needs have changed such that the current service or level of care that you provide is no longer clinically appropriate, you must offer education and assistance to the member about available options and best practices. Once a new service and/or service provider is identified, you must assist the individual in transitioning to the new provider of his or her choice as outlined above. It is never acceptable to maintain an individual in a service or level of care that is not medically necessary solely because you are not contracted to offer the service or level of care that would be more appropriate.

## Voluntary Provider Closure

In the event that a Network Provider is voluntarily closing a site, service or operations, the following information must be communicated in writing to [ProviderInfo@smokymountaincenter.com](mailto:ProviderInfo@smokymountaincenter.com):

- Whether the entire organization is closing, or only a part of it, and which part(s) or site(s), and also

whether you are closing all operations within the State of North Carolina;

- The date of site closure, end of operations, or effective date of specific service elimination;
- A list of the names and dates of birth of affected members and the services they are currently receiving;
- Which notifications you have made and when (e.g., to government agencies, to members, to other providers), and the method of such notifications;
- A list of consumers currently receiving medication management services, with prescription due dates. You are strongly encouraged to issue ninety (90) day prescriptions to individuals prior to closure or service termination, when applicable;
- Whether you have made any arrangements for referral of Smoky members to other providers;
- Identity and contact information for the primary person within the organization responsible for coordination of member referrals;
- A written plan for the transfer to the receiving provider for affected members, including a master list of such individuals;
- A list of credentialed practitioners who will no longer be employed by you, if applicable; and
- A list of employees who will continue to have access to the AlphaMCS system during the closing process, including which specific functions within AlphaMCS, and the date such access should be terminated.

In voluntary closure situations, you must send a written notification to members/ guardians advising of the closure, including effective date, must immediately begin to work on referrals of members to other service providers. Smoky will also send a written notice to affected members and/or guardians. If you have not provided any services to Smoky members and have no active service authorizations within the preceding 90 days, then no notification to members is necessary.

## **Involuntary Provider Closure**

In the event that Smoky decides not to renew your contract, site or service, or decides to terminate or suspend your contract, we will send you a written notice with guidance regarding member transition. It is not acceptable to interfere with or prevent member transition in such circumstances, or to discourage the member from transitioning to another Network Provider. The written notice will include a form you must complete and submit within 5 days of receipt of the notice in order to help us gather the following information:

- A list of the names and dates of birth of affected members and the services they are currently receiving;
- A list of consumers currently receiving medication management services, with prescription due dates. You are strongly encouraged to issue ninety (90) day prescriptions to individuals prior to closure or service termination, when applicable;
- Whether you have made any arrangements for referral of Smoky members to other providers;
- Identity and contact information for the primary person within the organization responsible for coordination of member referrals;
- A written plan for the transfer to the receiving provider for affected members, including a master list of such individuals;

- A list of credentialed practitioners who will no longer be employed by you, if applicable; and
- A list of employees who will continue to have access to the AlphaMCS system during the closing process, including which specific functions within AlphaMCS, and the date such access should be terminated.

For involuntary closure situations, Smoky will provide assistance with member referrals but transition is still your primary responsibility. We will also send a written notice to affected members and/or guardians explaining our decision and the transition process, including notification of other provider choices available, if any.

## **Closure Responsibilities**

Regardless of the reason, if your contract is not renewed, is terminated or voluntarily withdrawn in its entirety, please note the following requirements:

- If requested by the receiving provider, you must actively participate in treatment team, transition and/or discharge planning meetings until such time as all members in your care have been transitioned or discharged.
- You may be subject to a final post-payment review to occur within 60 days of contract non-renewal/ termination/ withdrawal.
- You must submit a Master Records List which includes: Member's Name, Service Record Number, Date of Birth, Last Date of Service, Medicaid Number and County of Medicaid Origin, if applicable.
- All claims for services must be submitted within 60 days of contract non-renewal/ termination/ withdrawal. Claims will be adjudicated on the published checkwrite schedule, unless Smoky suspends your final payment to ensure compliance with all transfer and closure requirements outlined in this Section:
  - If you fail to comply with member records transfer or other referral or transition obligations, we reserve the right to withhold any remaining payments that may be due until such time as the Smoky Legal & Compliance department approves release of funds.
  - If you fail to submit an acceptable records management plan, we reserve the right to withhold any remaining payments that may be due until such time as the Smoky Legal & Compliance department approves release of funds.
  - If you owe any outstanding overpayments or other amounts to Smoky, we will apply any remaining payments that may be due against your accounts receivable before releasing any funds remaining.

## **Records Maintenance and Retention Plan**

You must submit a written plan for maintenance and storage of all records of services provided to Smoky Health Plan members at least 30 days prior to the end date of your contract. Records must be stored in an environment that ensures the continued preservation and safeguarding of records to protect their privacy, security, and confidentiality for the duration of the statutorily required record retention period. The written plan must include

a copy of your record storage log and documentation that outlines where the records are stored, the designated custodian of records, and contact information for the custodian of records. Smoky has the sole discretion to approve or disapprove such plan.

If the plan is not approved, we may require you to arrange for electronic or paper copies of such records to be transferred to our possession within 15 days of the request. You must provide a copy of the record storage log and contact information for a staff person who will assist with Smoky taking possession of the records. Records must be transferred in an organized and searchable format.

**Paper Record Storage Logs must include:**

- SMOKY/Department
- Date of storage
- Series/box number (Box 1 of 3)
- Start date and the end date of the contents in the box
- Location of where the box is stored
- Record type or the name of the individual. Record type refers to the classification of the particular information contained the box. Please store records of the same type in the same box.
- Record ID number or any other identifying number or information.
- Date of birth is recorded for individual service records. In the case of personnel records, the employee's date of birth is to be recorded for quick reference.
- Timeframe of the information stored in a particular box. For example, you would record an admission of 1/2/09 –9/13/09, or an employment period of 2/12/09 – 12/13/09 or a specific timeframe (e.g., October 2002 Cost Reporting, etc.).

**\*\*\*COMING SOON: RETENTION REQUIREMENTS\*\*\***



# Section 13: The NC Innovations Waiver

This Section is intended to provide a general overview of the Innovations Waiver for Network Providers who may not be familiar with services for individuals with intellectual and/or developmental disabilities. As we move forward with integrated care, it is important that Network Providers develop relationships across the service system in order to treat the whole person, including learning more about treating individuals with co-occurring MH/SA and I/DD needs. This Section also includes requirements specific to providers of Innovations Waiver services.

**What is the NC Innovations Waiver?** The NC Innovations Waiver is a home and community based services (HCBS) waiver that allows persons with intellectual and/or developmental disabilities to receive services in the community instead of institutions (including state facilities such as J. Iverson Riddle Developmental Center or Intermediate Care Facilities known as ICF-IIDs). The Waiver includes many services and supports designed to integrate the person with disabilities into his or her community and help him or her to be as independent as possible.

**How does someone become eligible for Waiver services?** NC Innovations is a capitated or slot-based program. Slots are allocated by DHHS, and we are required to serve a set number of persons each year through Innovations. Unfortunately, there is more demand for the program than there are available slots. Because of this, we maintain a waitlist for NC Innovations called the Registry of Unmet Needs. Eligibility is determined by availability of a slot and an approval process that requires formal assessment of cognitive and adaptive functioning conducted by licensed psychologists, psychological associates or physicians as appropriate based on the disability of the participant.

**What is the Registry of Unmet Needs?** The Registry of Unmet Needs is a list of persons that are considered potentially eligible for NC Innovations.

**What does potentially eligible mean?** To be considered potentially eligible for NC Innovations, documentation of an intellectual disability or a closely related condition other than mental illness and information about the resulting impairment to adaptive functioning is required.

**What is an intellectual disability?** Intellectual disability involves impairments of general mental abilities that impact adaptive functioning. Typically, a person has an intelligent quotient (IQ) of 70 or below that impacts the person's ability in the conceptual, social, and practical domains of adaptive functioning in a clinically significant way. Intellectual disability is considered a chronic condition and must manifest during the developmental period – typically prior to the age of 22. It often co-occurs with other mental conditions like depression, attention-deficit/hyperactivity disorder, and autism spectrum disorders.

**What does clinically significant mean?** Clinically significant is usually defined as deficits in cognitive ability or adaptive function that is two standard deviations below what a typically developing person would score on

standardized tests that are administered by psychologists. With intelligence tests, a score of 70 is two standard deviations below the average. Scoring is similar for standardized tests of adaptive functioning.

**What is a closely related condition?** Closely related conditions refers to individuals who have a severe, chronic disability that is attributable to cerebral palsy, epilepsy, or any condition, other than mental illness, found to be closely related to an intellectual disability because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of persons with an intellectual disability. The condition must be chronic and manifest before the age of 22. There must be documentation that the person has substantial functional limitation in 3 of the 6 identified major life activities. Autism spectrum disorder is an example of a related condition when it is not co-occurring with an intellectual disability.

**What are the 6 major life activities?**

- Self-care (ability to take care of basic life needs such as food, hygiene, and appearance)
- Understanding and use of language (ability to both understand others and to express ideas or information to others either verbally or non-verbally)
- Learning (ability to acquire new behaviors, perceptions, and information, and to apply experiences to new situations)
- Mobility (ambulatory, semi-ambulatory, non-ambulatory)
- Self-direction (managing one's social and personal life and ability to make decisions necessary to protect one's life)
- Capacity for independent living (age-appropriate ability to live without extraordinary assistance)

**How long does a person have to wait for Innovations?** There are approximately 1,000 persons waiting for Innovations Waiver services across the State. Smoky is allowed to fill a very limited number of slots each year. The number of slots available varies based on a number of factors which include legislative actions regarding the State Medicaid budget, lifespan and support needs of current Waiver participants, and geographic location. Therefore, it is very difficult to predict the length of wait for Innovations services. While waiting, a person that is identified as potentially eligible may receive state funded I/DD services and/or services available due to the savings realized through managed care (Respite and Supported Employment funded through (b)(3) dollars).

**Can someone be terminated from the Waiver?** Yes, there are a number of reasons why Smoky might have to terminate a slot. For example, Innovations Waiver participants must receive at least one service per month to avoid possible termination from the Waiver. These services are authorized because they have been determined necessary to ensure the health and safety of the person receiving services. If they are not being provided, we must question whether the person remains eligible, being mindful of the long waiting list for services.

**Why is it called a Waiver?** It is called a "waiver" because CMS has waived some of the requirements of the Social Security Act that traditionally apply to Medicaid. For example, the Innovations Waiver includes services and supports such as home modification and respite that are not within the scope of services traditionally covered by Medicaid.

**How long has this Waiver been in existence?** The NC Innovations Waiver was originally approved in 2008 for use as part of the Piedmont Behavioral Health (PBH) 1915(b)/(c) waiver model in five counties. The previous HCBS waiver in North Carolina was known as the CAP-MR/DD Waiver, later called the CAP-I/DD Waiver. Both the CAP-I/DD Waiver and the Innovations Waiver were drafted by DMA and approved by CMS through a waiver application process. The rest of the state continued to operate under the CAP-I/DD Waiver until the 1915(b)/(c) waiver model was expanded statewide beginning in 2012. Smoky began Waiver operations on July 1, 2012.

**Are there any guidelines or polices for the Waiver?** DMA issued an Innovations Technical Manual to serve as a guide on June 25, 2012; this document was revised in September 2013 and ultimately replaced by Clinical Coverage Policy No. 8P, effective August 1, 2014.

**Will there be any changes to the Waiver?** The Waiver was renewed and amended effective August 1, 2013, and a second Waiver amendment is pending CMS approval with a target date of January 1, 2016. Any changes to the Waiver must be approved by CMS and are posted to the DMA website for comment. We have a monthly Innovations Stakeholder meeting to discuss and receive feedback about upcoming changes.

**Does the Waiver have any limits?** Yes. Below is a summary of current limits. Note that some, but not all, limits may be exceeded for children under age 21 under the EPSDT benefit discussed at Section 6 of this Manual.

- The Innovations Waiver has a **\$135,000.00** annual budget ceiling per participant established by DMA and approved by CMS. Any request to exceed that limit will result in denial of the plan. If an individual's needs cannot be met under the \$135,000 cost limit, he or she should be evaluated for referral and placement in an ICF-IID.
- Adults over 21 who live in private homes cannot be authorized for more than 84 hours per week for any combination of community networking, day supports, supported employment, personal care and/or in-home skill building.
- Children under 21 who live in private homes cannot be authorized for more than 54 hours per week during the school year, or 84 hours per week when school is not in session, for any combination of community networking, day supports, supported employment, personal care and in-home skill building.
  - Adult and child beneficiaries who live in private homes with intensive support needs may request authorization from the LME/MCO for up to an additional 12 hours per day of in-home intensive supports to allow for 24 hours per day of support. There are specific criteria for approval of this service based on the individual's assessment results and it must be reviewed every 90 days.
- Adults over 21 who receive residential supports cannot be authorized for more than 40 hours per week for any combination of community networking, day supports and supported employment services.
- Children under 21 who receive residential supports cannot be authorized for more than 20 hours per week during the school year, or 40 hours per week when school is not in session, for any combination of community networking, day supports and supported employment services.
- Individual Goods and Services cannot exceed \$2,000 per plan year.

- Payment for attendance at classes and conferences may not exceed \$1000 per plan year for participants (under Community Networking).
- Payment for attendance at classes and conferences may not exceed \$1000 per plan year for caregivers (under Natural Supports Education).
- Community Transition funds are limited to \$5000 over the duration of the Waiver.
- Assistive Technology Equipment & Supplies are limited to expenditures of \$15,000 over the duration of the Waiver.
- Home Modification funds are limited to expenditures of \$20,000 over the duration of the Waiver.
- Vehicle Adaptation funds are limited to expenditures of \$20,000 over the duration of the Waiver.

**Do all Waiver participants receive care coordination?** Yes, we are required to assign a care coordinator to each Innovations Waiver participant. The care coordinator must conduct monthly monitoring visits to ensure the health and safety of individuals on the Waiver. Most monitoring is done face to face, although telephonic monitoring may occur as needed. The care coordinator also works with the family and service provider to develop and submit an Individual Support Plan (ISP) during the participant's birth month.

**Is Respite available under the Waiver?** Yes. Respite services provide periodic or scheduled support and relief to the primary caregiver(s) from the responsibility and stress of caring for the individual. The service enables the primary caregiver to meet or participate in planned events, and to have planned time for him/her and/or family members. Respite may be utilized during school hours for sickness or injury. Respite may include in and out-of-home services, inclusive of overnight, weekend care, or emergency care (family emergency based, not to include out of home crisis). The primary caregiver is the person principally responsible for the care and supervision of the beneficiary and must maintain his/her primary residence at the same address as the beneficiary. This service may not be used as a daily service in individual support. Respite Care may not be provided by any person who resides in the beneficiary's primary place of residence. The cost of 24 hours of respite care cannot exceed the per diem rate for the average community ICF-IID Facility. If providing Nursing Respite, the worker must be a Licensed RN or Licensed LPN in North Carolina.

**Are there copayments for Innovations Waiver services?** No. There is no copayment for the services available through the NC Innovations waiver, but there may be a copayment for medical services reimbursed by DMA. A copayment is a fee that Medicaid beneficiaries are required to pay when they receive certain services. Copayments often are \$3.00 depending on the type of service. If the NC Innovations participant is unable to pay the copayment, many offices will allow the individual or family to open an account and pay the amount owed as a copayment at a later date. The following services may require a copayment for NC Innovations participants:

- Visits to a medical doctor
- Prescriptions
- Specialist visits
- Optical services and supplies
- Clinic services
- Hospital emergency room visits when emergency care is not needed

- Dental services

## **Innovations Provider Responsibilities**

Prior Authorization: All Innovations Waiver services, with the exception of Crisis Services, require prior authorization by Smoky. Innovations providers work with the assigned Care Coordinator to acquire prior authorization for services.

- Innovations providers are required to actively participate in the development of the ISP by attending meetings scheduled by the Care Coordinator and/or the person receiving Innovations Waiver services.
- An ISP will be developed at the time an individual is admitted. Services must be implemented within 45 days of ISP approval.
- A new ISP, to be implemented on the first day of the month following the individual's birth month, will be developed on an annual basis thereafter.
- The ISP is developed using a person-centered planning process and must verify a proper match between the participant's needs and the service and/or supports provided. All services, paid and unpaid (including natural supports) should be reflected in the ISP. Care coordinators will never ask someone to sign a plan of care the member or family disagrees with, but may provide education about Waiver limits.
- The ISP is signed by the Care Coordinator, the person receiving Innovations Waiver services and/or the legally responsible person if applicable. Other persons that participate in the development of the ISP may sign if desired.
- Upon completion, the Care Coordinator submits the ISP to the Smoky Clinical Operations department for approval. The ISP must be reviewed against medical necessity criteria and service definitions found in DMA Clinical Coverage Policy No. 8P. The Care Coordinator also completes service authorization requests (SARs) for each distinct service in the Alpha MCS system.
- The Innovations provider is responsible for ensuring prior authorization is acquired prior to the provision of Innovations Waiver services. The Innovations provider must implement services on the effective date of the authorization within the parameters outlined in DMA Clinical Coverage Policy No. 8P - NC Innovations.

Planning Responsibilities: All Innovations providers are required to actively participate in the person-centered planning process. The ISP outlines long-range outcomes for the person receiving Waiver services. The Care Coordinator, in collaboration with the person-centered planning team, is responsible for developing the long-range outcomes. The Innovations provider is responsible for developing the short-range goals that help the person receiving services achieve the identified long-range outcomes. Each short-range goal must include the strategies and interventions that direct support professionals will use to help the person receiving services achieve the goal. Innovations providers are responsible for monitoring provision of the services that they have been authorized to provide. This includes regular review and, as necessary, adjustment of short-range goals to enable the person receiving services to achieve his/her highest success. The Innovations provider is responsible for ensuring direct support professionals receive supervision as required by DMA Clinical Coverage Policy No. 8P

- NC Innovations.

Scheduling: The Innovations Waiver is expected to leverage natural and community supports and foster the development of stronger natural support networks that enable Innovations Waiver participants to be less reliant on formal support systems. To achieve these outcomes, the Innovations Waiver requires that providers ensure that services and/or supports are rendered to participants in accordance with an established schedule or plan. The ISP indicates the average weekly hours of service and/or supports to be used and the total number of authorized units in an approval period. Smoky sends authorizations to the providers identified in the ISP for the rendering of identified services and/or supports. The community-based service provider is charged with implementing the Innovations participant's ISP by providing services and/or supports that enhance the participant's quality of life as defined by the participant.

The weekly schedule is a tool that is used in plan development. The purpose of the schedule is to help determine what is important to/for an Innovations Waiver participant. To meet requirements of the Innovations waiver, natural and community supports should be scheduled first, along with the participant's interests and habits. Because of the goals embedded in the Waiver of leveraging natural and community supports, formal supports should be built around natural and community supports. The weekly schedule must take into account many things such as when a person learns best and when they need breaks. The weekly schedule informs the ISP. The weekly schedule reflects the generally scheduled hours of service each day. It is a projection of the Innovations Waiver participant's typically scheduled week and a guide for consideration during mandated monitoring conducted by Smoky. Thus, there is flexibility around service and/or supports delivery that allows for non-routine deviations due to illness, participant choice, or unexpected events.

Deviations are made only at the request of the participant – not for provider convenience. Deviations must be documented by the provider agency. If there is to be a routine/ongoing deviation to the schedule due to changes in the participant's wants or needs, it is recommended that the person-centered planning team update the weekly schedule to reflect the change. Such updates will encourage better communication between all parties. Under no circumstances should the schedule be amended based on the needs of the provider agency. Unless there is a change to the total number of hours per year, the updated schedule would not need to be submitted to or approved by Clinical Operations but would be uploaded into the electronic record by the Care Coordinator. Once the schedule is established, only changes initiated by the participant or legally responsible person (LRP) may occur. Back-up Staffing Incident reports must be completed for all deviations that are not service breaks. Post-payment reviews and routine monitoring reviews will audit documentation of deviations from the schedule and a Plan of Correction may be required. \*\* Clear notation on grids, services notes, or on a QP communication log regarding episodic changes at the participant's/LRP's request serve as evidence of adherence to the intent of the Innovations Waiver.

Documentation: Innovations providers are required to document services as outlined in the DMH/DD/SAS Records Management & Documentation Manual, APSM 45-2, and as specified in this Provider Operations Manual. This includes, but is not limited to, adequate documentation of required staff training and service notes that include time in/ time out.

Back-up Staffing: During the person-centered planning process, an agency Back-up Staffing Plan is developed. The Innovations provider Back-up Staffing Plan for services authorized must be indicated in the “Agency Back-Up (mandatory)” section of the ISP. The Innovations provider is required to provide this information during the person-centered planning process. The ISP should also explain how the person receiving services needs shall be met when there is failure to provide back-up staffing, especially in the event of an emergency. The person receiving services cannot waive the Innovations provider’s responsibility to identify the mandatory Back-up Staffing Plan. However, the person receiving services may choose to decline back-up staffing offered by an Innovations provider. Failure to provide mandatory agency back-up staffing is considered a Level 1 Incident. When a back-up staffing incident occurs, the Innovations provider agency must submit a Back-up Staffing Incident Report within 72 hours of the incident into the AlphaMCS system. Questions about Back-up Staffing Incident Reports should be addressed to [incidentreport@smokymountaincenter.com](mailto:incidentreport@smokymountaincenter.com). The Back-up Staffing Incident Report is required when:

- Scheduled services do not occur because no back-up direct support professional is available.
- The person receiving services declines the back-up direct support profession offered by the provider agency

Examples of Back-up Staffing Level 1 Incidents include but are not limited to:

- Regularly scheduled direct support professional is out due to illness. Back-up direct support professional is offered but person receiving services did not want to work with the offered direct support professional.
- Regularly scheduled direct support professional quit. Back-up direct support professional was offered but person receiving services did not want to work with the offered direct support professional.
- Regularly scheduled direct support professional quit. No Back-up direct support professional was offered or available and regularly scheduled services do not occur.
- Direct support professional or person receiving services did not notify the supervisor that regularly scheduled services did not occur until several days after the fact.
- New regularly scheduled direct support professional is in the process of being hired. Back-up direct support professional offered during interim but declined.

Service breaks do not require the submission of a Back-up Staffing Incident Report. Service breaks occur when a participant misses services for holidays, family vacations, weather conditions, illnesses, and scheduling conflicts that cause a brief interruption in services. Service breaks must be documented by the Innovations provider and monitored by the Care Coordinator. Examples of service breaks include but are not limited to:

- Person receiving services had a doctor’s appointment and services were not provided.
- Person receiving services went on vacation and did not receive services.
- Person receiving services not utilizing all authorized service units available. A person-centered planning meeting should occur to review the needs of the person receiving services. If the service continues to be a need, other Innovations providers may be considered.

## Guidance for Using Protective Devices

Innovations Waiver services are home and community based services provided to persons with intellectual and/or developmental disabilities in the home and community of his/her choice. These services are provided to persons that would otherwise receive services in an intermediate care facility for individuals with intellectual disabilities. Because of this, many of the rules that Innovations Waiver service providers must follow are written for facilities. This causes confusion for persons receiving, providing, and monitoring Innovations Waiver services. The purpose of this section is to clarify the application of rules regarding protective devices to home and community-based Innovations Waiver services.

Protective devices, as defined at 10A NCAC 27C .0102(b)(20), are devices used to provide support for persons who are medically fragile or to enhance the safety of persons that are self-injurious. Smoky must ensure that protective devices are monitored in accordance with 10A NCAC 27E .0105. Sometimes, protective devices are used to control the behavior of persons. Protective devices that are used to control a person's behavior must be treated as a restrictive intervention and must be monitored in accordance with 10A NCAC 27E .0104. Smoky provider contracts require all provider agencies to have a Human/Client Rights Committee in accordance with 10A NCAC 27G .0504. In order to ensure adherence to these rules, we require the following for all Innovations Waiver participants:

- During development of the ISP, the team will consider all material supports the person needs to live successfully in the community. These needs will be documented in Section B – Material Supports of the Risk/Support Need Assessment. The identified material support needs will be discussed by the ISP team. Some material support needs may be identified as a protective device. Each material supports considered in the discussion must be identified as either a protective device or behavioral control in the Medical/Behavioral “What others need to know to best support me...” section of the ISP.
- If a material support is identified as a protective device, the provider agency must review the material support(s) through their Human/Client Rights Committee annually in conjunction with development of the ISP.
- If any member of the person's ISP team expresses concern that the material support is being used for behavioral control, the provider agency must review the material support through their Human/Client Rights Committee in accordance with 10A NCAC 27E .0104.
- When the Care Coordinator is monitoring services, the participant/legally responsible person signature on the ISP will constitute consent for material support items deemed protective devices by the ISP team. Material items that are deemed protective devices will not automatically be considered a restrictive intervention. However, if monitoring reveals that a protective device appears to be used for the purpose of behavioral control, the Care Coordinator will complete an investigation referral. If monitoring reveals potential abuse or neglect of the participant, the Care Coordinator will file an APS report with the applicable county Department of Social Services.



## Relative as Direct Support Employee (RaDSE)

The NC Innovations Waiver is designed to leverage existing natural and community supports while fostering the development of stronger natural support networks. This enables Innovations participants to be less reliant on formal support systems. However, there are times when it is necessary for relatives/legally responsible persons that share a home with the Waiver participant (“relative”) to provide paid supports in order to ensure that the participant is able to remain in the home and community of his/her choice, particularly in our more rural communities. “Legally responsible person” means the court appointed guardian for an adult who has been adjudicated incompetent.

For this reason, DMA Clinical Coverage Policy No. 8P - NC Innovations allows for Innovations providers to employ relatives to provide certain Innovations Waiver services (In-Home Skill Building, Personal Care, In-Home Intensive Supports and Residential Supports) within specific parameters. (Residential Supports may not be provided by parents, step-parents, adoptive parents, or other individuals living in the participant's natural home.) Innovations providers must acquire prior approval from Smoky before employing a relative to provide services to a participant.

With feedback from the Smoky Innovations Stakeholders Committee, Smoky has created a completely electronic prior approval procedure for Relative as Direct Support Employee (RaDSE) requests. The procedure must be initiated by the Innovations provider through DocuSign. Complete instructions and the link for beginning the process is available at <http://www.smokymountaincenter.com/providers.asp?section=radse>. The form requires the Innovations provider to enter detailed information that will provide Smoky with all information necessary to approve or deny the request. Completion of the form will generate a prior approval request. The form will be reviewed for complete information and a decision rendered within 14 days. Please note this form is required to be submitted annually, in conjunction with the ISP. Approval in one year does not guarantee approval in subsequent years.

Smoky will review location information and attestations indicated on the request form and an authorization decision will be made based on this information. For approvals, the Innovations provider will receive the approved DocuSign form. For denials, the Innovations provider will receive the denied DocuSign form and a formal letter that explains the decision. Rejections due to improper or incomplete requests will not be followed by a formal letter. If the request is rejected because of incomplete information, the provider may resubmit. **Please note that the NC Office of Administrative Hearings has determined that RaDSE decisions are not appealable, but you or the participant may file a grievance by calling the Smoky Customer Services Line at 1-888-757-5726.**

Relatives providing paid supports is not the preferred option for adults on the Innovations Waiver. It is our hope that relatives are allowed to be just that, relatives, and provide the same natural supports as they would for any family member. Some of the questions family members and employing providers should ask themselves are:

- Is this about the participant's wishes, desires and needs or about supplementing a family member's income?
- As an adult is it appropriate or best for the individual to still have mom and dad with the participant throughout the day?
- If a family member supports an individual from birth onwards into adulthood, does the individual learn to adapt to different people and increase his/her flexibility and independence?
- If a participant with a disability is always supported by a family member, what happens when that caregiver becomes unable, through age, disability or death, to care for the participant? Who else knows how to interact with and care for the participant?
- Can a family member be a barrier to increased community integration or friendship development?
- Does having a family member as direct support staff expand the participant's circle of support or risk shrinking it?

In general, there are only two circumstances where a relative should provide paid supports. They are when:

- No other staff is reasonably available to provide the service; or
- A qualified staff is only willing to provide the service at an extraordinarily higher cost than the fee or charge negotiated with the qualified family member or legal guardian.

Therefore, requests for relatives to provide paid supports will require documented efforts of attempts to find direct support professionals through multiple Innovations providers. Ordinarily, a relative will not be approved to provide more than 40 hours of paid supports per week (or seven daily units per week). Additional paid supports by a relative may be authorized to the extent that another provider is not available or is necessary to assure the participant's health and welfare.

The Innovations provider is responsible for communicating Smoky's RaDSE decision to the affected participant and relative. It is important to remember that relatives who are direct support professionals are employees of the Innovations provider, and must comply with all requirements applicable to provider staff. The Innovations qualified professional is required to provide supervision as outlined in DMA Clinical Coverage Policy No. 8P - NC Innovations. Supervision includes clear communication regarding authorization decisions resulting from this relative as direct support employee prior approval procedure.

Smoky will review RaDSE data collected quarterly. This data will be used to inform network development decisions. Smoky is invested in ensuring a quality network of Innovations providers that, to the fullest extent possible, works towards increasing natural home and community connections for persons with intellectual and/or developmental disabilities. Requests to employ relatives should be made only after all other options have been exhausted with multiple providers.

Questions regarding this procedure may be addressed to [RaDSE@smokymountaincenter.com](mailto:RaDSE@smokymountaincenter.com).

## Alternative Family Living (AFL) Requirements

- The AFL provider must be an agency. Individuals and independent practitioners may not contract with Smoky to operate an AFL.
- The AFL provider must maintain personnel files for all employees, including documentation of training and background checks for both primary staff and back up staff.
- The AFL site must be the primary residence of the AFL Provider (includes couples or single person) who receives reimbursement for cost of care.
- If services are offered outside the scope of the AFL compensation and/or requirements, the individual providing the services must be an employee of the AFL Agency.
- If the AFL serves more than one member or a member under 18 years of age, the site must be licensed by DHSR. AFL Providers are not permitted to provide services to another member while serving a primary member for AFL services at an unlicensed site.
- A back-up Staffing Plan must be in place and the backup staff must be employees of the AFL provider.
- The AFL provider must cooperate with required annual Health and Safety Reviews completed by the Smoky Contract Performance Team.
- AFL Providers must notify the assigned Care Coordinator prior to moving a member to a new AFL site. Failure to do so may result in adverse action, including but not limited to overpayment for claims billed to wrong site and/or contract termination.
- All AFL Providers must meet Smoky insurance requirements, including coverage for General Liability, property and automobile liability.
- All documentation for service provision must meet requirements of Controlling Authority and be readily available for review upon request.

# Section 14: Block Grant Requirements

If your agency receives Federal Substance Abuse or Mental Health Block Grant funds from Smoky, you are responsible for meeting federal Block Grant (FBG) requirements. It is your responsibility to know whether you receive these funds. In order to be eligible for Block Grant funds, you must be a nonprofit entity. You will be monitored by DMH/DD/SAS and Smoky for adherence to the FBG requirements. To ensure you are prepared to meet all requirements, please refer to the 2014 archived DHHS Block Grant audit information available here: <http://www2.ncdhhs.gov/mhddsas/providers/Audits/2014samhblockgrant/index.htm>.

You are responsible for responding to all standard reporting requirements and any additional information DMH/DD/SAS or Smoky request regarding provision of federal Block Grant services. You must participate in annual required training. In addition, you are responsible for ensuring all financial documentation is filed accurately and in a timely manner.

## **Mental Health Block Grant Requirements**

The following requirements must be implemented by Network Providers for individuals, services, and/or programs funded with Federal Mental Health Block Grant dollars. It is your responsibility to know whether these requirements apply to your organization:

- Evidence that individuals served with Block Grant funds have a principal or primary diagnosis of Serious Mental Illness or Severe Emotional Disturbance (SED).
- Evidence of member, youth and/or family involvement in treatment planning and system of care.
- Evidence that the services provided are comprehensive and integrated for individuals with SED or who have multiple and complex needs.
- Member records contain a signed release of information that is time limited (no more than 12 months) with clear reference to the specific information to be released and specific language regarding the prohibition of re-disclosure.
- Evidence that funds are used to provide access to services to underserved mental health populations including homeless persons, rural populations and older adults.
- Evidence of implementation of evidenced based treatment services.
- Evidence that services are provided to meet the needs of specific eligible mental health populations.
- Demonstrate that you have a system in place to prevent inappropriate disclosure of individual records.

## **Substance Abuse Prevention and Treatment Block Grant Requirements**

The following requirements must be implemented by Network Providers for individuals, services, and/or programs funded with Federal Substance Abuse and/or Prevention Block Grant dollars, as well as certain programs funded with state service dollars. It is your responsibility to know the requirements that apply to your

organization. Please note that this Section includes the general requirements that apply to all Substance Use Prevention and Treatment populations/ programs as well as specific population/program requirements. Additional requirements may be included in your contract with Smoky for specific programs or populations listed below. Please refer to the Scope of Work in your contract to verify any additional requirements. It is your responsibility to be aware of and comply with all requirements of your contracts with Smoky.

General Requirements (Note: Not all general requirements apply to prevention only services. Please refer to your contract for verification of requirements.)

- A Comprehensive Clinical Assessment which meets the required elements of DMA Clinical Coverage Policy 8C must be completed for all individuals served.
- Recommendation regarding target population/benefit plan that is consistent with NC Tracks eligibility criteria must be completed for all individuals served.
- American Society of Addiction Medicine (ASAM) Patient Placement Criteria (Third Edition, 2013) must be utilized during the admission process to establish the appropriate type and level of care based on all six dimensions of multidimensional assessment.
- In the case of an individual with co-occurring disorders, any co-occurring mental health condition(s) must be addressed as part of the treatment continuum.
- The medical record must contain a signed, valid consent for release of information that includes an expiration date of no more than twelve months following signature, along with clear reference to the specific information to be released, and 42CFR Part 2 language including specific language that prohibits re-disclosure of information relating to substance abuse issues.
- Connection with or referral to a primary care physician (PCP) must be completed and documented. Evidence of a signed, valid consent for release of information to the PCP must be in the medical record if a referral was made.
- Tuberculosis (TB) screening must be completed at the time of admission. If the screening indicated presence of TB symptoms, the medical record must include evidence of documentation of symptoms and referral for appropriate follow-up testing and/or other services, and counseling the consumer about TB. You must meet all state TB reporting requirements while adhering to federal and state confidentiality requirements.
- Priority for admission for treatment must be as follows:
  - Pregnant injecting drug users
  - Pregnant substance abusers
  - Injecting drug users
  - All others
- The organization must widely publicize the availability of treatment services for women and admission preference for pregnant women. This can include street outreach programs, ongoing public service announcements, regular advertisements in local/regional print media, posters placed in targeted areas, frequent notification of availability of such treatment distributed to the network of community-based organizations, health care providers and social services agencies.
- The organization must make continuing education available to employees who provide services for this

population, covering substance abuse treatment, state and federal confidentiality requirements and disciplinary action that may occur upon inappropriate disclosure.

- The organization must have in effect a secure system to protect member records from inappropriate disclosure in connection with any activity supported through FBG funds.
- The organization must have a Drug Free Workplace Policy in effect.
- The organization must complete initial and subsequent NC Treatment Outcomes and Program Performance System (NC-TOPPS) at required intervals.

Women's Set Aside Funding Requirements: These services are targeted for pregnant women and/or women with dependent children, including women who are attempting to regain custody of their children. The following requirements shall be demonstrated either through direct provision or a documented sub contractual arrangement with an appropriate provider:

- Individuals served must have a principal or primary DSM-V Substance Use diagnosis
- Primary medical care needs are addressed, including referral for prenatal care and, while women are receiving such services, child care
- For individuals with children, primary pediatric needs and therapeutic needs of the children are addressed, including but not limited to immunizations, developmental needs, abuse (sexual or physical) and neglect
- Gender specific substance use disorder treatment and other treatment therapeutic interventions that may address issues of relationships, sexual and physical abuse, parenting, and child care while women are receiving these services
- Sufficient case management and transportation to ensure that women and children have access to the services outlined above
- Timely admission or referral to appropriate services
- Member assessed for pregnancy
- Active outreach programs and priority admissions directed towards pregnant women who are substance abusers
- Written program description for pregnant women and women with dependent children that includes the following:
  - Treating the family as a unit.
  - Provision for primary medical care and primary pediatric care services.
  - Provision of gender specific substance use disorder treatment.
  - Provision for therapeutic interventions for children in the custody of women in treatment.
  - Provision of sufficient case management and transportation to access services.

Requirements for Programs that Provide Services to Pregnant Women:

- Admission preference shall be given for pregnant women.
- Priority admission shall be given to pregnant IV drug users.

- The organization must make interim services available within 48 hours to pregnant women who cannot be admitted into needed services with provider agency or other appropriate treatment provider because of lack of capacity or availability. The purpose of interim services is to reduce the adverse health effects of substance abuse, promote the health of the consumer and reduce risks of transmission of disease. When appropriate, interim services shall include:
- The organization provides counseling and education about HIV and TB infection, the risks of needle-sharing, the risks of transmission to sexual partners and infants, and steps that can be taken to ensure that HIV and TB transmission does not occur.
- The organization makes referrals for HIV and TB treatment services, if necessary.
- The organization provides counseling on the effects of alcohol and other drug use on the fetus.
- The organization makes referrals for prenatal care.

Requirements for Programs that Provide Services to Persons Identified as IV Drug Users:

- Priority admission must be given to each individual who requests and is in need of treatment for IV drug use. This means that IV drug users shall be admitted to a program through the provider agency or referral to another appropriate program no later than 14 days after making the request for admission.
- If no such program has the capacity to admit the individual, the member must be admitted within 120 days after the date of such request. For these members, interim services, including referral for prenatal care if indicated, must be made available to the person no later than 48 hours after the request for admission and continue until the member is admitted into treatment. At a minimum, interim services shall include counseling and education about HIV and TB, the risks of needle sharing, the risks of transmission to sexual partners and infants, and steps that can be taken to ensure that HIV and TB transmission does not occur, as well as referral for HIV and TB treatment services if necessary.
- For individuals in need of IV treatment who cannot be placed in comprehensive treatment within 14 days, the program shall develop a mechanism for maintaining contact with the individual awaiting admission.
- If a person cannot be located for admission into treatment or if a person refuses treatment, that person may be taken off the waiting list and need not be admitted within the initial 120 day period. If the individual later requests treatment and placement on a waiting list is necessary, interim services are to be provided and placement in treatment program would need to occur within 120 days of the latter request.
- If the program is at capacity for this population, you must establish a waiting list that has a unique identifier for each IV drug user seeking treatment, including those receiving interim services while awaiting admission.
- The organization must notify DMH/DD/SAS and Smoky when the program reaches 90% capacity for this population.
- The organization must carry out activities to encourage individuals in need of such treatment to undergo treatment which may include the following:
  - Use outreach models that are scientifically sound or an approach which can be reasonably expected to be effective

- Select, train and supervise staff to provide outreach
- Contact, communicate and follow up with high risk substance abusers, their associates, and neighborhood residents
- Promote awareness among injecting drug users about the relationship between injecting drug abuse and communicable diseases such as HIV
- Recommend steps that can be taken to ensure that HIV transmission does not occur
- Encourage entry into treatment

Primary Prevention Services Requirements: Primary prevention programs are those directed at individuals who have not been determined to require treatment for a substance use disorder. Such programs are aimed at educating and counseling individuals on such abuse and providing activities to reduce the risk of such abuse.

- Priority shall be given to populations that are at risk of developing a pattern of such abuse.
- The organization must ensure that programs receiving priority develop community-based strategies to discourage use of alcoholic beverages and tobacco by individuals to whom it is unlawful to sell or distribute such beverages or products.
- The organization must develop and implement comprehensive prevention programs that include a broad array of prevention strategies directed at individuals not identified to be in need of treatment.
- Services must include activities and services provided in a variety of settings for both the general population as well as targeting sub-groups who are at high risk of substance abuse.
- In implementing these provisions, prevention providers shall use a variety of the following defined strategies:
  - Information Dissemination
  - Education
  - Alternatives
  - Problem Identification and Referral
  - Community-Based Process
  - Environmental
- The organization must use evidence-based prevention practices in the provision of services.
- The organization must deliver evidence-based programs to selected and indicated populations.
- Smoky will ensure that a total of 48 hours of Synar Amendment activities are conducted every 6 months through all contracted prevention providers. Synar Amendment activities are those designed to reduce youth access to tobacco products through community collaboration, merchant education, law enforcement and related activities or media/ public relations. At the beginning of each fiscal year, Smoky will notify each contracted prevention provider of the number of required hours that must be devoted to Synar Amendment activities per six months.



Work First/CPS Substance Abuse Initiative Requirements: This Initiative serves DSS Work First Program, Food and Nutrition Services and Child Protective Services referrals.

- A qualified substance abuse professional must be devoted to this Initiative.
- A clinician with a professional license whose permitted scope of work includes substance use disorders must conduct Comprehensive Clinical Assessments. Smoky requires that this individual be a North Carolina Substance Abuse Professional Practice Board licensed or associate licensed Clinical Addictions Specialist (LCAS or LCAS-A).
- The SUDDS V or other pre-approved alternative assessment instrument must be utilized for each member.
- A signed, valid consent for release of information between the member's referring county Department of Social Services and the organization must be in place to communicate information regarding assessment recommendations, disposition and treatment compliance.
- Monthly reports indicating treatment compliance must be submitted to DSS for each member being served.

Juvenile Justice Substance Abuse Mental Health Partnership (JJSAMHP) Requirements:

- Each member must meet the requirements of the designated target population/benefit plan of Child Substance Abuse Disorder.
- For uninsured members, the organization must require documentation of application for NC Medicaid/Health Choice.
- The organization must have a signed, valid consent for release of information with Juvenile Justice for each child being served.

# Section 15: Compliance & Quality Management

This section provides a high-level overview of your compliance and quality management requirements as a Smoky Network Provider. It is not intended to summarize every legal standard that applies to providers of MH/IDD/SA. You are required under your contract with Smoky to be familiar with all federal and state laws, rules, regulations and payor program requirements applicable to your provision of services, including but not limited to the following (referred to in your contract as “Controlling Authority”):

- Title XIX of the Social Security Act (the “Act”) and its implementing regulations, including those set forth at 42 CFR Parts 438, 441, 455, and 456 concerning care coordination, access to care, utilization review, clinical studies, utilization management, care management, quality management, and disclosure requirements.
- The North Carolina State Plan for Medical Assistance
- The North Carolina combined Medicaid Waiver authorized by CMS pursuant to sections 1915(b) and 1915(c) of the Act
- All federal and state civil and criminal laws, rules and regulations governing the provision of publicly-funded health care services
- The Anti-Kickback law codified at 42 U.S.C. § 1320a-7b(b) and its implementing regulations
- The federal False Claims Act, 31 U.S.C. §§ 3729 – 3733 and its implementing regulations
- The North Carolina Medical Providers False Claims Act, N.C.G.S. § 108A-70-10 *et seq.*
- Applicable provisions of N.C.G.S. Chapters 108A, 108D, 122C, 131D and 131E
- All federal and state member rights and confidentiality laws, rules and regulations, including but not limited to:
  - N.C.G.S. §§ 122C-52 through 56
  - The DMH/DD/SAS Client Rights Rules in Community Mental Health, Developmental Disabilities & Substance Abuse Services, APSM 95-2
  - The DMH/DD/SAS Confidentiality Rules, APSM 45-1;
  - The Health Insurance Portability and Accountability Act of 1996 (“HIPAA”)
  - The HIPAA Administrative Simplification Regulations found at 45 CFR Parts 160, 162, and 164
  - Alcohol and drug abuse patient records laws and regulations codified at 42 U.S.C. §290dd-2 and 42 CFR Part 2
- Medical and/or clinical coverage policies promulgated by DHHS in accordance with N.C.G.S. § 108A-54.2
- The Americans With Disabilities Act
- Titles VI and VII of the Civil Rights Act of 1964
- Section 503 and 504 of the Vocational Rehabilitation Act of 1973
- The Age Discrimination Act of 1975
- The Drug Free Workplace Act of 1988

- State licensure, accreditation, and certification laws, rules and regulations applicable to your operations
- DMH/DD/SAS Rules for MH/DD/SA Facilities and Services, published as APSM 30-1 and codified at Title 10A of the North Carolina Administrative Code
- DMH/DD/SAS Records Management and Documentation Manual, APSM 45-2
- The Record Retention and Disposition Schedule for DMH/DD/SAS Provider Agencies, APSM 10-5
- The Records Retention and Disposition Schedule for State and Area Facilities, APSM 10-3
- The DHHS Records Retention and Disposition Schedule for Grants
- This Provider Operations Manual
- Any other applicable federal or state laws, rules or regulations in effect at the time MH/IDD/SA services are rendered to Smoky Health Plan members

## Compliance Program

The Patient Protection and Affordable Care Act requires all health care providers to establish and implement a compliance program. You must develop a formal Compliance Plan that includes procedures designed to guard against fraud and abuse. The plan should include the following elements at a minimum:

- An internal audit process to verify that services billed were furnished by appropriately credentialed staff and appropriately documented.
- The plan will ensure that staff performing services under your contract with Smoky are not excluded from participation in Federal Health Care Programs under either Section 1128 or 1128A of the Social Security Act.
- Written policies, procedures and standards of conduct that articulate your commitment to comply with the Controlling Authority listed above.
- Designation of a Compliance Officer and Compliance Committee.
- A training program for the Compliance Officer and organization employees.
- Well-publicized systems or mechanisms for reporting suspected fraud and abuse by employees and members and protections for those reporting.
- Provisions for internal monitoring and auditing.
- Procedure for response to detected offenses and for the development of corrective action plans.
- Reporting to oversight and law enforcement agencies, including Smoky.

For more information and guidance about your compliance responsibilities as a health care provider that accepts public funding, please refer to the U.S. Health and Human Services' Office of Inspector General "Compliance 101" page at: <http://oig.hhs.gov/compliance/101/>.

Smoky has a written Compliance Plan that includes the OIG "Seven Effective Elements" and is approved by our Board of Directors. We have a Compliance Officer and Compliance Committee that are accountable to senior management, as well as procedures to ensure the compliance of Smoky and the Provider Network, including the

establishment of monitoring and auditing systems that are reasonably designed to detect conduct in violation of applicable federal and state laws, rules, regulations, guidelines, policies and standards.

## **Prevention of Fraud, Waste and Abuse**

Health care fraud, waste and abuse affects each and every one of us. It is estimated to account for up to 10% of the annual expenditures for health care in the U.S. We are responsible for preventing, monitoring and guarding against fraud, waste and abuse of public funds, and ensuring that all services and claims paid by Smoky are in compliance with Controlling Authority and Generally Accepted Accounting Principles at the point of delivery and/or payment.

Medicaid fraud is estimated by the U.S. Office of Management and Budget to cost taxpayers over \$15 billion annually. According to the National Association of State Medicaid Fraud Control Units (NAMFCU), perpetrators of Medicaid fraud run the gamut from the solo practitioner who submits claims for services never rendered to large institutions that exaggerate the level of care provided to their patients and then alter patient records to conceal the resulting lack of care. CMS, NAMFCU and other organizations have identified the following as typical schemes that providers use to defraud the Medicaid program:

- Billing for services not provided – A provider bills for services or items never rendered or furnished.
- Medical identity theft – A provider uses stolen identity to bill for services not provided, including the billing of services allegedly rendered to someone who has been discharged from care or is deceased.
- Billing for Unnecessary Services or Tests – A provider falsifies the diagnosis and symptoms on recipient records and billings to obtain payments for unnecessary services, laboratory tests or equipment.
- Billing for services that lack documentation – A provider bills for services for which the provider knows that required documentation is absent or inadequate.
- Double Billing – A provider bills both Medicaid and a private insurance company (or member) for the same treatment, or two providers request payment on the same member for the same procedure on the same date.
- Upcoding – A provider bills at a level of complexity that is higher than the service actually provided or documented. For example, billing for 60 minute therapy sessions when you only spend 5 minutes or less with the member.
- Unbundling – A provider bills for services separately (using multiple procedure codes) rather than using the fixed daily “bundled” rate or single comprehensive code.
- Billing for Unreasonable or Inflated Hours - Inflating the amount of time a provider spends with patients, for example a psychiatrist that bills for more than 24 hours of psychotherapy treatment on a day.
- Falsifying Credentials – Misrepresenting the license or credentials of a practitioner in order to bill Medicaid.
- Substitution of Generic Drugs – A pharmacy knowingly bills Medicaid for the cost of a brand-name prescription when, in fact, a generic substitute was supplied to the member at a substantially lower cost to the pharmacy.

- Billing for More Expensive Procedures than were Performed – A provider bills for a comprehensive procedure when only a limited one was administered or bills for expensive equipment and actually furnishes cheap substitutes.
- Kickbacks – A hospital requires another provider, such as a laboratory or ambulance company, to pay a certain portion of the money received for rendering services to patients in the facility. Or a provider induces Medicaid beneficiaries to enroll with the provider or request services in exchange for gifts or payments. Examples include gift cards, vacation trips, personal services and merchandise, leased vehicles, and direct payments.
- False Cost Reports – A provider includes personal expenses in its Medicaid cost reports. These expenses often include the cost of personal items.

**All Network Providers must monitor for the potential for fraud, waste and abuse and take immediate action to address reports or suspicion.** We use the following federal and state definitions and guidance in evaluating suspected fraud, waste or abuse reported to Smoky:

**Fraud** is defined as “An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable federal or state law.” 42 CFR § 455.2. The term “fraud” includes misappropriation and other irregularities including dishonest or fraudulent acts, embezzlement, forgery or alteration of negotiable instruments such as checks and drafts, misappropriation of an agency’s, employee, customer, partner or supplier assets, conversion to personal use of cash, securities, supplies or any other agency assets, unauthorized handling or reporting of agency transactions, and falsification of an agency’s records, claims or financial statements for personal or other reasons. The above list is not all-inclusive but intended to be representative of situations involving fraud. Fraud may be perpetrated not only by an agency’s employees, but also by agents and other outside parties.

**Waste** involves the taxpayers’ not receiving reasonable value for money in connection with any government funded activities due to an inappropriate act or omission by player with control over, or access to, government resources. Waste goes beyond fraud and abuse and most waste does not involve a violation of law. Waste relates primarily to mismanagement, inappropriate actions and inadequate oversight. - From the Office of Inspector General.

**Abuse** is defined as “Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary costs to the Medicaid program.” 42 CFR Part § 455.2. Abuse is also defined at 10A NCAC 22F .0301 to include “any incidents, services, or practices inconsistent with accepted fiscal or medical practices which cause financial loss to the Medicaid program or its beneficiaries, or which are not reasonable or which are not necessary including, for example, the following:

1. Overutilization of medical and health care and services.

2. Separate billing for care and services that are part of an all-inclusive procedure, or included in the daily per-diem rate.
3. Billing for care and services that are provided by an unauthorized or unlicensed person.
4. Failure to provide and maintain proper quality of care, appropriate care and services, or medically necessary care and services within accepted medical standards for the community.
5. Breach of the terms and conditions of participation agreements, or a failure to comply with requirements of certification, or failure to comply with the provisions of the claim form.”

For more information, please refer to this helpful Fraud, Waste and Abuse toolkit for providers, created by CMS and available at:

<https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/Downloads/fwa-overview-booklet.pdf>.

## False Claims Act

According to the U.S. Department of Justice, the False Claims Act (FCA), 31 U.S.C. §§ 3729 – 3733, was enacted in 1863 by a Congress concerned that suppliers of goods to the Union Army during the Civil War were defrauding the Army. The FCA provided that any person who knowingly submitted false claims to the government was liable for double the government’s damages plus a penalty for each false claim. Since then, the FCA has been amended several times to increase the penalties.

The FCA covers fraud involving any federally funded contract or program, with the exception of tax fraud, which is covered by a separate IRS whistleblower program. **Under the FCA, it is illegal to submit claims for payment to Medicare or Medicaid that you know or should know are false or fraudulent.** Filing false claims may result in fines of up to three times the program’s loss plus \$11,000 per claim filed. Under the civil FCA, each instance of an item or a service billed to Medicare or Medicaid counts as a claim, so fines can add up quickly. The fact that a claim results from a kickback or is made in violation of the Stark law also may render it false or fraudulent, creating liability under the civil FCA as well as the Anti-Kickback Statute or Stark law.

Under the civil FCA, no specific intent to defraud is required. The civil FCA defines "knowing" to include not only actual knowledge but also instances in which the person acted in deliberate ignorance or reckless disregard of the truth or falsity of the information. There also is a criminal FCA (18 U.S.C. § 287). Criminal penalties for submitting false claims include imprisonment and criminal fines. Practitioners have gone to prison for submitting false health care claims. The OIG also may impose administrative civil monetary penalties for false or fraudulent claims.

The civil FCA contains a whistleblower provision that allows a private individual to file a lawsuit on behalf of the United States and entitles that whistleblower to a percentage of any recoveries. Whistleblowers could be current or former employees, patients, or competitors. Because you receive Medicaid funds, you are required to establish and implement an education plan for your employees, managers, contractors and agents, which includes written policies and detailed guidance on the FCA, state false claims laws, and the rights and

protections afforded whistleblowers under the FCA and its state counterparts.

## Compliance Hotline

You are required to establish a system or mechanism for your employees, contractors and persons receiving services to report potential fraud, waste, abuse or violations of the FCA. You must also ensure that your employees, contractors and persons receiving services are aware of the following mechanisms to report potential fraud, waste, abuse or violations of the FCA directly to Smoky or other oversight authorities:

- Call the Smoky Confidential Compliance (Fraud and Abuse) Hotline at 1-866-916-4255 (24 hours a day, seven days a week, allows for anonymous reporting). Reports may also be made by calling any of the Smoky office numbers and asking for the Compliance Officer.
- Report online at <https://www.integrity-helpline.com/smc.jsp> (allows for anonymous reporting)
- Call the NC Medicaid fraud, waste and program abuse tip line at 1-877-DMA-TIP1 (1-877-362-8471)
- Call the U.S. Office of Inspector General's Fraud Line at 1-800-HHS-TIPS (1-800-447-8477)

We encourage all members and Network Providers to report any suspicious billing practices or other activity you think may be fraud, waste or abuse (including Medicaid beneficiary fraud). Reporters can remain anonymous or leave their name, but detailed information will help us with our investigation. If you contact us, please provide the name/MID of the member involved, the name of the provider, the date(s) of service, the amount of claims billed or paid and a description of the fraudulent or suspicious activity. Network Providers may not intimidate or impose any form of retribution against an employee, agent, or member that utilizes our reporting system in good faith to report suspected violations.

## Continuous Quality Improvement

Smoky is committed to working in collaboration with our Network Providers to achieve the highest standards of quality in service delivery. We understand the important role of quality management in protecting members and promoting high quality treatment. We maintain a strong commitment to continual improvement of our programs and services and the services provided directly to members. A focus on quality requires basic principles, which include:

- Commitment to the involvement of members in all areas and levels of the service system in regards to analysis, planning, implementing changes, and assessing quality and outcomes.
- Commitment to strengthen systems and processes – By viewing the system as a collection of interdependent processes we can understand how problems occur and can strengthen the system as a whole.
- Encouraging participation and teamwork – Every member of the system can help assure quality if they are included in processes and are empowered to solve problems and recommend improvements.

- Decisions are based on reliable information – By collecting and analyzing accurate, timely and objective data we can identify system problems, implement changes and measure progress.
- Improvement in communication and coordination – Various members of the system can work together to improve quality if they share information freely and coordinate their activities.

Smoky has numerous quality, satisfaction, performance indicator and financial reporting requirements under our DMA and DMH/DD/SAS contracts, including requirements to measure and report indicators in the following domains: Access, Availability, Quality of Care, Quality of Services, Appropriateness of Services, System Performance, and Satisfaction. The Quality Improvement Committee (QIC) regularly and annually evaluates Smoky's performance on these measures. The Board of Directors also maintains a Performance & Quality Committee that regularly hears reports on these measures. In addition to our URAC accreditation reviews and regular reviews by the DHHS Intra-Departmental Monitoring Team (IMT), an External Quality Review Organization (EQRO) also monitors Smoky annually, as per Medicaid regulations.

Smoky maintains an established quality structure that ensures the participation of all persons and agencies involved in the service system. The QIC is a cross functional team which includes representatives from Smoky staff, members and Network Providers. The purpose of the Committee is to ensure that we are all working together to achieve system improvements, and to monitor the overall quality of services. Smoky, alone, cannot maintain quality. This partnership is critical for success. The Smoky QIC develops a single Quality Improvement Plan for the Smoky System with input and feedback from the QIC and other relevant stakeholders. The plan identifies organizational goals and includes program description, structure, authority, accountability, a requirement for a work plan and an annual report. Through the required Annual Report, Smoky makes available information about its performance to Network Providers, practitioners, members and stakeholders on the Smoky website. A printed copy of the information can be provided upon direct request to Smoky.

The continual self-assessment of services, operations and the development and implementation of plans to improve outcomes to member is a value and requirement for all Network Providers. You are required to be in compliance with all federal and state Quality Assurance and Performance Improvement standards, including but not limited to:

- The establishment of a formal Quality Committee to evaluate services, plan for improvements and assess progress made towards goals. The assessment of need as well as the determination of areas for improvement must be based on accurate, timely, valid data. Your quality assurance (QA) and quality improvement (QI) system will be evaluated during the Routine Monitoring review conducted every 2 years.
- Maintain and submit Client Rights Committee minutes if applicable
- Development and submission of your annual Quality Improvement Plan
- Participate in Performance Improvement Projects required under our DMA and DMH/DD/SAS contracts
- Report Incidents and follow-up as needed
- Cooperate with Smoky's grievance, monitoring and program integrity activities
- Actively participate in provider and member satisfaction surveys



## Satisfaction Surveys and Mystery Shopping Program

Smoky values the satisfaction of members, relatives, natural supports and other community stakeholders with the services you provide. We also value member, stakeholder and provider satisfaction with our management of services. There are various ways this satisfaction can be measured. These include annual surveys and “mystery shopping.” The goal of these initiatives would be to gather feedback on how Network Providers and Smoky perform during random and anonymous monitoring. This information can then be used to identify needed services, training or other quality improvement initiatives.

## Reporting and Monitoring of Incidents

We are required to monitor certain types of incidents that occur involving Network Providers and providers who operate within our 23 county catchment area. An incident is an event at a facility or in a service that is likely to lead to adverse effects upon a client. Incidents are classified into several categories according to the severity of the incident. **Network Providers are required to report all level II and level III incidents in the State’s Incident Response Improvement System (IRIS).** Failure to do so is a violation of your contract and the North Carolina Administrative Code. In addition, you must submit a summary of all Level I incidents to Smoky on a quarterly basis. Out of state providers must also submit paper copies of the incident report to DHHS and to Smoky.

Network Providers must implement procedures that ensure the review, investigation and follow up for each incident that occurs through its own internal Quality Management process. This includes:

- A review of all incidents on an ongoing basis to monitor for trends and patterns
- Strategies aimed at the reduction/elimination of trends/patterns
- Documentation of the efforts at improvement as well as an evaluation of ongoing progress
- Ensure that mandatory reporting requirements are followed

Smoky receives and tracks all incident reports filed in IRIS that involve providers operating in our catchment area. Upon receipt, we review incidents for completeness, appropriateness of interventions, and achievement of short and long term follow up for the member and the Network Provider’s service system. All member deaths and Level III incidents will be reviewed by Smoky’s Critical Incident Review Committee (CIRC), which is chaired by our Chief Medical Officer. The CIRC may request more extensive documentation regarding the member if deemed necessary. You must cooperate with this process and submit records as requested. Network Providers are required to develop and maintain a system to collect and track documentation on any incident that occurs in relation to a member. If concerns are raised related to the member’s care or services or your response to an incident, the CIRC will refer the matter for potential investigation.

- For more information about IRIS and your reporting responsibilities, please refer to:  
<http://www.ncdhhs.gov/providers/provider-info/mental-health/nc-incident-response-improvement-system>.

- For IRIS resources, including the Incident Response and Reporting Manual and NC IRIS Technical Manual, please refer to: <http://www.ncdhhs.gov/document/iris-resources>.

## Abuse, Neglect and Exploitation

Children receiving services from you, or whose parents, guardians or caretakers are receiving services from you, are at higher risk for potential abuse, neglect and/or exploitation. Adults with disabilities may also be more vulnerable to abuse, neglect and exploitation. County Departments of Social Services receive and evaluate reports to determine whether children and disabled adults are in need of protective services. Income is not a factor in the protective services process. The reporting of suspected child abuse or neglect or suspected abuse, neglect or exploitation of disabled adults is mandated by separate statutes in North Carolina.

Please note that reporting **is not optional** and is required in any instance where a Network Provider has “cause to suspect” abuse or neglect of a juvenile, regardless of whether another individual, entity or agency may have also reported the suspected abuse, neglect or exploitation. Reporting is also required in any instance where a Network Provider has “reasonable cause to believe” a disabled adult is in need of protective services. The statutes provide immunity from liability to anyone who files a report in good faith. Medical or clinical privilege is not an acceptable excuse for the failure to report. Please make sure that you and your staff understand and are familiar with the statutory reporting requirements listed below:

### **N.C.G.S. §7B-301. Duty to report abuse, neglect, dependency, or death due to maltreatment.**

(a) Any person or institution who has cause to suspect that any juvenile is abused, neglected, or dependent, as defined by G.S. 7B-101, or has died as the result of maltreatment, **shall** report the case of that juvenile to the director of the department of social services in the county where the juvenile resides or is found. The report may be made orally, by telephone, or in writing. The report shall include information as is known to the person making it including the name and address of the juvenile; the name and address of the juvenile's parent, guardian, or caretaker; the age of the juvenile; the names and ages of other juveniles in the home; the present whereabouts of the juvenile if not at the home address; the nature and extent of any injury or condition resulting from abuse, neglect, or dependency; and any other information which the person making the report believes might be helpful in establishing the need for protective services or court intervention.

Definitions of abuse and neglect with respect to juveniles can be found here: [http://www.ncleg.net/EnactedLegislation/Statutes/HTML/ByArticle/Chapter\\_7B/Article\\_3.html](http://www.ncleg.net/EnactedLegislation/Statutes/HTML/ByArticle/Chapter_7B/Article_3.html)

### **N.C.G.S. § 108A-102. Duty to report; content of report; immunity.**

- (a) Any person having reasonable cause to believe that a disabled adult is in need of protective services **shall** report such information to the [DSS] director.
- (b) The report may be made orally or in writing. The report shall include the name and address of the disabled adult; the name and address of the disabled adult's caretaker; the age of the disabled adult; the nature and extent of the disabled adult's injury or condition resulting from abuse or neglect; and other pertinent information.

Definitions of abuse, neglect and exploitation with respect to disabled adults may be found here: [http://www.ncleg.net/EnactedLegislation/Statutes/HTML/ByArticle/Chapter\\_108A/Article\\_6.html](http://www.ncleg.net/EnactedLegislation/Statutes/HTML/ByArticle/Chapter_108A/Article_6.html)

**NOTE:** If a report alleges the involvement of you, your employee or contractor in an incident of abuse, neglect or exploitation, you must ensure that members are protected from involvement with that staff person until the allegation is proved or disproved. You must take swift, appropriate action if the report of abuse, neglect or exploitation is substantiated.

## **Health Information Technology**

In today's information age, the provision of high quality services is often dependent upon the use of electronic health records (EHRs) instead of paper medical records to maintain people's health information, as well as other systems that involve information technology. Health information technology (health IT) makes it possible for health care providers to better manage patient care through secure use and sharing of health information. As our health care system shifts toward integrated, whole person care, health IT will become even more important. For more information about health IT, please refer to <https://www.healthit.gov/>.

As a Network Provider, you are required to have and maintain high speed internet connectivity, comply with the HIPAA Security Rule and the Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009, provide complete and accurate data in all submissions to Smoky, follow Smoky's technical support procedures including accessing the Help Desk, complete AlphaMCS Provider Portal Training, and sign and adhere to the AlphaMCS User Agreement. Use of AlphaMCS is a privilege and requires certain responsibilities, including the responsibility to prevent sharing of AlphaMCS logins, ensure that all staff complete AlphaMCS Provider Portal Training, and notify us if an individual with a login leaves your employment.

You should also be working towards compliance with North Carolina's Health Information Exchange (HIE) efforts and Medicaid EHR Incentive Programs, which provide financial incentives for "meaningful use" of certified EHR technology. The NC HIE is a secure, standardized electronic system in which providers can share important patient health information. The use of this system promotes the access, exchange, and analysis of health information and enables participating organizations to save time, reduce paperwork, facilitate more informed treatment decision-making, and improve health data analytics. Ultimately, the use of the HIE is designed to lead to improved care coordination, higher quality of care, and better health outcomes across the State of North Carolina. For more information about the HIE, please refer to <http://www.nchie.org/>.

## **Documentation Requirements**

**\*\*\*COMING SOON\*\*\***

## **Monitoring to Ensure Quality of Care**

Smoky must ensure the provision of high-quality services by our Network Providers. This includes monitoring of member health and safety, investigation, monitoring and resolution of grievance and incidents, member rights protection, ensuring provider qualification, evaluating member satisfaction, assessment of outcomes to determine efficacy of care, use of evidence-based and best practices and implementation of preventive health initiatives. We are also charged with conducting compliance reviews and audits of medical records, administrative files, the physical environment, and other areas of Network Provider service delivery including cultural competency reviews. These monitoring and program integrity activities are discussed in the next Section.

# Section 16: Audits, Monitoring & Investigations

At Smoky, we want to ensure that tax dollars are spent wisely and that members receive high-quality, appropriate care. We have an obligation to prevent fraud, waste and abuse of public funds, to investigate complaints we receive and to monitor your delivery of services. We accomplish these functions through program integrity activities that include but are not limited to billing audits, post-payment reviews, investigations, routine and focused monitoring, data mining and trend analysis, and a robust internal process for reporting concerns and requesting investigations.

Smoky employees are strongly encouraged to report any instance of potential fraud, waste or abuse occurring at Smoky or by a Network Provider. We have a robust internal reporting process and evaluate all referrals and concerns that are reported. While ensuring quality and preventing fraud, waste and abuse is the responsibility of every Smoky employee, we have two teams that are primarily responsible for program integrity and monitoring activities: the Special Investigations Unit (SIU) and the Contract Performance Team.

## **The Special Investigations Unit**

Under our DMA Waiver Contract, we are required to have a special investigations unit responsible for program integrity activities, including identification, detection, and prevention of fraud, waste, and abuse. All allegations of fraud, waste or abuse received by Smoky are routed to the SIU for review and investigation. The SIU also conducts data mining, data analysis and systematically monitors paid claims data to look for trends and patterns suggestive of fraud, waste or abuse. If we determine that a complaint, allegation or trend rises to potential fraud, we must forward the information and any evidence collected to DMA, who will make a determination about whether the allegation is credible and whether to make a referral to the Medicaid Investigations Division of the North Carolina Attorney General's Office (MID). If we determine that there is no potential fraud, but that waste or abuse are present, we will continue with our investigation. In making these determinations, we use the federal and state definitions and guidance described in the previous Section.

The first step in most investigations is to request records documenting service delivery. If you receive a request for records from the SIU, you must respond within the timeframe stated in the letter. The letter will also include a contact number for you to reach the investigator assigned to the case. Please call us if you have any questions about the records request or investigation process. If you do not return records as requested, we may determine that all claims reimbursed for the dates of service and individuals under review constitute an overpayment.

SIU will review the records and determine if any overpayment is due. This primary includes a review to determine if the documentation submitted is in compliance with Controlling Authority and supports the billing

of services. We have licensed practitioners on staff who may also review claims against medical necessity requirements. As stated in Section 6 of this Manual, authorization is not a guarantee of payment. If the SIU determines that medical necessity was not present at time of service delivery based on the documentation you provide, we may identify an overpayment. Smoky's Finance Department and certified accountants can also assist SIU with the review of financial reports, financial statements, and Generally Accepted Accounting Principles.

If the first records request indicates a high percentage of out-of-compliance findings or reveals other concerns or potential waste or abuse, we may issue another records request to expand the scope of the review. You will be notified in writing if the SIU identifies an overpayment based on abuse, waste, overutilization or non-compliance with your contract, including Controlling Authority. Notifications will include the amount owed, process for dispute resolution, deadline and mechanism for repayment, and the process for requesting a payment plan. The Finance Department is responsible for collection of overpayments, and will work with Smoky's legal staff to pursue collection whenever practicable. We may pursue a variety of collection options, including withholding of future claims payments, invoicing and collection from the Network Provider (with collection efforts to include initiating legal action and obtaining a judgment and execution of the judgment against the Network Provider for the amount), or referring the assessment to a third party collection agency.

## **The Contract Performance Team**

The Contract Performance Team conducts health and safety site reviews, routine and focused monitoring and complaint and grievance investigations of Network Providers. These monitoring and investigation activities may result in an educational letter, warning letter, plan of correction or adverse action described below, based on the outcome of the investigation or review. Findings may also trigger a report to:

- The Smoky Special Investigations Unit to review potential fraud, waste or abuse;
- Division of Health Service Regulation (licensure or healthcare personnel registry violations);
- DMA, DMH/DD/SAS or other behavioral health MCOs in North Carolina;
- County Departments of Social Services (abuse, neglect, or exploitation);
- Provider Accrediting Bodies;
- Practitioner Licensure or Certification Boards; or
- Law enforcement.

Health and Safety Site Reviews: The Contract Performance Team conducts health and safety site reviews as part of the initial enrollment and re-credentialing process, whenever a Network Provider requests to add a new site to their contract, and whenever a complaint is received about the quality of office, facility or residential space or that indicates a member's life, health, safety or welfare is in jeopardy. The types of grievances that may trigger a site visit include but are not limited to: unsafe office environment, lack of handicap accessibility, abuse, neglect, exploitation, fraud and financial abuse issues including availability of records and inadequacy of treatment record keeping, HIPAA/ confidentiality violations, lack of appointments including office hours, and lack of

adequate and confidential waiting areas. We also complete annual site reviews of Alternative Family Living (AFL) sites in accordance with DHHS requirements.

During the enrollment site visit, we will evaluate your readiness to provide services using a Site Review Tool mandated by DHHS. Smoky requires that all Network Providers meet the following standards, at a minimum, for office sites where members are seen:

- Physical Accessibility: Sites are handicapped accessible
- Physical Appearance: Office site is well maintained, neat and clean
- Office hours are prominently posted
- Adequacy of waiting and offices/examining room space:
  - Waiting and Examining Rooms are well lit
  - Adequate seating is available
- Responsiveness of office staff (Wait time standards are met):
  - Scheduled appointment: Individual seen within one (1) hour
  - Walk-In: Individual seen within two (2) hours or schedule for subsequent appointment
  - Emergency: Individual seen within one (1) hour
  - Life-threatening emergencies: Individual must be seen immediately.
- Availability of Appointments:
  - 24 hour life-threatening emergency coverage for members under your care
  - Emergent care appointments within 2 hours
  - Urgent care appointments within 48 hours
  - Routine care appointments within 14 days
- Adequacy of Treatment Record Keeping:
  - Compliance with all Controlling Authority
  - Medical records shall be maintained in a secure/confidential filing system
  - Medical records not commingled
  - Medical records shall have legible file markers
  - Medical records are easily located

Routine Monitoring: Smoky evaluates Network Provider compliance and performance utilizing the DHHS Provider Monitoring Process for LME/MCOs. We must complete routine monitoring of every provider in our network at least once every two years. Routine is defined as “meeting compliance-based standards only.” Independent practitioners, group practices and agencies which provide outpatient behavioral health services only are monitored using the DHHS Review Tool for Routine Monitoring of Licensed Independent Practitioners. All other providers are monitored with the DHHS Review Tool for Routine Monitoring of Provider Agencies, using the sub tools required by the services which that agency provides.

Routine monitoring consists of completion of the routine monitoring tool and the post-payment review tool. For providers of services in licensed facilities which are monitored annually by DHSR, only the post-payment review tool is completed. For more information about the routine monitoring process, including the review tools,

please refer to <http://www.ncdhhs.gov/MHDDSAS/providers/providermonitoring/index.htm>. We strive to be transparent throughout the Routine Monitoring process:

- You will be notified of the scheduled review date in writing 21 – 28 calendar days prior to the date of the review.
- You will be notified of the specific service records needed for the review no less than 5 business days prior to the date of the review.
- Reviews will include an opening and exit conference. Any follow up to be completed by the Network Provider or Smoky are reviewed during the exit conference. **You must present all information by the conclusion of the monitoring event.** After the review is concluded, any additional information submitted will not be used to change any established scores or out of compliance findings, but may be considered in implementation of a plan of correction (if required).
- You will be notified in writing of the results of the Routine Monitoring within 15 days of completion of the review. Monitoring tools are scored automatically in accordance with the guidelines provided with the tools. The tools will state if you have not met threshold standards.
- Smoky will issue a plan of correction or adverse action in response to any of the following failures to meet threshold standards:
  - Any score below 85% on a sub-tool or sub-section of the Routine Monitoring tool.
  - A score below 100% on the question regarding restrictive interventions.
  - Monitoring reveals systemic compliance issues as determined by Smoky.

Focused Monitoring: We conduct Focused Provider Monitoring: (a) in response to significant indicators and/or reported trends that you may not be in compliance with Controlling Authority identified in your contract, including but not limited to the 1915(b)/(c) Waiver, DMA Clinical Coverage Policies, DMH/DD/SAS service definitions, the DMH/DD/SAS Records Management and Documentation Manual, APSM 45-2, North Carolina Administrative Code provisions governing delivery of MH/IDD/SA services, and any other service-specific standards, contract or administrative requirements, (b) to verify your contract compliance; and/or (c) in response to priorities for compliance verification as identified by utilization, costs, and needs. Focused Monitoring may also be conducted in conjunction with DHHS Divisions, other MCOs or other Smoky departments.

- A focused monitoring can be conducted as a desk review or as an announced or unannounced site review.
- On site reviews will have an opening and exit conference similar to a Routine Monitoring. Any follow up to be completed by the Network Provider or Smoky are reviewed during the exit conference. **You must present all information by the conclusion of the monitoring event.**
- You will be notified in writing of the results of the Focused Monitoring within 15 days of completion of the review.

Grievance and Complaint Investigations: As discussed in Section 7 of this Manual, Smoky will investigate any complaint or grievance that we are unable to resolve informally or that we determine is not appropriate for



informal resolution. If information gathered during the informal resolution process suggests misuse of public funding or beneficiary or provider fraud, waste or abuse, it will be referred to the Smoky Special Investigations Unit. However, if information gathered during the informal resolution process suggests that your practices do not meet required standards as defined by applicable federal and state laws, rules, regulations, manuals, service definitions, contract requirements and policies, the grievance or complaint will be referred to the Contract Performance team. **Referrals to the Contract Performance team will also be made in situations in which there are concerns requiring immediate on-site monitoring to assess the health and safety of members.**

- Investigation of complaints and grievances may be desk or on site reviews, and may be announced or unannounced.
- On site reviews will have an opening and exit conference similar to a Routine Monitoring. Any follow up to be completed by the Network Provider or Smoky are reviewed during the exit conference. **You must present all information by the conclusion of the monitoring event.**
- You will be informed of the results of the investigation in writing within 15 days of completion of the investigation.

**NOTE:** Smoky specifically **reserves the right** to issue an educational or warning letter, Plan of Correction (POC), or adverse action, up to and including termination of your contract(s) with Smoky, in response to any findings from a Site Review, Routine Monitoring, Focused Monitoring, complaint or grievance investigation, or other program integrity activity conducted by Smoky. Any claim/ date of service cited as out of compliance in the post-payment review tool or otherwise will be reported to the Special Investigations Unit for overpayment determination. **We are not required to issue a warning letter or give you the opportunity to complete a POC prior to issuing an adverse action.**

**What is a Plan of Correction?** This is a written document developed by you in response to a Report of Findings from Smoky. The POC must specify how you will address each out-of-compliance finding, violation or deficiency identified by Smoky. The POC must be approved by the Contract Performance team as adequately addressing the issues in need of correction. Smoky will conduct on-site monitoring to ensure that the plan has been implemented and fully integrated into your operation(s) and that all deficiencies have been corrected and are unlikely to re-occur. We follow the process and timelines outlined in the DHHS Policy and Procedure of the Review, Approval and Follow-Up of Plan(s) of Correction currently available on the archived DHHS website at: <http://www2.ncdhhs.gov/mhddsas/statspublications/Policy/policy-acc002.pdf>. Failure to submit or implement an acceptable POC or substantially minimize or eliminate deficiencies may result in sanction up to and including termination from the Network.

## **Suspensions for Health and Safety**

Smoky is required by our accrediting body to suspend your contract if our Chief Medical Officer, Associate Medical Director or another Senior Clinical Staff Person determines that a Network Provider may be engaged in behavior or practicing in a manner that appears to pose a significant risk to the health, welfare, or safety of any member. This is usually the result of a complaint and on-site investigation. If a decision is made to suspend your

contract for health and safety reasons, we will notify you within 1 business day of the decision. The notice will include the basis for our determination, the effective date of the suspension, and instructions to discontinue the delivery of services until further notice and to direct consumers in urgent need of services to contact the Access the Services line at **1-800-849-6127**.

Following issuance of the emergency suspension notice, we will complete a full investigation into the allegations and issue a final decision. We make every effort to expedite these investigations but we will not compromise the outcome to complete the case quickly.

- In the event that the allegations are found to be unsubstantiated, your contract will be reinstated immediately retroactive to the date of suspension and we will send you a written notice to this effect.
- If any of the allegations are substantiated, Smoky will make a determination about further action. This may be a Plan of Correction all the way through full contract termination. We are not required to offer you a POC. You will be notified in writing of the outcome of the investigation and any decision to issue a POC or administrative action or sanction.

## **Adverse Actions**

Smoky's policy is to ensure that any adverse actions issued against Network Providers are fair, consistent and in accordance with this policy. We may issue an adverse action in response to any finding that you are out of compliance with or applicable federal and state laws, rules, regulations, manuals, policies or guidance, this Manual, contracts between Smoky and the provider, and any other applicable payor program requirements. However, we reserve the right to issue an adverse action at any time and for any reason deemed appropriate by Smoky. Adverse actions issued by Smoky fall into two categories: Administrative Actions and Sanctions.

**What is an Administrative Action?** This is an action against a Network Provider that does not result in a change to your status within the Closed Network. Examples of potential administrative actions include but are not limited to:

- Moratorium on the Expansion of Sites or Services: An administrative action whereby you may not submit an application to add additional sites or services to your contract, and may not respond to any Smoky procurement activity, including an RFP or RFI.
- Payment Suspension: An administrative action whereby we continue to process your authorizations and claims, but your payments will be suspended (wholly or partially) for a designated time period not to exceed six (6) months, unless payment suspension is required by 42 C.F.R. § 455.23, in which case the suspension period remains in effect until the N.C. Department of Justice Medicaid Fraud Investigations Division completes its investigation or legal proceedings related to the alleged fraud have been completed.
- Probation (increased monitoring): An administrative action whereby you may be placed on probation

with increased monitoring for a specified period of time, not to exceed one (1) year.

**What is a Sanction?** This is an action against a Network Provider based on professional competence or conduct or resulting in a change to your status within the Closed Network. Examples of potential sanctions include but are not limited to:

- Contract Suspension: A sanction whereby your contract is suspended and the Network Provider is prohibited from participating in the Smoky Closed Network for a period of time, during which all enrollees served are transitioned to other Network Provider(s). This includes a Suspension to Ensure Health and Safety issued by the Chief Medical Officer. Smoky will not make referrals or process new authorizations during any period of suspension. Claims for services delivered on or after the effective date of the Suspension will not be processed.
- Credentialing Actions: These are described more fully in Section 3 of this Manual.
- Exclusion from Participation in Closed Network: A sanction whereby the Network Provider's Network Contract is terminated and they are prohibited from re-applying for participation in the Closed Network. Network Providers who fail to provide the required written notice of network withdrawal and/or contract termination within the prescribed timeframe are automatically subject to exclusion by the Provider Sanctions Committee.
- Limiting or Suspending Referrals: A sanction whereby Smoky does not refer new or additional consumers to a Network Provider, only makes a limited number or type of referrals, or only makes referrals to specific services and/or sites.
- Site or Service Specific Termination: A sanction whereby one or more sites and/or services are terminated from the Network Contract.
- Termination from Closed Network: A sanction whereby the Network Contract is terminated for all sites and services.

Our adverse action decisions are based on fair, impartial, and consistent factors, including but not limited to documentation or other evidence tending to show one or more of the following:

- The provider has violated a contractual, legal and/or administrative requirement, including but not limited to documentation, billing or other requirements set forth in DMA Clinical Coverage Policies and Manuals and DMH/DD/SAS Service Definitions and Manuals
- The provider meets the "Substantial failure to comply" standard as defined by 10A NCAC 26C .0502(6)
- The provider has violated professional and/or ethical standards, including tolerating or covering up such violations on the part of its employees
- The provider has engaged in unlawful acts, including orchestrating, promoting, tolerating, or covering up

any illegal activity on the part of its employees

- The provider is jeopardizing the health and safety of members

## **Automatic (Immediate) Termination**

We may revoke your credentials and/or terminate your contract immediately upon notice of any of the following occurrences:

- DHSR issues a revocation, suspension, or Type A1 penalty against your license to operate or provide services
- CMS issues an Immediate Jeopardy finding against your facility
- Your accrediting body suspends or revokes your accreditation
- A practitioner's licensing or certification authority suspends or revokes the practitioner's license or certification
- DHHS or another state Medicaid agency suspends or terminates your participation in a state Medicaid program
- CMS suspends or terminates your participation in the Medicare program
- DHHS issues a payment suspension against you in accordance with 42 CFR § 455.23
- DHHS issues a revocation of your ability to receive state and federal funding in accordance with 10A NCAC 26C .0504

## **Notification of Adverse Action**

We will always send you a written notice if we issue an adverse action. Depending on the nature of the decision, we may also call you. Notices will identify the nature and effective date of the adverse action, the basis for the decision, an explanation of how to initiate the dispute resolution process and how to submit additional information, and the timelines for doing so. All notifications are sent via electronic mail to the primary email contact on file with Smoky. If you do not signify acceptance of the email within 1 business day, the notification is sent via trackable mail. For purposes of calculating the appeal timeframes described in the next Section, we consider that correspondence is received by you on the date of the attempted email delivery, regardless of whether you signify acceptance, unless it was sent to the wrong address based on a Smoky error, in which case the date it was sent to the correct address shall apply.

On a monthly basis, we are required to notify DMA of all denials of a provider's application to join our network and any termination of a Network Provider's contract, as well as any action taken against a Network Provider for program integrity reasons. We will also notify other behavioral health MCOs operating in North Carolina and any applicable accrediting bodies or licensing boards.

# Section 17: Dispute Resolution

## Policy Statement

Smoky's policy is to implement a fair, consistent, respectful, timely, objective and impartial process to address significant disputes or problems with Network Providers, including Administrative Actions and Sanctions. Dispute resolution will be available to any Network Provider who wishes to initiate the process in response to an action or issue that is within the scope of this Section. Our dispute resolution process includes methods for you to present relevant information as well as clear time frames from initiation through issuance of a written decision.

Unless resulting from a change in applicable laws, rules or regulations or State requirements requiring a shorter timeframe, we will provide you with at least thirty (30) days' notice of any significant revision to the dispute resolution process through notification to the Provider Advisory Council, a Communication Bulletin and associated website posting.

## Scope

This dispute resolution process does not apply to appeals filed by a member, Legally Responsible Person, or personal representative (including a Network Provider) contesting decisions of Smoky to deny, reduce, terminate or suspend a covered service in accordance with N.C.G.S. Chapter 108D and 42 CFR Part 438, Subpart F. Those decisions are handled through Smoky's member reconsideration and appeals process explained at Section 6 of this Manual. This dispute resolution process is only available to Network Providers, with the exception of the process for contesting claim denials, which is open to all providers who submit claims to Smoky.

**Can a Network Provider appeal every dispute it has with Smoky?** No. The following issues may not be appealed through Smoky's reconsideration process and are not subject to dispute resolution:

- Refusal to process or denial of a request to participate in the Closed Network;
- Refusal to process or denial of a request to add a site or service to an existing Network Contract;
- Refusal to award a service, program and/or funding as part of any Smoky procurement process;
- Refusal to process or denial of an initial application for credentialing;
- Refusal to renew or extend a Network Contract beyond its original term;
- Issuance of a warning letter, educational letter, Report of Findings or Plan of Correction that does not change your status within the Closed Network;
- A decision to place a Network Provider on Prepayment Review;
- Formal report by Smoky to oversight authorities, including but not limited to the following:
  - DMA Program Integrity, the Medicaid Investigations Division of the NC Department of Justice or the U.S. Office of Inspector General (Medicaid fraud);

- Division of Health Service Regulation (licensure or healthcare personnel registry violations);
- DMH/DD/SAS (authorization to receive public funding for the provision of MH/DD/SA services);
- County Departments of Social Services (abuse, neglect, and exploitation);
- Provider Accrediting Bodies;
- Practitioner Licensure or Certification Boards; or
- Law enforcement.

Network Providers also may not appeal or initiate dispute resolution in response to any of the following “direct and contractually or administratively explicit consequences” of violating a contract and/or administrative requirement, such as a contract termination or suspension based on the following:

- Notification of exclusion from participation in state or federally-funded health care programs by the U.S. HHS Office of Inspector General or NCDHHS;
- Immediate Jeopardy finding issued by the Centers for Medicare and Medicaid Services;
- Action taken by the NC Department of Health and Human Services or any of its Divisions to terminate, suspend or revoke a contract or provider status;
- Loss of required facility or professional licensure, accreditation or certification; or
- Federal, state or local funds allocated to Smoky are revoked or terminated in a manner beyond the control of Smoky for any part of the Contract period.

**What can be appealed?** This dispute resolution process is available to any Network Provider who wishes to initiate it in response to any of the following:

- Any Notice of Administrative Action, Overpayment or Sanction issued by Smoky against a Network Provider as described in Section 16 of this Manual;
- An emergency contract suspension issued by the Chief Medical Officer against a Network Provider to protect the life, health, safety or welfare of any consumer as described in Section 16 of this Manual;
- A Notice of Credentialing Action (NCA) issued by the Smoky Credentialing Committee to revoke or restrict the credentials of any Network Provider or credentialed practitioner as described in Section 3 of this Manual;
- Final notification of a Claim Denial;
- Any other significant dispute that cannot be resolved informally and which has direct implications for the Network Provider, unless excluded as described above.

Any Requests for Reconsideration concerning disputes that do not obviously fall into a category listed above will be reviewed by Smoky for determination of whether it is a valid dispute, and if so, whether it should be categorized as administrative or clinical. If the appeal is determined to be invalid or untimely, Smoky will send you a written notification no more than fourteen (14) days following receipt of the Request. The letter will explain why the issue raised is not subject to the dispute resolution process, is untimely or is otherwise invalid.

## Dispute Resolution Overview

There are three tracks for dispute resolution. One track is for administrative actions and offers a mechanism for you to request a Reconsideration Review from a 3-member panel of Smoky representatives who were not involved in the initial decision and/or subject of the dispute. Another track is for sanctions and disputes of a clinical nature and offers a mechanism for you to request a Reconsideration Review from a first and second level review panel. These 3-member panels will include a **peer** from within the Closed Network, along with two Smoky representatives who were not involved in the initial decision and/or subject of the dispute. A **peer** is a practitioner with equivalent credentials or qualifications as the practitioner who initiated the appeal, or, with respect to agencies, facilities or hospitals, a qualified individual employed by a Network Provider that provides the same or similar services as the provider that initiated the appeal and/or are the subject of the dispute. Peer participation is a requirement of Smoky's accrediting body. The third track is for claim denials and is discussed in a separate section, below.

Disputes of a **clinical** nature are those that pertain to your professional conduct or competence in relation to matters such as, but not limited to, the following:

- The quality of professional services including assessment, treatment, consultation and referral;
- The appropriateness of interactions between a treating professional and a consumer; or
- Conduct by a professional that may adversely affect treatment outcomes – e.g., failure to exercise professional judgment in disclosing therapeutic information.

Disputes of an **administrative or non-clinical** nature are those pertaining to matters such as, but not limited to, the following:

- Claims and billing;
- Adequacy of documentation, facility or staffing; or
- Compliance with laws, rules, regulations, contract requirements, policy, or manuals.

Disputes that are found in favor of the Network Provider at any level do not need to go to the next level. Reimbursement will continue during the dispute resolution process **unless** a payment suspension is issued for any reason, including receipt of a credible allegation of fraud or abuse (42 CFR § 455.23), or Smoky believes continued reimbursement is likely to increase any overpayment amount due.

**How do I request reconsideration?** A Reconsideration Request Form ("Form") will be included with any written notification of an administrative action or sanction you receive from Smoky ("Notice"), except for claim denials, which are discussed below. The Form will include the specific address for mailing. You have the option to submit in-person, electronically or by mail to the address listed in the Form. The Form must be signed by someone with authority, i.e. the disputing practitioner or an Owner/ Operator/ Managing Employee of a provider organized as a corporate entity. The Form must be completed in its entirety, include detailed contact information, identify the specific action or actions which are being disputed, and explain your specific dissatisfaction with such

action(s). **You must select the type of panel meeting you prefer (telephone, in-person, desk review), and identify all persons you plan to bring to the meeting.** Only one reconsideration request may be submitted per dispute or Notice.

**How much time do I have to request reconsideration?** You have 30 days to request reconsideration from the date of the applicable Notice. We will consider our action final if a fully completed and signed reconsideration request is not received at the address listed in the Form by 5:00 p.m. on the 30th day following mailing of the Notice. Extensions of the time for filing will not be granted. It is your responsibility to ensure delivery, and provide proof of mailing if needed.

**What happens after I submit a request for reconsideration?** If we receive a signed, complete, timely request, we will send you a written notification with the date, time and location of the panel meeting. If you are represented by legal counsel, the notice will be sent to your legal counsel and we will do our best to accommodate his or her schedule.

**How do I submit additional documentation for consideration by the Panel?** Any documentation you wish to be considered by a panel must be submitted electronically, either via secure encrypted email, through submission of a secure USB drive or through a secure File Transfer Protocol (FTP). Documentation will only be accepted within the following timeframes.

- For general administrative actions, documentation must be submitted at least five (5) days prior to the date of the scheduled panel hearing.
- For overpayments, documentation must be submitted at least ten (10) days prior to the date of the scheduled panel hearing.
- For sanctions (both Level 1 and Level 2), documentation should be submitted at least three (3) days prior to the date of the scheduled panel hearing. Documentation may be accepted at the panel hearing itself at the discretion of the Facilitator, but will only be accepted if you bring an original and five (5) additional copies. We will not make copies on site.
- For claim denials, documentation for the first level review must be submitted with the request for reconsideration. Documentation for the second level review must be submitted at least five (5) days prior to the date of the scheduled second level review.

Your time is valuable. If documentation you submit prior to the review supports overturning Smoky's decision, we will notify you and cancel the panel meeting.

## **Panel Meeting Process**

**Are all reconsiderations in person?** No. You may request that your panel meeting be conducted by telephone, in-person or paper (desk) review.



**How soon will the panel meeting be scheduled?** For most administrative actions and sanctions, the panel meeting will be scheduled to occur no later than 14 days from the receipt of a signed, complete Request Form, excluding paid Smoky holidays, unless there are documented extenuating circumstances for the Network Provider or Smoky. For overpayments, the panel meeting will be scheduled to occur between 60 and 90 days from the date of the Notice of Overpayment, not including paid Smoky holidays, unless there are documented extenuating circumstances for the Network Provider or Smoky. If the reconsideration is postponed or otherwise rescheduled due to extenuating circumstances, the documentation due date does not change but you may be granted up to a fifteen (15) day extension on this deadline at the discretion of the Panel Facilitator.

**Can I reschedule if needed?** Once scheduled, panel meetings will not be rescheduled unless there are documented extenuating circumstances, which include but are not limited to death, serious illness, severe inclement weather, or unavailability of a clinical peer. Overpayment panels are generally held on a standing, bi-monthly schedule. If you need to request that a panel meeting be rescheduled, approval of the extension will be dependent upon your signed agreement that you will not use our decision to reschedule the panel meeting as a basis to challenge the validity of the reconsideration decision.

**Do I need an attorney?** We cannot make that decision for you. You may want to consider the amount or issue at stake. A Smoky attorney is usually present at all panel meetings, except for claim denial reconsiderations. However, panel meetings are informal and non-adversarial. Witnesses are not sworn and cross-examination is not permitted. You must notify us in advance of the number of persons who will be present. The number of participants may be limited in order to accommodate meeting room space. All participants will be required to sign our Visitor Log, which includes a confidentiality disclaimer.

**How long will the panel meeting last?** In general, the meeting time frame will be limited to a maximum of two (2) hours, with additional time scheduled for the panel to deliberate. For disputes involving a large volume of claims, additional time may be scheduled.

**Is the meeting recorded?** No. The meeting may not be recorded by audio or video means. Our Legal and Compliance Coordinator or another designated staff person will take minutes for the meeting.

**What happens at an in-person panel meeting?** The Panel Facilitator will provide an opening statement explaining the agenda and requesting all parties present to state their name and title. A Smoky staff person will first present our view of the dispute in an objective manner. You may then present a narrative summary of the facts, evidence or arguments in support of your position. It is helpful to refer to documentation or laws, rules, regulations or policies in support of your position. Smoky staff may then respond to your presentation as needed. Throughout the presentations the panel members will review relevant documentation and may ask you questions. Smoky's legal counsel may provide advice or counsel to Smoky staff or panel members at any point in the process. At the end of the meeting, the Facilitator will ask you to sign an Attestation acknowledging that the agenda and role(s) of each person present were explained, that all parties were able to present their information fully and in a fair and equitable manner, and that the anticipated timing for a written decision was shared.

**What happens at a telephonic panel meeting?** A telephonic meeting generally follows the same process as an in-person meeting. We will mail you the Attestation in advance of the meeting and ask that you return it via facsimile or email immediately following the meeting.

**What happens at a desk review?** Desk reviews consist of a scheduled meeting where the panel reviews documentation, deliberates and reaches a decision without hearing presentation(s) from Smoky staff or the Network Provider. While reviewing documentation, the panel may contact Smoky staff, legal counsel or providers to ask specific questions necessary to reach a decision. Our Legal and Compliance Coordinator or another designated staff person will take minutes for the meeting.

**How and when does the panel reach a decision?** Following the meeting, the panel will deliberate and vote on a determination to uphold, revise, or overturn the decision, or pend for more information. Smoky legal counsel may be present during the deliberation to answer legal questions. All three panel members must be present for a vote to take place, and determinations are reached by majority vote. The Legal and Compliance Coordinator or other designated staff will draft a Panel Decision based on the minutes that clearly explains the basis for the panel's determination as to each issue. The written decision will be sent to you electronically, securely as necessary no later than 14 days after the panel meeting, unless additional time is needed due to extenuating circumstances. The date of the decision letter is the date of the final decision by Smoky. Please be aware that Smoky's Executive Leadership Team has the authority to overturn or revise the decision of any Smoky reconsideration panel.

**Are panel meetings confidential?** Smoky is a government entity subject to the NC Public Records Act, N.C.G.S. Chapter 132. While there are some exceptions (for example protected or competitive health information), some of our written material can be produced in response to a public records request. We are also required to notify DMA whenever we terminate or suspend a provider's participation in our network. However, to protect confidentiality, uphold professionalism and preserve objectivity for second level panels, panel members and participating staff will refrain from discussing the review with providers, peers or colleagues who are not on the panel or directly participating in the process, except as necessary to respond to requests from consumers or family members impacted by the dispute.

**Is the panel decision final?** Panel decisions on administrative actions and overpayments are final and may not be appealed any further with Smoky. However, if you are not satisfied with the first level decision issued about a sanction, you may request reconsideration by a second level panel within 10 days of the date of the decision. If you do not request a second level panel review by 5:00 pm on the tenth day after the date of the first level decision, the sanction decision will be final. Please note that Smoky will assess late payment penalties and monthly interest if you do not pay back an identified overpayment within 30 days after the issuance of a final overpayment decision.

**How does the second level panel process work?** Within 14 days from the date we receive a signed, complete, timely request for reconsideration of a first level decision, not including paid Smoky holidays, we will schedule a second level panel, unless there are documented extenuating circumstances for you or Smoky. We will notify

you of the date and time of the scheduled panel meeting in writing. The second level panel will include different panel members, but otherwise the process is the same. Please note that the second level decision is final and may not be appealed further with Smoky.

**Can I file an appeal with the Office of Administrative Hearings if I am dissatisfied with Smoky's decision?** You will need to check with your legal counsel on options for appealing Smoky's final decision. Our position is that OAH lacks jurisdiction over disputes between Smoky and Network Providers.

## **Disputing Claim Denials**

**What is a Claim Denial?** This is a request for payment that is received as clean and processed by Smoky but which does not meet all of the required criteria to be approved for payment. Notification of Claim Denials will be transmitted to you via Remittance Advice (RA) or other final notification of payment, payment denial, disallowance, payment adjustment, or notice of program or institutional reimbursement. You must submit all requests for reconsideration of Claim Denials within 30 days from this notification (usually the RA).

**Where can I find the Reconsideration Request Form?** The Level 1 Request for Reconsideration of Claim Denial form ("Level 1 form") can be found on the Smoky website or may be requested from a Smoky representative: [http://www.smokymountaincenter.com/documents/providers/billinfo/Claims\\_Reconsideration\\_Request\\_Form\\_%28Level\\_1%29\\_2015-03-23.pdf](http://www.smokymountaincenter.com/documents/providers/billinfo/Claims_Reconsideration_Request_Form_%28Level_1%29_2015-03-23.pdf). The submitted form must include specifics regarding the claim(s) including but not limited to the consumer's name, member record number, date of service, service code, claim header information and all other relevant information regarding the claim. If a signed, complete Level 1 form is not received within the required 30 day period, Smoky's action to deny the claim is final without further written notification.

**When will a panel meeting be scheduled?** Level 1 Claim Denials are reviewed through a Desk Review process. Smoky will schedule a Level 1 Desk Review panel meeting within 60 days, not including paid holidays, from the receipt of a signed, complete and timely Level 1 form, unless there are documented extenuating circumstances for you or Smoky. Following the desk review, a decision will be made to uphold, overturn, adjust, or determine that more information is needed. The panel will issue a written decision within 60 days from the date of the Level 1 Desk Review. The panel may request additional time to issue the decision if necessary, or may request that a Level 2 meeting be scheduled in order to get more information.

**What if I disagree with the Level 1 decision?** If you are dissatisfied with the Level 1 reconsideration decision, you can submit a written request for a Level 2 reconsideration review. The form to request Level 2 reconsideration will be attached to the Level 1 reconsideration decision. You must submit a signed, complete Level 3 form within 30 days from the date of the Level 1 decision. In the Level 2 form, you must specify whether you will participate in the Level 2 reconsideration in person, telephonically, or by submitting additional documentation. If a signed, complete Level 2 form is not received within the required 30 day period, Smoky's decision is final without further written notification, unless the panel determined more information was needed during the Level 1 Desk Review.

**When will the Level 2 panel meeting be scheduled?** Smoky will schedule a Level 2 Desk Review panel meeting within 30 days, not including paid holidays, from the receipt of a signed, complete and timely Level 2 form, unless there are documented extenuating circumstances for you or Smoky. If you do not attend the Level 2 reconsideration review meeting (in person or by phone) or do not submit additional documentation as previously arranged, the Level 2 reconsideration will be dismissed and the Level 1 reconsideration decision will become final. Following the Level 2 review, a decision will be made to uphold, overturn, adjust, or determine that more information is needed. The panel will issue a written decision within 30 days from the date of the Level 1 Desk Review. The Level 2 Claim Denial Decision is final and may not be appealed further with Smoky. Please consult with your legal counsel on options for appealing Smoky's final decision.

# Section 18: Community Collaboration

Smoky's Community Collaboration department has a number of important teams that provide community engagement and critical support services to Smoky Health Plan members, families, and stakeholders. These teams include:

- Community Outreach Team
- Consumer Relations Team
- Crisis Coordination Team
- Geriatric and Adult Mental Health Specialty Teams (GAMHST)
- Hospital and State Facility Liaison Team
- Housing and Employment Team
- Transitions to Community Living Team

Functions and services of these teams include:

- Support for local Collaboratives that increase service capacity on a community level;
- Strategic planning, technical assistance and focused education to community stakeholders and families to build knowledge, skills, and community supports in prevention, early intervention, crisis service coordination, geriatric mental health, and access to care; and
- Direct support to members in every county from staff specialized in transitions to community living, housing, employment, successful wellness and recovery planning and systems of care.

## **Community Outreach (Community Capacity Building)**

- Community Specialists provide System of Care (SOC) Coordination activities and training for the implementation of SOC core values
- Support for Community Collaboratives/Health and Wellness Coalitions
- Focus on Prevention and Early Intervention activities, programs and training
- Technical Assistance and Community Education – Training library of more than 100 presentations; certified trainers in Person Centered Thinking (PCT), Darkness to Light Stewards of Children (D2L), Child & Family Team (CFT) I and II, Youth Mental Health First Aid and other evidence based programs

## **Consumer Relations**

- Maintain and support the Consumer & Family Advisory Committee (CFAC) and Human Rights Committee (HRC)
- Employ Peer and Family Support Specialists who assist members and families in navigating the system,

develop and maintain member and family support networks, provide Wellness Recovery Action Plan (WRAP) and Peer Support specialist trainings, and provide individualized peer support for consumers with identified unmet needs.

- Employ Family Partners who work with Community Specialists to carry out the SOC core values and principles, provide telephonic support and referrals to community resources to members and families needing additional guidance in navigating the system, support families to lead the person and family centered planning process, and coordinate Customer Satisfaction Surveys to ensure that individuals reaching out to our Call Center receive superior customer service.

## **Crisis Management / Crisis and ED Initiative**

- Daily management of data and coordination of services for members in emergency departments (EDs).
- Facilitation of local Crisis Emergency Department Initiative (CEDI) committees focused on crisis management and prevention; including training and consultation with community partners to improve local crisis responses/ continuums .
- Leadership in building community capacity to prevent crisis, support individuals in crisis, and to ensure evidence based practice in crisis management through CEDI.
- Training for Magistrates, law enforcement, ED staff, DSS staff and others regarding crisis management and involuntary commitment, including partnering with Smoky Training staff to support Crisis Intervention Team Training (CIT).

## **Geriatric and Adult Mental Health Specialty Team (GAMSHT/GERO Team)**

- The Gero Team is comprised of registered nurses, licensed clinicians, and qualified mental health professionals serving the 23 counties in Smoky's catchment area along with Burke , Catawba, Iredell, Surry and Yadkin Counties
- The team provides education and consultation for staff of long-term care facilities. The team may also assist caregivers of individuals 60 years and older with mental illness or who are experiencing emotional or behavioral challenges or under 60 years of age that are experiencing early onset dementia and other geriatric type illnesses.

## **Hospital Liaisons**

- These staff are embedded at local hospitals and state facilities to ensure effective discharge planning of high-need members admitted to 24-hour inpatient facilities by evaluating their needs/level of care and assisting with a smooth transition and adequate linkage to Smoky Care Coordination and providers in the community upon discharge.

## Housing and Employment

- This team provides information on available housing options to members, families, community stakeholders and providers, administers the Housing and Urban Development (HUD) Shelter Plus Care and other Smoky housing programs and works to increase housing resources through partnerships with affordable housing providers.
- Employment activities include working with employment service providers to increase the quality of services, providing information on available supported employment options to members, families, community stakeholders and providers, and working directly with members when paid employment supports are not successful.

## Transition to Community Living Initiative (TCLI) Team

- This team is responsible for implantation of a mandated comprehensive housing initiative for people with severe and persistent mental illness to transition from institutional settings into community housing where permanence will be ensured through evidence-based treatment, supported employment, and tenancy support.
- The TCLI implementation and oversight team is equally balanced with mental health professionals and NC Certified Peer Support Specialists, while additional support to participants comes from the cooperative efforts of Smoky's Care Coordination Department, Housing Specialists, and Employment Specialists.

As a Network Provider, you must cooperate with our Community Collaboration efforts. Minimum requirements include the following:

- Actively participate in Community Collaborative efforts to develop prevention, education, and outreach programs.
- Assist in the development of educational material and brochures on mental illness, intellectual/developmental disabilities, and substance use/ addiction to educate the community about the needs of people with disabilities.
- Provide education to stakeholders and members on services available within Smoky's Closed Provider Network, appeals and grievances, and advance directives.
- Cooperate with and/or actively participate in Smoky in In-Reach and TCLI team activities, as applicable.
- Participate in local Crisis/Emergency Department Initiative (CEDI) Committee activities.
- Make referrals to GAMHST for caregivers of older adults needing additional education, support, and resource information as needed.
- Participate in or refer landlords and other stakeholders to Smoky's housing initiatives.
- Participate in Smoky's internal and/or external trainings to implement evidence-based Supported Employment (SE) within your organization as applicable.
  - The primary outcome of SE is competitive employment in an integrated setting (50% or

more non-disabled) consistent with an individual's strengths, resources, priorities, concerns, abilities, capabilities, interests, and involving informed choice.

- To establish a valued sense of integrity and purpose within SE/Long Term Vocational Support (LTVS), Network Providers must gather/ collect and report requested data to Smoky for use in determining needs and barriers to employment within our catchment area.
- For those providers who are contracted to provide SE or ACTT services, you must provide SE program data that includes: Member development/phase of service (i.e. job development, creation of small business/micro-enterprise, placement, or long term vocational support) and outcomes, including the number of individuals who have obtained jobs, the consumer's start date, hours worked, wages and benefits, and pertinent employer information. Reporting must be submitted electronically on a quarterly basis to the following email address: [SupportedEmployment@smokymountaincenter.com](mailto:SupportedEmployment@smokymountaincenter.com)
- For those providers who are contracted to provide State Funded Residential Services (SFRS):
  - Maintain a current list of those members for whom the agency is receiving SFRS funding
  - Submit Unused Bed Day Census reports monthly
  - Notify Smoky of vacancies within one day
  - Follow guidelines for the SFRS Referral Process
- For providers who have signed a Memorandum of Agreement to make referrals into the Shelter Plus Care/Permanent Supportive Housing (SPC/PSH) Program:
  - Provide ongoing services to SPC/PSH referred participants as needed and provide monthly reports of those services
  - Communicate regularly with the Housing Coordinator when changes occur, such as the participant's stability, income, household composition, etc.
  - Assist participants as needed to remain stably housed



# Appendix A: Code of Ethics

## PREAMBLE

The PAC shall facilitate an open exchange of ideas, shared values, goals, and visions and bring forward concerns and solutions while promoting collaboration, ethical operations, mutual accountability, and quality services. The PAC strives to achieve best practices to empower consumers within our community to achieve their personal goals. PAC members commit to:

- Assure that their staff adhere to this code of ethics;
- Provide support to other member agencies; and
- Advocate for the further development of resources on a local and state level for consumers served.

## PURPOSE

PAC members agree to abide by this Code of Ethics. Member agencies shall:

- Become familiar with and encourage their Board of Directors, Owners, and staff to adhere and follow the Code of Ethics;
- Agree that actions which violates the Code would be considered unethical;
- Agree that a lack of knowledge is not a defense for unethical conduct;
- Strive to achieve the highest standards of professional conduct;
- Acknowledge that all member agencies be committed to best practices in their specific area through involvement with continued education and review of relevant research;
- Have an obligation to report in writing any direct knowledge of perceived violations of the code of ethics;
- Offer age appropriate services which promote dignity and empower the individual; and
- Reflect the beliefs, values, heritage, and customs of individuals supported by offering culturally competent services.

PAC Members will discuss known violations of standard ethical practices by members with the offending colleague or agency director. In the event that this does not end in resolution of the issue, the member shall consult with the Ethics Committee of the PAC regarding their responsibility.

## CORE VALUES

The PAC embraces the following core values, which serve as the foundation of the Provider Advisory Council:

- Integrity: Provide accurate and truthful representation.
- Competence: Honor responsibilities to achieve and maintain the highest level of professional competence for members and those in their employ.
- Professional Conduct: Promote the dignity and autonomy of the profession, maintain harmonious inter-professional and intra-professional relationships, and accept the profession's self-imposed standards. All professional relationships should be directed to improving the quality of life of the individuals who receive supports from the member agency.

- Individual Value, Dignity, and Diversity: Provide supports and services that promote respect and dignity of each individual supported.
- Social Justice: Assure that the right of individuals and those who make decisions regarding services to them have complete and accurate information on which to make choices.
- Social Capital: Network Providers support the importance of Social Capital in each individual supported.
- Partnership: Network Providers will work together in partnership to develop and achieve an individual's desired outcomes.

## **ETHICAL PRINCIPLES**

The following broad based principles are based on the Core Values of the PAC. These principles set forth ideals to which all Network Providers should aspire.

**VALUE: INTEGRITY** – Provide accurate and truthful representation.

**ETHICAL PRINCIPLE:** Network Providers will not knowingly permit anyone under their supervision to engage in any practice that violates the Code of Ethics. Network Providers will not engage in dishonesty, fraud, deceit, misrepresentation of themselves or other providers, or any form of conduct that adversely reflects on their profession, the PAC, or on the Network Provider's ability to support consumers professionally. Network Providers will not commit unethical practices that include, but are not limited to, deceptive billing, falsification of documentation, commission of a felony, gross neglect and fiduciary impropriety.

**VALUE: COMPETENCE** – Honor responsibilities to achieve and maintain the highest level of professional competence for themselves and those in their employ.

**ETHICAL PRINCIPLE:** Network Providers will represent their competence within their scope of practice. Network Providers will engage in only those aspects of the profession that are within the scope of their competence, considering their level of education, training, and experience. Network Providers will allow individual staff to provide only those services that are within the staff member's competence, considering the employee's level of education, training, and experience. Network Providers agencies will demonstrate compliance with state and federal rules, regulations and laws regarding standards for training and credentials for supports provided.

**VALUE: PROFESSIONAL CONDUCT** – Uphold the dignity and autonomy of the profession, maintain harmonious inter-professional and intra-professional relationships, and accept the profession's self-imposed standard. All professional relationships should be directed to improving the quality of life of the individual who receives support from the member agency.

**ETHICAL PRINCIPLE:** Network Providers will not participate in activities that produce a benefit for themselves over the individuals they support or may potentially support, always giving priority to professional responsibility over any personal interest or gain. Network Providers will make all reasonable efforts to prevent any incidents of abuse, neglect and exploitation. Abuse means the infliction of mental or physical pain or injury by other than accidental means, or unreasonable confinement, or deprivation by an employee of services, which are necessary to the mental or physical health of the individual. Temporary discomfort that is a part of an approved and documented treatment plan or use of a documented emergency procedure shall not be considered abuse.

Neglect means the failure to provide care or services necessary to maintain the mental or physical health and well being of the individual. Network Providers will promptly report and thoroughly investigate all allegations of abuse, neglect, and exploitation. Under no circumstance will the support relationship between the program, staff, and individuals receiving services, and/or their families or legal guardian be exploited. Exploitation is defined as the illegal or unauthorized use of a service user or a service user's resources for another person's profit, business or advantage. Network Providers will train staff to recognize and report any suspected incidents of abuse and neglect and exploitation.

**VALUE: INDIVIDUAL VALUE, DIGNITY AND DIVERSITY** – Provide supports and services, which promote respect and dignity of each individual served.

**ETHICAL PRINCIPLE:** Network Providers will comply with all Federal and State rules and laws related to confidentiality and protected health information, including but not limited to, N.C.G.S. 122C; -52 through 122C-56, the Health Insurance Portability and Accountability Act of 1996 (HIPAA); the HIPAA final administrative simplification regulations codified at 45 CFR Parts 160, 162 and 164; and 42 CFR Part 2. Network Providers will not discriminate in their relationships or services provided to individuals receiving supports, contractors, and colleagues on the basis of race or ethnicity, gender, age, religion, national origin, sexual orientation, or disability. Network Providers will provide individuals and families a means of submitting grievances that is fair and impartial. Network Providers will comply with N.C.G.S. § 35A – 1201, which allows for individuals who have been adjudicated incompetent to be involved in decisions and choices that impact their lives. Network Providers will make all reasonable efforts to ensure individuals and families participate in the development and revision of any plan for services. Network Providers will not abandon individuals and families. Network Providers will consistently demonstrate efforts to assure that their services eliminate the effects of any biases based upon individual and cultural factors. Network Providers will support the recovery and self-determination of each individual.

**VALUE: SOCIAL JUSTICE** – Assure the rights of individuals receiving supports and others who make decisions regarding services have complete information on which to make their choices.

**ETHICAL PRINCIPLE:** Network Providers will accurately portray their services and capacities through public and private statements. Network Providers will not engage in false and deceptive representation of their services. Network Provider's marketing strategies will not offer inducements to primary individuals receiving supports or their legal representatives in exchange for business gained. Network Providers will accurately portray their ownership, board of directors and management through public and private statements. Network Providers will follow required laws and standards regarding the hiring of staff. Network Providers will not make initial contact with employees of other providers for the purpose of offering employment to that individual employee for the purpose of gaining clients. This does not preclude the individual client to make a choice. Network Providers will use the standards means of advertising for hiring staff.

**VALUE: SOCIAL CAPITAL** – Network Providers support the importance of social capital for each individual supported.

**ETHICAL PRINCIPLE:** Network Providers will support and promote opportunities for individuals they support to develop valued relationships with members of the community in which they live or work. Network Providers

will support and promote opportunities for individuals they support they be treated with respect and dignity within the community they live or work. Network Providers will support and promote opportunities for individuals they support developing roles in the community in which they live or work.

**VALUE: PARTNERSHIP** – Network Providers will work together in partnership to develop and achieve individual desired outcomes:

**ETHICAL PRINCIPLE:** Network Providers shall collaborate to share resources that enhance the functions of the Network to develop solutions for gaps in services and will work in partnership:

To assure continuity of care for consumers, and

To assure linkage for services, and

With consumers, stakeholders, parents, significant others, and Smoky to support the attainment of each individual's goals

# Appendix B: Comprehensive Care Center Model

See <http://www.smokymountaincenter.com/documents/providers/Comprehensive-Care-Centers.pdf>

## Appendix C: Hospital Mixed Services Payment Protocol

Services	Claim Processing and/or Financial Liability
<b>Inpatient Charges for Psychiatric and Substance Abuse Diagnostic Related Groupings (DRG range 876 - 897)</b>	<b>LME/MCO</b>
<b>Outpatient X-ray and Lab Work</b>	
<ul style="list-style-type: none"> <li>• Prescribed by an LME/MCO network provider on an Inpatient basis such as: VDRL, SMA, CBC, UA (urinalysis), Cortisol, x-rays for admission physicals, therapeutic drug levels.</li> <li>• Prescribed by LME/MCO network provider on an outpatient basis such as therapeutic drug levels.</li> <li>• Ordered for evaluation of medical problems or to establish organic pathology, cat scans thyroid studies, EKG etc. or any tests ordered prior to having a patient medically cleared.</li> <li>• Other tests ordered by non-LME/MCO physician</li> </ul>	<b>Bill direct to NC DMA / Medicaid</b>  <b>EXCEPTION:</b> Bill LME/MCO for Eligible Recipient's services provided during Emergency Department visit for treatment is where Primary Diagnosis is within the <b>Designated Behavioral Health Range*</b>
<b>Drugs</b>	
<ul style="list-style-type: none"> <li>• Outpatient prescription drugs and take-home drugs</li> </ul>	<b>Bill direct to NC DMA / Medicaid</b>
<b>Ambulance</b>	
<ul style="list-style-type: none"> <li>• Transport to the hospital when the primary diagnosis is behavioral care</li> <li>• Transport to a hospital prior to a medical emergency when the primary diagnosis is medical</li> </ul>	<b>Bill direct to NC DMA / Medicaid</b>
<ul style="list-style-type: none"> <li>• Transfers authorized by LME/MCO from non-network facility to a network facility</li> </ul>	<b>LME/MCO</b>
<b>Consults</b>	
<ul style="list-style-type: none"> <li>• Mental Health or Alcohol/Substance Abuse on Medical Surgical Unit</li> <li>• Mental Health or Alcohol/Substance Abuse in a Nursing Home or Assisted Living Facility</li> </ul>	<b>LME/MCO</b>
<ul style="list-style-type: none"> <li>• Medical/Surgical on Mental Health/Substance Abuse Unit</li> </ul>	<b>Bill direct to NC DMA / Medicaid</b>
<b>Emergency Room Charges – Professional Services</b>	
<ul style="list-style-type: none"> <li>• Emergency Department services for treatment where Primary Diagnosis is within the <b>Designated Behavioral Health Range*</b></li> <li>• Emergency Mental Health, Alcohol/Substance Abuse services provided by MH/SA practitioners</li> </ul>	<b>LME/MCO</b>
<ul style="list-style-type: none"> <li>• Emergency room services where the Primary Diagnosis is <b>NOT</b> within the <b>Designated Behavioral Health Range</b></li> </ul>	<b>Bill direct to NC DMA / Medicaid</b>

Services	Claim Processing and/or Financial Liability
<p align="center"><b>* Designated Behavioral Health Primary Diagnosis Code Ranges: 290 - 319 (ICD 9) or F01 - F99 (ICD-10)</b></p>	
<p><b>Emergency Room Facility Charge.</b></p>	
<ul style="list-style-type: none"> <li>Emergency Department services for treatment where Primary Diagnosis is within the <b>Designated Behavioral Health Range*</b></li> </ul>	<p><b>LME/MCO</b></p>
<ul style="list-style-type: none"> <li>Emergency room services where the Primary Diagnosis is <b>NOT</b> within the <b>Designated Behavioral Health Range*</b></li> </ul>	<p><b>Bill direct to NC DMA / Medicaid</b></p>
<p><b>Medical/Neurological/Organic Issues</b></p>	
<ul style="list-style-type: none"> <li>Stabilization of self-induced trauma poisoning</li> <li>Treatment of disorders which are primarily neurologically/organically based, including delirium, dementia, amnesic and other cognitive disorders</li> </ul>	<p><b>Bill direct to NC DMA / Medicaid</b></p> <p><b>EXCEPTION:</b> Bill LME/MCO for Eligible Recipient's services provided during Emergency Department visit for treatment is where Primary Diagnosis is within the <b>Designated Behavioral Health Range*</b></p>
<p><b>Alcohol Withdrawal Syndrome and Delirium Tremens</b></p>	
<ul style="list-style-type: none"> <li>Alcohol withdrawal syndrome. Ordinary Pharmacologic syndrome characterized by elevated vital signs, agitation, perspiration, anxiety and tremor that is associated with the abrupt cessation of alcohol or other addictive substances.</li> <li>Detoxification services authorized by LME/MCO.</li> </ul>	<p><b>LME/MCO</b></p>
<ul style="list-style-type: none"> <li>Delirium Tremens (DTs), Complication of chronic alcoholism associated with poor nutritional status This is characterized by a major physiologic and metabolic disruption and is accompanied by delirium (after persecutory hallucination), agitation, tremors (frequently seizures) high temperatures and may be life-threatening.</li> </ul>	<p><b>Bill direct to NC DMA / Medicaid</b></p> <p><b>EXCEPTION:</b> Bill LME/MCO for Eligible Recipient's services provided during Emergency Department visit for treatment is where Primary Diagnosis is within the <b>Designated Behavioral Health Range*</b></p>
<p><b>Miscellaneous</b></p>	
<ul style="list-style-type: none"> <li>Pre-Authorized, Mental Health, Alcohol/ Substance Abuse admission, History and Physical</li> <li>Adjunctive alcohol/substance abuse therapies when specifically ordered by a network or LME/MCO authorized physician</li> </ul>	<p><b>LME/MCO</b></p>

**\* Designated Behavioral Health Primary Diagnosis Code Ranges: 290 - 319 (ICD 9) or F01 - F99 (ICD-10)**