



Provider Forum Webinar September 11, 2019 1pm – 3pm

Welcome to the Quarterly Webinar:

- ▶ Beth Lackey, Provider Network Director, is your moderator for today's webinar.
- ▶ The audience is in "listen only mode." You can only hear us talking, but you can't talk with us through the phone in an interactive way.
- ▶ Today's webinar is recorded and will be posted to the Partners BHM web page under the Provider Knowledge tab. Any handouts will be uploaded to this page as well. Previous webinars are also on this page for your viewing pleasure!
- ▶ You may submit questions from today's webinar to:
questions@partnersbhm.org



Agenda

- ▶ Partners Updates
- ▶ Provider Network Updates
- ▶ Crossover to NC Medicaid Managed Care: LME-MCO
Provider Education
- ▶ Credentialing Update
- ▶ Enrollment Update
- ▶ QM Updates
- ▶ UM Updates
- ▶ Provider Council Reminder



9/18/2019

3

Partners Updates

- ▶ Trainings for Raise the Age
- ▶ Measurement Based Care focus and Training
- ▶ Provider Network Account Specialist Changes
- ▶ Communication Bulletins
- ▶ Managed Care Launch Changes



9/18/2019

4

Trainings for Raise the Age

Please see the following link about upcoming Raise the Age Workshops.

<https://www.sog.unc.edu/courses/raise-age-workshop>

These workshops are designed to be most beneficial to law enforcement, School Resource Officers, or any interested persons of the court (district court, magistrates, clerks, prosecutors, and defenders).



9/18/2019 5

Measurement Based Care Requirement November 1, 2019

- ▶ As Partners communicated in the August 15, 2019 Communication bulletin we are requiring Providers (Agencies and LIPs) to identify and **begin to use a Measurement Based Care Instrument and those requirements are effective November 1, 2019.**
- ▶ [Register Here](#) for the Webinar on Measurement Based Care
- ▶ To further support Provider understanding of this requirement, Partners has scheduled a webinar specifically focused on Measurement Based Care on October 2, 2019, 1pm to 3pm. Please register for the webinar.
- ▶ In advance of this webinar, additional resources can be accessed at the following site: https://thekennedyforum-dot-org.s3.amazonaws.com/documents/KennedyForum-MeasurementBasedCare_2.pdf



9/18/2019 6

Provider Account Specialist Changes

- Provider Network has restructured the role of the Provider Network Account Specialist
- Provider Assignments have changed and we have restructured to assign our State funded providers, those with b3 dollars, and those in need of heavy technical assistance to assigned Account Specialists.
- All other providers will have access to Provider Network Account Specialists through a helpdesk function via the group email address pnas@partnersbhm.org
- Phone Contact: 877-267-7454 ext 4, then 1 for the Account Specialists.



9/18/2019 7

Managed Care Launch Changes

- On September 3, 2019, NCDHHS announced that it will extend open enrollment for Medicaid beneficiaries and move to a statewide transition to managed care on February 1, 2020.
- DHHS shared the following announcement: *Managed care in North Carolina was scheduled to roll out in two phases, with Medicaid beneficiaries in part of the state beginning managed care services on Nov. 1, 2019 and most of the state beginning on Feb. 1, 2020.*
- *With today's announcement managed care will now go-live in one phase for the whole state **beginning on Feb.1, 2020.***
- *The timeline has been adjusted because DHHS cannot implement critical actions to go-live with managed care under the current continuing resolution budget. The updated timeline only impacts counties that were in Phase 1; it does not impact counties that were scheduled for Phase 2. The date of Feb. 1, 2020 for statewide implementation remains unchanged.*



9/18/2019 8

Managed Care Launch Changes

Why does DHHS need to revise the timeline for Managed Care?

The transition to managed care is the most significant change ever undertaken by NC Medicaid. For the past four years, the department has achieved significant milestones to keep the state on track for launch of the program.

- ▶ The next set of activities that must be implemented depend upon budget action, including finalizing the rates to pay health plans and providers, ensuring health plans have enough providers in their networks to meet the needs of beneficiaries, deploying a complex algorithm to assign beneficiaries who do not self-select plans and doctors and obtaining federal approval to launch. Since July, DHHS has advised its partners and the North Carolina General Assembly that the timing of the budget would impact the state's schedule for moving to managed care.
- ▶ Furthermore, ongoing budget uncertainty has been an impediment to health plans finalizing contracts with doctors and health providers. An essential component of a well running managed care system is the strength of the health care network available to beneficiaries.



9/18/2019

9

Medicaid Managed Care – Statewide Rollout and Open Enrollment Extension – Message for Call Centers

▶ For beneficiaries calling about launching Medicaid managed care for the entire state on Feb. 1, 2020, instead of in 2 phases.

- Medicaid managed care services will begin Feb. 1, 2020.
- If you received a notice to enroll in a Medicaid managed care health plan by Sep. 13, you now have until Dec. 13. Your managed care services will begin Feb. 1, 2020, instead of Nov. 1, 2019.
 - The 27 counties where open enrollment will be extended are Alamance, Alleghany, Ashe, Caswell, Chatham, Durham, Davidson, Davie, Forsyth, Franklin, Granville, Guilford, Johnston, Nash, Orange, Person, Randolph, Rockingham, Stokes, Surry, Vance, Wake, Warren, Watauga, Wilkes, Wilson and Yadkin.
- There are no changes for the remaining 73 counties. Open enrollment will be Oct. 14 through Dec. 13.
- Managed care services will begin Feb. 1, 2020.



9/18/2019

10

Medicaid Managed Care – Statewide Rollout and Open Enrollment Extension – Message for Call Centers

Additional information for inquiries from providers, internal PHP departments (e.g., Sales) and similar callers:

- ▶ DHHS remains committed to transitioning Medicaid and NC Health Choice from fee-for-service to managed care as directed by the NC General Assembly (Session Law 2015-245, as amended).
- ▶ All stakeholders should continue to work toward the Feb. 1, 2020 implementation date.
- ▶ It is critical that the health plans and doctors and health systems continue to work together on contracting.



9/18/2019 11



PARTNERS
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Crossover to NC Medicaid Managed Care: LME-MCO Provider Education



Credentialing Jason Arenillas - Supervisor

CAQH

- ▶ All clinicians must ensure that their CAQH information is up-to-date:
 - If a provider discloses information in Section C of CAQH “Professional Information”, a detailed explanation must be given on the supplemental form. Short and vague answers could result with the application being denied or pended and/or delay credentialing.
 - State release will be available in CAQH once credentialing staff add the clinician to the CAQH Partners roster
 - The state release can be found in the document section in CAQH, sign, date and upload back into CAQH



Re-Credentialing Notices

- ▶ A Re-credentialing notice is sent out at 6 Months and 90 days prior to the expiration of credentialing for each provider (associated clinicians, licensed independent practitioners and agencies).
 - The notice to associated clinicians and LIPs goes to the last e-mail address on file for the clinician/LIP.
 - The notice for agency re-credentialing goes to the agency credentialing primary contact via e-mail as well as to the CEO via certified mail.
- ▶ The expiration of credentialing for each provider (associated clinicians, licensed independent practitioners and agencies) is posted on Partners website and updated monthly. You can find that information at the following link:

<https://providers.partnersbhm.org/provider-enrollment-credentialing>



9/18/2019 15

Contract Notices

Agencies and LIP's also receive a **contract warning** notice via certified mail at 90 days prior to their credentialing expiration date.

- If Partners BHM has not received a **complete** re-credentialing application from LIPs and agencies **60 days prior to credentialing expiration** then Partners BHM issues a **contract non-renewal letter** via certified mail ending your participation in the Partners BHM network effective the date of the credentialing expiration.
- Partners BHM is required to begin notifying consumers that the provider is no longer eligible to offer services in the network at this point.



9/18/2019 16

Complete Application

- ▶ The application must be **complete** in order to avoid or stop the contract non-renewal process. A complete application means all attachments are received and correct and the information in the application is correct/accurate and no additional information is needed.



9/18/2019 17

Credentialing vs. Enrollment

- ▶ Credentialing and enrollment are two different processes and departments within Partners.
- ▶ In addition, enrollment with NC Tracks is separate from credentialing and separate from enrollment with Partners.
- ▶ Providers **MUST** be enrolled in NC Tracks in order to be eligible to apply to join Partners network.
- ▶ Enrollment with Partners (i.e. enrollment in Alpha) **CANNOT** be completed if enrollment with NC Tracks does not match the information submitted and verified through Credentialing.



9/18/2019 18

Associated Clinicians

- ▶ When initiating credentialing for an agency new to Partners network, be sure to submit the Provider Change Form to initiate credentialing for the associated clinicians that will provide services with the agency at the same time.
- ▶ The Provider Change Form lists out all the information needed to initiate credentialing for a clinician



9/18/2019 19

NPPES

- ▶ National Plan & Provider Enumeration System (NPPES)
- ▶ Addresses, taxonomies, NPI numbers must all match in NC Tracks, NPPES and Alpha.
- ▶ NPPES must have the most current address/taxonomy information for the agency under the NPI# associated with each site.
- ▶ Credentialing will verify that the site/taxonomy in the application are registered in NPPES under the NPI# listed for it.



9/18/2019 20

NPPES – Making Changes to Information

- ▶ If you need assistance making changes to NPPES:
 - For **individual** NPI numbers:
 - Call: **800-465-3203**
 - For **organization** NPI numbers:
 - Call **866-484-8049**
 - Select the option called “**Identity & Access**” (**I&A**)
 - Ask for guidance in processing a “**role request**” to gain access to organization NPI information
 - For all changes related to the organization NPI, you will likely need to have your W-9 handy when you call



9/18/2019 21

Making Changes to Provider Info

- ▶ For any changes such as name changes, license updates, adding a site, adding services, and updating taxonomy/NPI# to the Partners contract, the provider will need to submit a **Provider Change Form** with the specific changes and information listed.
- ▶ The **Provider Change Form** is found on the Partners website under the “Provider Knowledge Base” tab at the top of the website. Once in there, go to “Credentialing and Enrollment” tab. When you scroll down the page you will see an actions grid and the **Provider Change Form** will be there.
- ▶ Please submit a **Provider Change Form** to the credentialing team email (CredentialingTeam@partnersbhm.org) for any changes needed to be made to the agency.



9/18/2019 22

Agency Primary Contact Info

- ▶ Please ensure the primary contact information for the agency is correct in the application.
- ▶ If the primary contact for the agency changes let Partners know by submitting a [Provider Change Form](#) to update the primary contact info for the agency.
- ▶ This will ensure correspondence is not missed and communicated effectively.



9/18/2019 23

Clinician Insurance Requirements

- Must submit a Certificate of Insurance for the agency's Professional Liability insurance with Partners listed as a Certificate Holder.
- If the clinician is covered under the agency's Professional Liability insurance, please submit either a roster of covered employees or documentation on agency letterhead evidencing that the clinician is covered by the policy.
- In the event the clinician is not covered under the agency's Professional Liability, please submit a Certificate of Insurance for the clinician's individual/personal policy.
- This certificate must list Partners as a Certificate Holder as follows: Partners Attn: Credentialing Dept., 1985 Tate Blvd. SE, Suite 529, Hickory, NC 28602.



9/18/2019 24

Agency Insurance Requirements

- ▶ Partners is required to be listed as “additionally insured” under the General Liability coverage.
- ▶ Partners is required to be the “certificate holder” for all required insurance coverage policies for credentialing (General Liability, Professional Liability, Auto Liability, and Workers Compensation).



9/18/2019 25

Proposed bills to pay attention to

- ▶ Please see below the links to 3 bills that are being proposed that will impact Medical Board, Substance Abuse and Social Work Professionals. Providers will need to be paying attention to them.
- ▶ <https://lrs.sog.unc.edu/bill-summaries-lookup/H/203/2019-2020%20Session/H203>
- ▶ <https://lrs.sog.unc.edu/bill-summaries-lookup/H/228/2019-2020%20Session/H228>
- ▶ <https://lrs.sog.unc.edu/bill-summaries-lookup/H/887/2019-2020%20Session/H887>



9/18/2019 26

Questions?

- ▶ Jason Arenillas, Credentialing Supervisor
 - (828) 325 8142
 - Jarenillas@partnersbhm.org
- ▶ Credentialing Department
 - (704) 842-6483
 - CredentialingTeam@partnersbhm.org

Please be sure to communicate the credentialing information with the credentialing staff/primary contact for your agency, thank you!



9/18/2019 27



Enrollment & NC Tracks

Danielle R. Clark-Enrollment Supervisor

Enrollment in Alpha

- ▶ Provider Network Enrollment staff verifies that the provider is:
 - Credentialed with Partners
 - Enrolled in NC Tracks
- ▶ If provider is credentialed and enrolled in NC Tracks:
 - Enrolled in Alpha
 - Contract issued



9/18/2019 29

If Provider NOT Enrolled in NC Tracks

- ▶ Partners cannot enroll provider in Alpha and cannot issue a contract.



9/18/2019 30

Common Enrollment Issues for Associated Clinicians

- Practice address is not under Name/Address Tab in NC Tracks.
- License has expired
- Clinician not Affiliated with agency in NC Tracks
- Taxonomy is not loaded in NC Tracks/NPPES
- Taxonomy is not an acceptable billing taxonomy



9/18/2019 31

Enrollment Cannot

- ▶ Make changes in Alpha until the changes can be verified in NC Tracks.
- ▶ Accept a managed change request as proof changes have been made.



9/18/2019 32

If Enrollment Status Letter is received

- ▶ Once the manage change request is approved-Please let enrollment staff know, so that changes can be verified.
- ▶ Enrollment staff do not go back and check NC Tracks for changes unless they are notified.



9/18/2019 33

If you have Enrollment Questions

- ▶ Enrollment group email address is enrollment@partnersbhm.org
- ▶ Danielle R Clark-Enrollment Supervisor can be reached directly at dclark@partnersbhm.org or 828-325-8158



9/18/2019 34



QM Updates

Renae Cheek & Veronica Somerville

Back-Up Staffing Guidelines

- The back-up staffing plan is designed to assure the health and safety of consumers receiving Innovations services. Failure to provide back-up staffing is a Level I Incident and must be reported to the MCO. Partners has chosen Alpha MCS as the reporting method to be used by providers. If you do not have an Alpha log-in, contact the Partners IT Help Desk at 704-842-6431 to be given access.
- The NC Department of Health and Human Services (NC DHHS) communicated via Joint Communication Bulletin 256 (#J256) on July 3, 2017 that "It is the expectation that if a provider agency or Employer of Record (EOR) staff member is unable to provide back-up staff, the provider or EOR is required to report this lack of staffing to the LME-MCO." This is a requirement and back-up staffing reports should be submitted bi-weekly.
- In relation to back-up staffing, there are two types of service interruptions: Failure to Provide Back-Up Staffing and Service Breaks.



When to submit a Failure to Provide Back-Up Staffing Report

- 1) Regularly scheduled staff is unable to provide service(s) AND a back-up staff is not available.
- 2) Regularly scheduled staff is unable to provide service(s) and back-up staff is available BUT is declined by the member/legally responsible person.

The purpose of the back-up staffing report is to document the reason that BACK-UP STAFF was not provided, NOT why the primary staff was unable to provide the service. The Back-Up Staffing report is NOT used to report service breaks.



9/18/2019 37

Service Breaks

- Per Clinical Coverage Policy 8P <https://files.nc.gov/ncdma/documents/files/8-P.pdf>, and also communicated via Joint Communication Bulletin #J266 on September 21, 2017, service breaks do not require Back-Up Staffing reporting to the MCO. Service breaks are defined as holidays, vacations, weather conditions, illnesses, and scheduling conflicts. Services breaks should be documented in the consumer's record.
- The following table contains scenarios regarding when to complete a Failure to Provide Back-Up Staffing Report versus document a service break in the consumer's record. The scenarios are based on information provided by DMA in response to questions they have received from providers regarding completion and submission of *Failure to Provide Back-Up Staffing Incident Reports*.



9/18/2019 38

Scenario	Type of Incident	Provider Action Step	Submit via ALPHA PORTAL BUS MODULE
Consumer had doctor's appointment and services were not provided	Service Break	Document the service break in the consumer record	No
Consumer went on vacation and did not receive services	Service Break	Document the service break in the consumer record	No
Regularly scheduled staff out due to illness. Back-up staff was offered but consumer/family did not want another staff person or back-up staff was unavailable	Failure to Provide Back-Up	Complete Failure to Provide Back-up Staffing Incident Report	Yes
Regularly scheduled staff quit. Back-up staff was offered but consumer/family did not want another staff person or back-up staff was unavailable	Failure to Provide Back-up	Complete Failure to Provide Back-up Staffing Incident Report	Yes
Consumer/family not utilizing all authorized service units available	Service Break	Document the service break in the consumer record	No
Consumer/family did not notify the supervisor that regularly scheduled staff did not show up for work until several days after the fact	Failure to Provide Back-up	Complete Failure to Provide Back- up Staffing Incident Report	Yes
New regularly scheduled staff in the process of being hired. Back-up staff offered during interim but declined or back-up staff was unavailable	Failure to Provide Back-up	Complete Failure to Provide Back- up Staffing Incident Report	Yes
Consumer did not have services over a Christmas Holiday per Consumer/Family request	Service Break	Document the service break in the consumer record	No
Consumer/Parent/Guardian requested no staff to come to give consumer a break	Service Break	Document the service break in the consumer record	No
Consumer/Family requested no services due to inclement weather	Service Break	Document the service break in the consumer record	No
Consumer is sick and unable to participate in services	Service Break	Document the service break in the consumer record	No
Consumer is in the hospital	Service Break	Document the service break in the consumer record	No
Consumer/Family had a scheduling conflict and requested cancellation of services	Service Break	Document the service break in the consumer record	No
Provider is closed for a holiday	Service Break	Document the service break in the consumer record	No
Provider is closed or closes early due to inclement weather	Service Break	Document the service break in the consumer record	No



Examples....

Importance of Failure to Provider Back-Up Staffing

Submitting the Failure to Provide Back-Up Staffing Report is a requirement by DHSR. Information from reports submitted by providers is used in a quarterly report required to be submitted to the State by the MCOs. Partners also does quarterly reporting to our Human Rights Committee and a monthly snapshot of details to our Quality of Care Committee.



ENTERING THE FAILURE TO PROVIDE BACK-UP STAFFING REPORTS IN THE ALPHA PORTAL

Instructions for using the Back-up Staffing Module may be found upon logging into the Alpha portal and locating “Alpha University” in the menu, <http://www.alphacm.net/mcsuniversity/>. You will look for the Quality Management section and click on Backup Staffing V2 to bring up the instruction document. You may save but should also print to have when you enter the reports until you are familiar with the process.



9/18/2019 41

Highlights of the Instructions:

To begin, go back to the menu in Alpha, click on Quality Management → Backup Staffing → Create
When you create, Alpha will assign a unique BUS ID#. Fields with “asterisks” are required fields.
A report must be submitted for each date of incident, as the form does not allow for multiple dates.

To enter the consumer information, click on the “search” button, type in the last and first name and click “search” again and it should bring up the consumer. If it brings up more than one consumer with that name, look at the DOB and SSN before selecting.

Complete the provider details and contact information.

You will either check the box stating that Back-up Staffing was not available, or that back-up staffing was offered but declined. When either box is checked it will open additional fields, specific to the reason chosen, to be completed.

Service Details-begin typing the service code such as T2013TF or H2015 as this will cause the predictive text to pop up and you can click on it to populate the field.

Indicate the time of service and the hours without staff.

Choose the reason the BACK-UP staff was unavailable (not the primary staff) in the drop down. If “Other” is chosen as the reason, there must be an explanation of what “other” means in the field to the right of the reason field.

Do not submit a report for a date of incident prior to the actual date of incident.

At the bottom of the report, you have the option of clicking on the “Save” button then returning to the form to complete. When you are ready to complete and submit the report to the MCO, click on the “Submit” box on the left of the form, then click on the “Save” button on the right of the form to send the report to the MCO.



9/18/2019 42

Back Up Staffing Reminders

We plan to post a webinar on the process of completing back-up staffing reports in Alpha by the end of September.

If you have questions, please contact:

Rena Cheek, QM Analyst

336-527-3208

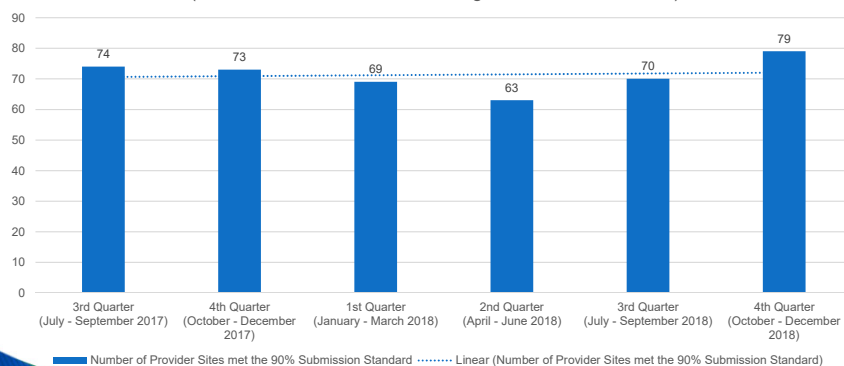
rcheek@partnersbhm.org



9/18/2019 43

NC TOPPS Quarterly Summary

NC-TOPPS Superstars Summary Results
SFY 2018 - 2019 Update Compliance
(Based on Initials Submitted During the Time Period Listed)



9/18/2019 44

4th Quarter FY 2019 Highlights (Based on Initials Submitted October - December 2018):

79 Provider sites met the 90% submission standard.
71 of the 79 Provider sites made 100% submission score.
8 of the 79 Provider sites made 90.9% to 96.9%.
2 Provider sites made it into the 80% range.
14 Provider sites fell below 80% submission.
121 Sites had no requirements for updates.
 Total of 216 Provider sites.

| Source: SFY 2019 Update Compliance by Provider Agency
 Report: Second Quarter Report | Distributed August 7, 2019
 from NCTOPPS



9/18/2019 45

NC-TOPPS Quarterly Snapshot Report

NC-TOPPS Quarterly Snapshot Report

4th Quarter FY 2019 (Based on Episode Completion Interviews April – June 2019) Highlights:

Decreasing symptoms (Goal: 60%) and improving quality of life (Goal: 50%) have continued to exceed their goals since March 2018.

Increase In-Person/Telephonic (Combined): All consumers groups for the past two quarters have fell below the goal of 65% except for Quarter 3 (January -March 2019) Adolescent SA was 66.7% and Quarter 4 (April – June 2019) Adolescent SA was 75.0%.

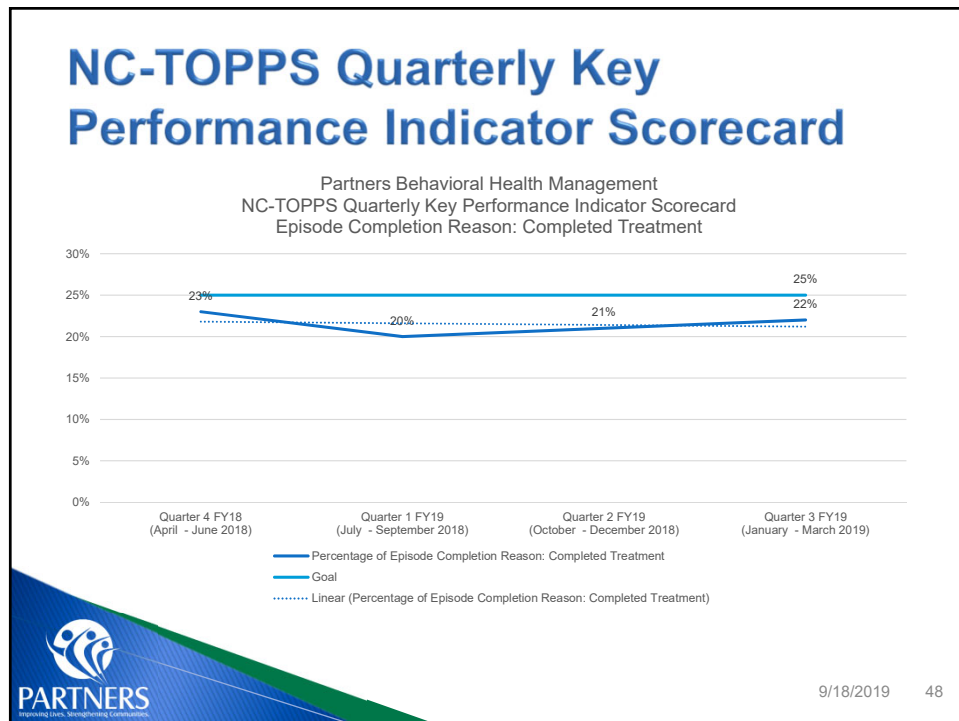
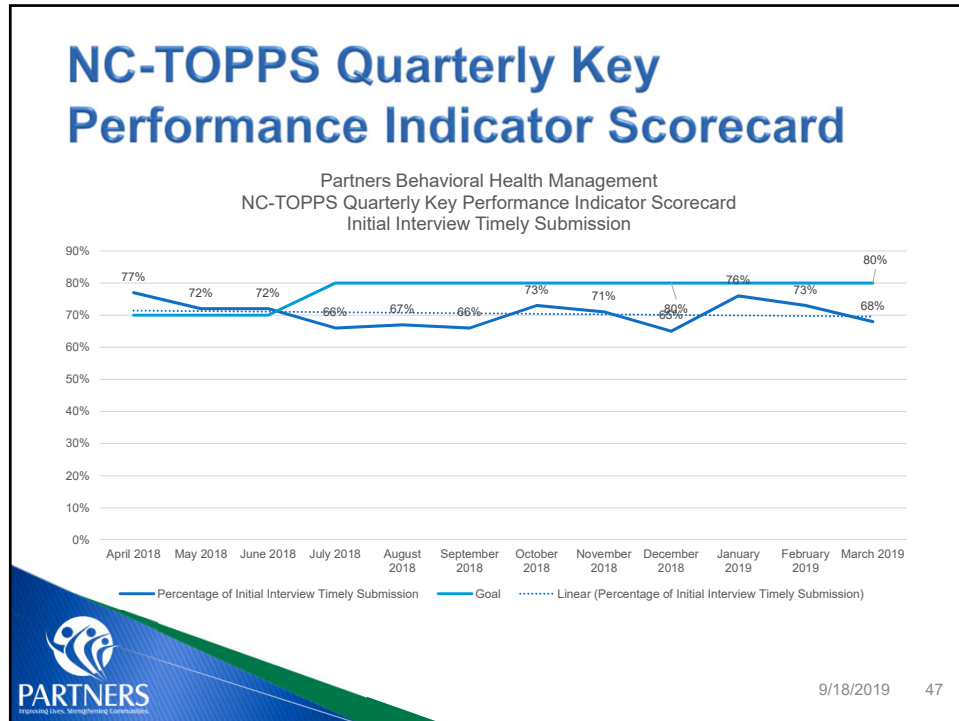
Barriers to Treatment:

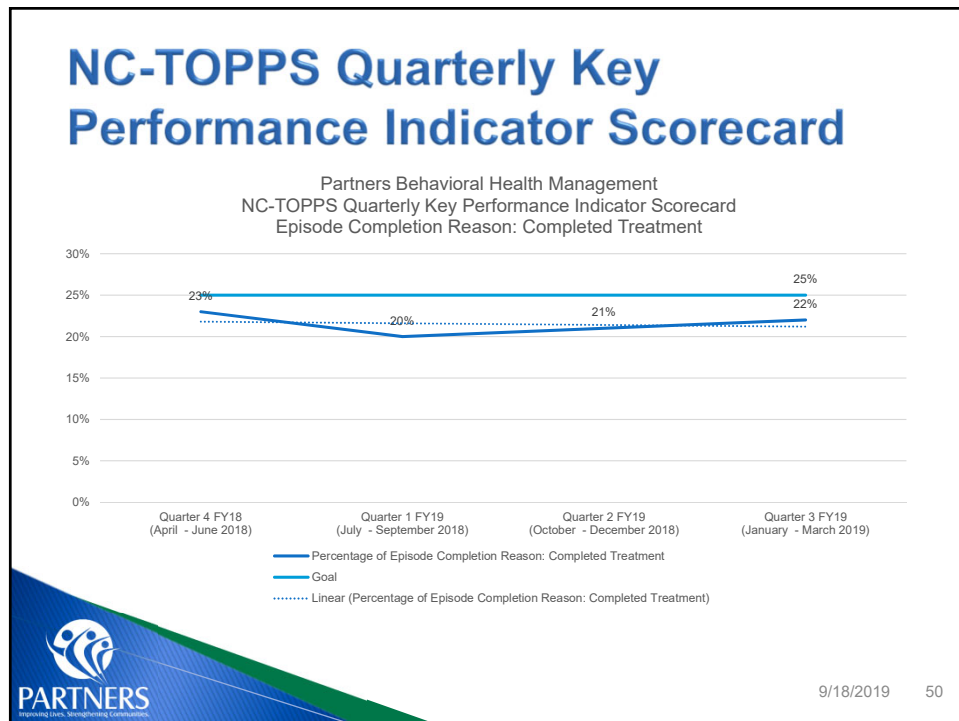
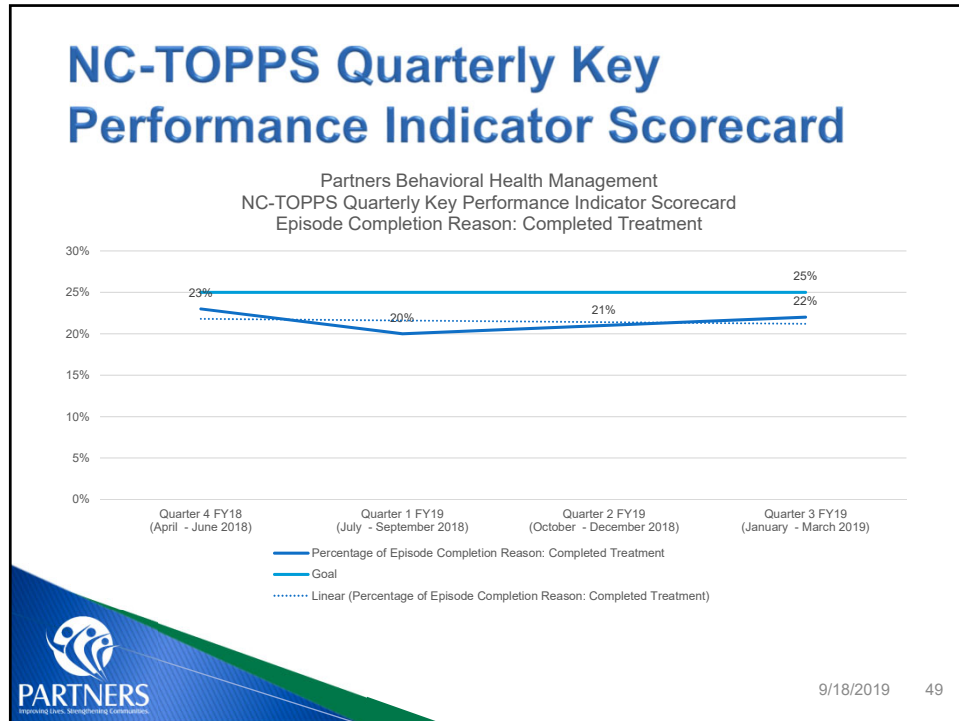
- Ranking 1-7: 1-Strength (Low Percentage) and 6- Area for Opportunity (High Percentage)
 - SA Symptoms
 - MH Symptoms
 - Transportation
 - Scheduling
 - Treatment Engagement
 - Family Issues

Source: NCTOPPS Simple Query | Date Generated: July 10, 2019



9/18/2019 46





3rd Quarter FY 2019 (Based on Episode Completion Interviews January – March 2019) Highlights:

Quarter 2 FY 2019 fell below the 80% goal in October (73%), November (71%) and December (65%). Quarter 3 FY 2019 increased in January (76%) but in February (73%) and March (68%) it experienced another decrease. Both quarters have fell below our goal of 80%.

Episode Completion Reason, Completed Treatment: Increased by 1 percentage point since the last quarter.

Interview Method, In-Person/Telephone: Increased from 31% to 38% (7 percentage points).

Quality Indicator, "Where services helpful with Symptoms?" "Very Helpful": Decreased from 51% to 50% (1 percentage point).

| Source: NC-TOPPS Raw Data Report, NCTOPPS Interview Search Report, Partners BHM Reports Manager (NC TOPPS DUE Based on Claims)
| Generated July 10, 2019 |



9/18/2019 51



Utilization Management Updates

Presented by:

Janet Reading, Ph.D., MH/SU UM Child Services Supervisor

Adult Services Provider Alert

Outpatient Opioid Treatment:

For State and Medicaid Members

- Effective 8/5/2019
 - Initial
 - H0020 : May request up to 90 units for 90 days authorizations
 - H0020U3BU : May request up to 13 units for 90 days
 - Concurrent
 - H0020 : May request up to 180 units for 180 days
 - H0020U3BU : May request up to 26 units for 180 days



9/18/2019 53

New Adult Service Office Based Opioid Treatment (OBOT) Bundle – YA396

New State-Funded Alternative Service: Effective 5/1/19

- This is an evidence-based treatment for Opioid Use Disorder (OUD)
- Provided in an outpatient office setting, rather than licensed Opioid Treatment Program.
- The cost of medication and of urine drug screening are covered in the bundled rate.
- Each phase has a different rate and must be identified by the correct modifier.
 - YA396 (S1) – Assessment/Induction Phase
 - YA396 (S2) – Stabilization
 - YA396 (S3) – Maintenance
- Documentation Requirements:
 - Initial: CCA, Treatment Plan, Urine Drug Screen Results, and Service Order
 - Concurrent: Urine Drug Screen Results and updated Treatment Plan w/ each request



9/18/2019 54

Adult and Child Services Provider Alert

- Effective 7/10/19: All Basic Outpatient Behavioral Health Services, both Medicaid and State, will become unmanaged and no authorization required.
- Outpatient providers will need to submit claims to Partners Claims Department for reimbursement of unmanaged Basic Outpatient Services.
- For additional information, you may review the Provider Alert posted on 7/15/19.
- <https://providers.partnersbhm.org/basic-outpatient-services/>
- **Note:** Outpatient Specialty services with enhanced rates will continue to be managed



9/18/2019 55

New Child Services High Fidelity Wrap Around – H0032 HF

High Fidelity Wraparound (HFW) is an intensive, team-based, person-centered service

- Provides coordinated, integrated, family-driven care to meet the complex needs of youth who are involved with multiple systems
- For Youth who experiences serious emotional or behavioral difficulties
- For Youth who have dual diagnosis (MH and/or SUD, and IDD) with high service needs
- For Youth at risk of placement in PRTFs or other institutional settings
- For Youth aging out of Department of Social Services (DSS) care

HFW activities are grouped into four phases:

- 1) Engagement and Team Preparation
- 2) Plan Development
- 3) Plan Implementation
- 4) Transition

HFW provides intense case management but does not include therapeutic treatment.
HFW will be a maximum of 18 months.



9/18/2019 56

RB-BHT Updates

RB-BHT Code	Description	Unit	Rate	Provider Type	NEW Units/Frequency*	Initial Request	Concurrent Request
97151 97151NC (For OT or SLP)	RB-BHT Comp Assessment	15 min	\$26.56	LQASP	Up to 2 assessments per rolling calendar year. Each assessment is up to 6 units.	*Service order PHD, PSYD, MD, DO *No Treatment Plan needed if a standalone code *Definitive ASD diagnosis documentation needed utilizing a scientifically validated diagnostic tool for diagnosis of ASD *Current (within 3 years) Behavioral, Functional or Adaptive Assessment utilized to inform the service order	*Updated Treatment Plan at least every 6 months and rewritten annually. *Service order re-signed annually *Copy of assessment completed with initial 97151 code.
97152 97152NC (For OT or SLP)	RB-BHT Assessment FIU	15 min	\$ 53.65	LQASP	Up to 8 units per month	*Service order PHD, PSYD, MD, DO *Treatment Plan signed/dated/Credentials by LQASP (who develops the plan) and legally responsible person. *Service Order statement needs to cover the amount of time provider wants their plan to be valid for. Plan/service order can be valid for up to one year if indicated.	*Updated Treatment Plan at least every 6 months and rewritten annually. *Service order re-signed annually. *Copy of assessment completed with 97151 code. If requesting all codes upon initiation of service, the assessment is required for the 1st concurrent request.
97153	RB-BHT ABA	15 min	\$ 18.09	LQASP, C-QP, Paraprofessional***	Service hours up to 10-25 hours (40-100 units) per week. Includes 97153 and 97154.	*Definitive ASD diagnosis documentation needed utilizing a scientifically validated diagnostic tool for diagnosis of ASD *Current (within 3 years) Behavioral, Functional or Adaptive Assessment utilized to inform the service order	
97154	RB-BHT ABA 2 or more	15 min	\$ 9.88	LQASP, C-QP, Paraprofessional***	Service hours up to 10-25 hours (40-100 units) per week. Includes 97153 and 97154.		
97155	RB-BHT Supervision, Parent Training	15 min	\$ 28.00	LQASP, C-QP	Up to 3 hours per week		
97156	RB-BHT Parent Training without Child	15 min	\$ 20.60	LQASP, C-QP, Paraprofessional***	Up to 16 units per month.	*Copy of assessment completed with 97151 code. If requesting all codes upon initiation of service, the assessment is required for the 1st concurrent request.	
97157	Parent Training- Group	15 min	\$ 10.00	LQASP, C-QP, Paraprofessional***	Up to 16 units per month.		
***Need attestation letter on file that supervision is received from a LQASP or C-QP							
** Requesting timeframe for each code is up to 180 calendar days. For each code place of service can be home, school, community or office							
Updated 8/20/19							



9/18/2019 57

UM Contact Information

Utilization Management Contact Information:

CONTACT INFORMATION

UM STAFF

MH/SA UM Workgroup	X 6436	Direct In-dial Number	1-704-842-6436
IDC/Innovations Workgroup	X 2605	Direct In-dial Number	1-704-884-2605
Inpatient Reviewers Workgroup	X 6434	Direct In-dial Number	1-704-842-6434
Appeals Department Workgroup	X 2650	Direct In-dial Number	1-704-884-2650

UM Fax/ Phone Numbers

UM MH/SA Faxcore: 704-884-2701
 Inpatient Faxcore: 704-884-2703
 Gastonia: 704-866-7727
 Hickory: 828-325-9826
 UM Appeals Faxcore: 704-884-2720
 UM IDD Faxcore: 704-884-2690
 PBHM Service Desk-704-842-6431



9/18/2019 58

Provider Council Updates

- ▶ Next Meeting September 27, 2019 at 9:30 am
– Hickory Multipurpose Room – open meeting



THANK YOU FOR YOUR ATTENTION

- Thank you for attending our webinar; this concludes our session
- Please submit questions regarding this webinar to questions@partnersbhm.org

