



Provider Forum
March 11, 2020
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Provider Network Director

Agenda

- ▶ Provider Council updates
- ▶ After Hours Crisis Response
- ▶ Utilization Management Updates
- ▶ Reducing Risk of Overpayments: Service Orders, CCA's and PCP's
- ▶ Incident Response Improvement System
- ▶ Social Determinants of Health
- ▶ Provider Operations Manual: March update
- ▶ Communication Bulletin/Training



Provider Council Updates

- ▶ Leadership
 - Beth Brown, Chair
 - Alicia Emmons, Vice Chair
 - Teagan Brown, Secretary
- ▶ Provider Council is an open meeting that occurs Monthly, with the exception of December and July.
- ▶ Provider Council meets at 9:30am in Hickory on the 4th Friday of each month in the Multipurpose room
- ▶ Next Meeting – 3/37/2020 at 9:30am – This is your meeting, Partners is invited to attend!





After Hours Crisis Coverage and Response

Emergency Department Use Plan

Ongoing Initiatives

- ▶ Survey providers about after hours crisis response
- ▶ Bulletin reminders of first responder responsibilities
- ▶ Mystery Shopping calls to providers
- ▶ Crisis and ED use campaign with materials for members and families
- ▶ Follow up with providers and continued provider mystery shopping



Reducing Unnecessary BH ED Use

- ▶ **Dec 2019** Surveyed providers for their crisis numbers, voicemail scripts, and crisis materials
- ▶ **Jan 2020** Testing first responder capability with mystery shopping calls with 159 enhanced service providers
- ▶ **Feb-March** Sharing preliminary results



January 16, 2020

After-Hours Coverage & Crisis Plan Requirement Reminder



Provider Bulletin #101

🏠 / Provider Communication Bulletin / Provider Bulletin #101

- **Holiday Closing**
- **January Provider Council Meeting**
- **Appointment Scheduling**
- **Reminder of After-Hours Coverage and Crisis Plan Requirements**
- **Utilization Management Updates**
- **Clinical Practice Guidelines**



Partners' Mystery Shopping Results

- ▶ **Preliminary results from first round of after-hour calls:**
 - 159 Calls made to Enhanced Providers by Access to Care staff
 - Only 5.66% of the 159 calls made after-hours were answered by a staff member at an agency (live person)
 - 10 of the numbers listed in Alpha were not in service across 8 different provider agencies
 - Less than 70% of the 149 working numbers not answered had voicemail capability



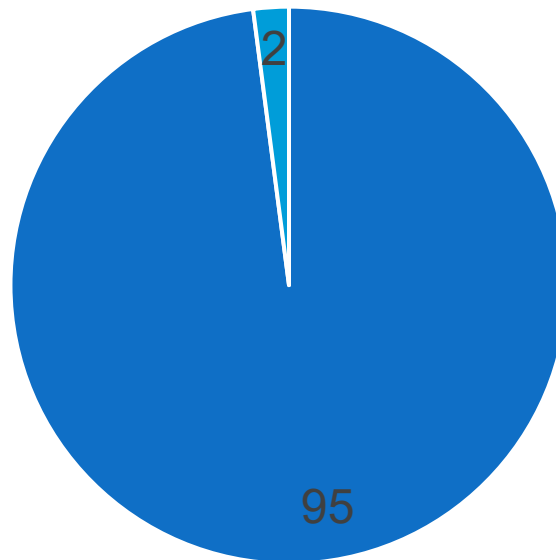
Partners' Mystery Shopping Results

- ▶ **Preliminary results from first round of after-hour calls:**
 - 2 of the 95 voicemails left were returned by staff
 - Partners' staff stated in voicemail that this was a test of their emergency number
 - 4 agencies returned the call even though a voicemail wasn't left 😊



Returned Calls from Partners' Voicemail Messages

Returned Calls from VM messages left



■ # of VM left ■ Returned call



Mystery Calls Made Per Service

H2022-Intensive In-Home (FCT)	69 provider sites called
H2015- Community Support Team	9 provider sites called
H0040- ACTT	10 provider sites called
H2035-SACOT	2 provider sites called
H0015-SAIOP	2 provider sites called
No Service Codes Indicated	67 provider sites called



Partial Results By Service Type

SERVICE TYPE	PARTICAL RESULTS
CST	2 were non-working numbers or VM with no return call
ACTT	7/10 calls returned; 3/10 referred to ED or 911
SAIOP	1 non-working number; 1 answered by live person; 44% had a VM with no return calls & 4 directed callers to Partners (2) and 911 (2)
IIH	4/69 answered by live person (5%); 3 numbers not working; 39/69 had voicemail recordings with 2 of the 39 with return call
SACOT	2 called with one not answered and the other directed to another number with no VM capability



Reminders for After-Hour Coverage

- ▶ All network providers have a contractual obligation and are bound by specific **service definitions** to provide first responder capabilities for their members that include at a minimum:
 - Crisis plan that includes their contact information with helpful strategies to mitigate crisis
 - Availability for consult by phone and/or face to face in a crisis before consumer accesses a higher level of care
 - Answering service or voice mail with the agency's after-hours contact number – voicemail should not direct behavioral health consumers to 911 for BH issues nor the Emergency Department unless their emergency is life threatening



First-Responder Reminders

- ▶ Provide members with 24/7/365 telephonic availability and/or access to a clinician or qualified professional in the case of an MH/IDD/SU crisis or emergency
- ▶ This contact may not be 911 or Partners' Access to Care
- ▶ This contact also may not be a hospital or Mobile Crisis Team unless that is the service being provided under contract with Partners, or unless the Provider has subcontracted with and pays such Providers directly for emergency backup services
- ▶ Providers may consult and refer directly to MCM after their first responder intervention has failed to safely manage the crisis. Providers do not need to go through Access to Care to make a referral to MCM



Enhanced Service Caveats

- ▶ Crisis planning should incorporate any limitations or restrictions listed in individual enhanced service definitions. For example, **ACTT**, **IIH** and **MST** definitions state only the members of this team can respond to the consumer that team is serving; Mobile Crisis is not a funded option
- ▶ **Comprehensive Providers** that have a Mobile Crisis Management Team (MCM) should not use that team as the first responder for their existing consumers; *this does not meet the intent of a first responder*





Utilization Management Update

New Community Support Team (CST) Service Definition: Clinical Coverage Policy 8A-6

Provider Alert – Issued 1/31/20:

- ▶ Effective February 1, 2020, providers may begin submitting Service Authorization Requests (SARs) for Community Support Team (CST) under the Definitions List “Community Support Team” and Services Code List “All Services”. SARs may be submitted for members with either Medicaid or State-funded services



New Community Support Team (CST) Service Definition: Clinical Coverage Policy 8A-6

- ▶ The following CST codes and modifiers will be included in the “All Services” bundled list:
 - H2015 HT U1 – CST Peer Support Specialist
 - H2015 HT U1 DJ – CST DOJ Peer Support Specialist
 - H2015 HT HM – CST Paraprofessional
 - H2015 HT HM DJ – CST DOJ Paraprofessional
 - H2015 HT HN – CST Qualified Professional/Associate Professional
 - H2015 HT HN DJ – CST DOJ Qualified Professional/Associate Professional
 - H2015 HT HF – CST Substance Use Counselor (LCAS, LCAS-A, CCS, CSAC) *specific per service definition
 - H2015 HT HF DJ – CST DOJ Substance Use Counselor (LCAS, LCAS-A, CCS, CSAC) *specific per service definition
 - H2015 HT HO – CST Licensed Team Lead
 - H2015 HT HO DJ – CST DOJ Licensed Team Lead

New Community Support Team (CST) Service Definition: Clinical Coverage Policy 8A-6

- ▶ Both Medicaid and State funded members may receive CST beyond six months of services if they have a Comprehensive Clinical Assessment (CCA) Addendum or new CCA that recommends that the member continue CST after six months of service. The CCA Addendum may be completed by *any* licensed clinician at the provider agency
- ▶ A new Service Order is NOT required at or after six months of service. A new Service Order should be completed annually



New Community Support Team (CST) Service Definition: Clinical Coverage Policy 8A-6

Community Support Team Retroactive Service Authorization Requests:

- ▶ Partners Utilization Management (UM) will allow the submission of retroactive SARs for Medicaid-funded CST for review back to December 16, 2019. In the case of members seeking stable housing, providers MUST identify when the member started Permanent Supportive Housing Services. All retroactive SARs must be submitted to Partners UM by February 29, 2020. This does not apply to members receiving State-funded services



New Community Support Team (CST) Service Definition: Clinical Coverage Policy 8A-6

Provider Alert Issued 3/2/20:

- ▶ On January 31, 2020, Partners Utilization Management (UM) released a Provider Alert regarding CST Retroactive Service Authorization Requests (SARs) for State-funded members. This Alert instructed providers not to submit retroactive SARs for State-funded CST members.
- ▶ The State CST code (H2015HT) was end dated on 12/31/2019 in NC Tracks. For services beginning 1/1/2020, providers will need to submit State Benefit claims with the new CST codes showing a secondary modifier. State Benefit Claims dated 1/1/2020 that are currently submitted with procedure code H2015HT will be recouped.
- ▶ Also, providers will need to submit Retroactive SARS for State-funded CST members who do not have an authorization in place utilizing the new code. UM will process retroactive SARs back to 1/1/2020. Please remember to submit SARs under the Definitions List “Community Support Team” and Services Code List “All Services”. All retroactive SARs must be submitted to Partners UM by March 31, 2020.
- ▶ If you have additional questions regarding claims, please email the Claims Department at claimsdepartment@partnersbhm.org.
- ▶ If you have additional questions regarding SAR submissions, please contact the MH/SU Utilization Management Workgroup at (704) 842-6436.

New CST Benefit Grid for Medicaid & State-funded Adults

Service Description	Benefit Limit	Level of Care	Source	Documentation Requirements
Community Support Team: H2015 HT U1 (DJ) – CST Peer Support Specialist H2015 HT HM (DJ) – CST Paraprofessional H2015 HT HN (DJ) – CST Qualified Professional/Associate Professional H2015 HT HF (DJ) – CST Substance Use Counselor (LCAS, LCAS-A, CCS, CSAC) * specific per service definition H2015 HT HO (DJ) – CST Licensed Team Lead	Initial: Pass-through of 36 units for 30 days only once per treatment episode, once per fiscal year. 1st Concurrent: Up to 128 units per 60 days. For those seeking permanent supportive housing, up to 420 units for 60 days. 2nd Concurrent: Up to 192 units per 90 days. For those seeking permanent supportive housing, up to 630 units for 90 days.	LOCUS: 2-4 ASAM: 1-2.5	8A-6	Notification SAR is Required for Pass-through on Initial Service Authorization Request (SAR) 1st Concurrent: CCA, PCP, and Comprehensive Crisis Plan. Service Order is also required and is due on or before the first date of service. For those seeking permanent supportive housing, a housing goal must be included on the PCP. 2nd Concurrent: Updated PCP. New CCA or CCA Addendum needed if request exceeds 6 months per calendar year. For those seeking permanent supportive housing, a housing goal must be included on the PCP.



Changes to Assertive Community Treatment Team (ACTT) Benefit Grid: Medicaid

Service Description	Benefit Limit	Level of Care	Source	Documentation Requirements
Assertive Community Treatment Team (ACTT): H0040 (DJ)	Initial: 4 units for 30 days. 1st Concurrent: 24 units per 6 months. If member enters treatment with less than 14 days left in the calendar month, authorize 4 units for partial month +24 units per 6 months. 2nd Concurrent: 24 units per 6 months.	LOCUS: 3-5 ASAM: 1-2.5	8A-1	Initial: CCA and Service Order. Service Orders are valid for 1 year. Full PCP required by 1st Concurrent authorization. 1st Concurrent: PCP and CCP 2nd Concurrent: Updated PCP Note: If the provider submits the full PCP, CCP, CCA, and Service Order with the initial authorization—they may request 24 units per 6 months.



Changes to Assertive Community Treatment Team (ACTT) Benefit Grid: State

Service Description	Benefit Limit	Level of Care	Source	Documentation Requirements
Assertive Community Treatment Team (ACTT): H0040 (DJ)	Initial: 4 units for 30 days. 1st Concurrent: 16 units per 4 months. If member enters treatment with less than 14 days left in the calendar month, authorize 4 units for partial month +16 units per 4 months. 2nd Concurrent: 16 units per 4 months.	LOCUS: 3-5 ASAM: 1-2.5	8A-1	Initial: CCA and Service Order. Service Orders are valid for 1 year. Full PCP required by 1st Concurrent authorization. 1st Concurrent: PCP and CCP 2nd Concurrent: Updated PCP Note: If the provider submits the full PCP, CCP, CCA, and Service Order with the initial authorization—they may request 16 units per 4 months.



Changes to Peer Support Services (PSS): Clinical Coverage Policy 8G

Provider Alert – Issued 2/19/20:

- ▶ **Authorizations and Documentation**: Partners will align the authorization requirements for both State and Medicaid funded Peer Support services. There will be 64 unmanaged units for Peer Support regardless of funding source. When the provider wants to request more units beyond the unmanaged units, the provider must submit a service order, a person centered plan (PCP) and comprehensive clinical assessment (CCA).



Changes to Peer Support Services (PSS): Clinical Coverage Policy 8G

- ▶ It is ***important to note that the Service Order must be signed on the first day of service.*** The PCP and CCA should be completed during the unmanaged visits and ready to submit with the first authorization request beyond the unmanaged allowance.
- ▶ This change is effective February 17, 2020*.
- ▶ * We recognize that State-funded Peer Support units have been unmanaged. Providers delivering State-funded Peer Support have until April 1, 2020 to submit a service authorization request with all required documentation.

Changes to Peer Support Services (PSS): Clinical Coverage Policy 8G

- ▶ **Service Orders**: There have been questions about what should be included with a standalone Service Order. The following elements must be captured:
 - Full Name of Member
 - Date of Birth
 - Service Ordered
 - Diagnosis Code
 - Signature of Ordering Practitioner
 - Credential of Ordering Practitioner



Changes to Peer Support Services (PSS): Clinical Coverage Policy 8G

- ▶ **Training:** Providers have asked questions about the training requirements for Peer Support. Training can be face to face, webinar or by internal staff who have their certification from a Train the Trainer session. There must be a certificate for each peer support employee signed by the trainer and kept in each personnel file.



Changes to Peer Support Services (PSS)

Benefit Grid: Medicaid and State-funded Adults

Service Description	Benefit Limit	Level of Care	Source	Documentation Requirements
Medicaid PSS: H0038 – Peer Supports Individual H0038 DJ – Peer Supports Individual (DOJ) H0038 HQ – Peer Supports Group H0038 HQ DJ – Peer Support Group (DOJ)	No authorization required for members who receive 64 unmanaged units or less per fiscal year. For over 64 units, submit a Service Authorization Request (SAR) for prior approval. Initial: 270 units per 90 days. Concurrent: 270 units per 90 days.	LOCUS: 1 ASAM: 1	8G	Service Order is required and is due on or before the first date of service. Initial: CCA, PCP, Service Order, and Comprehensive Crisis Plan Concurrent: Updated PCP
State PSS: H0038 – Peer Supports Individual H0038 HQ – Peer Supports Group H0038 HK – Peer Supports Individual (Timely Follow Up)				

Retroactive Medicaid Service Authorization Requests

Effective February 24, 2020, Partners Utilization Management (UM) Department will review requests for Retroactive Medicaid requests within **90** days from the Modified Date in NC Tracks. This is a change from the 30-day timeframe we posted in February 2019 Provider Bulletin #90. All Retroactive Service Authorization Requests (SAR) must be submitted to UM for medical necessity review. For further questions on Retroactive Medicaid requests, please contact the MHSU UM Workgroup at **704-842-6436**





Reducing the Risk of Overpayments: Service Orders, CCAs & PCPs

Provider Webinar, March 11, 2020
Joy Chestnut, Program Integrity Investigator

Objectives of this training...

To enhance compliance and help providers reduce the risk of receiving an overpayment.

Objectives

- ▶ Where do I find the rules for service orders, comprehensive clinical assessments (CCA), and PCPs
- ▶ What must be included in a service order, CCA, and PCP
- ▶ What are the signature requirements of a service order, CCA and PCP

This presentation is a summary of the requirements outlined in CCP 8C, CCP 8A, Person-Centered Planning Instruction Manual, and APSM 45-2. Those sources are superior to any criteria outlined in this presentation.



Laws, Rules, Regulations, Policies...

- ▶ State Plan
- ▶ North Carolina General Statutes
- ▶ North Carolina Administrative Code
- ▶ Clinical Coverage Policies
- ▶ Service Definitions
- ▶ Records Management and Documentation Manual



NC State Plan, General Statutes, Administrative Code

- ▶ NC State Plan: Title XIX of the Social Security Act requires that North Carolina provide a plan to administer and manage the North Carolina Medicaid Program.
 - <https://medicaid.ncdhhs.gov/notices/medicaid-state-plan-public-notices>
- ▶ NC General Statutes: Chapter 122C-Mental Health, Developmental Disabilities and Substance Abuse Act of 1985.
 - <https://www.ncleg.gov/Laws/GeneralStatuteSections/Chapter122C>
- ▶ NC Administrative Code: Title 10A, Chapters 26, 27, 28 & 29
 - <https://www.ncdhhs.gov/divisions/mhddsas/commission/ncadministrativecode>



NC DHB Clinical Coverage Policies

- ▶ NC Medicaid and Health Choice Clinical Coverage Policies for Behavioral Health
 - <https://medicaid.ncdhhs.gov/providers/clinical-coverage-policies/behavioral-health-clinical-coverage-policies>



Clinical Coverage Policies

- ▶ 8A, Enhanced Mental Health and Substance Abuse Services
- ▶ 8A-1, Assertive Community Treatment (ACT) Program
- ▶ 8A-2, Facility-Based Crisis Service for Children and Adolescents
- ▶ 8A-6, Community Support Team (CST)
- ▶ 8B, Inpatient Behavioral Health Services
- ▶ 8C, Outpatient Behavioral Health Services Provided by Direct-Enrolled Providers
- ▶ 8D-1, Psychiatric Residential Treatment Facilities for Children under the Age of 21
- ▶ 8D-2, Residential Treatment Services
- ▶ 8E, Intermediate Care Facilities for Individuals with Intellectual Disabilities
- ▶ 8F, Research-Based Behavioral Health Treatment (RB-BHT) for Autism Spectrum Disorder (ASD)
- ▶ 8G, Peer Support Services (PSS)
- ▶ 8-I, Psychological Services in Health Departments and School-Based Health Centers Sponsored by Health Departments to the under-21 Population
- ▶ 8J, Children's Developmental Service Agencies (CDSAs)
- ▶ 8L, Mental Health/Substance Abuse Targeted Case Management
- ▶ 8N, NC Health Choice – Intellectual and Developmental Disabilities Targeted Case Management
- ▶ 8-O, Services for Individuals with Intellectual and Developmental Disabilities and Mental Health or Substance Abuse Co-Occurring Disorders
- ▶ 8-P, North Carolina Innovations



Service Definitions (DMHDDSAS)

▶ State Funded Services

- <https://www.ncdhhs.gov/divisions/mhddsas/servicedefinitions>
- Enhanced Mental Health and Substance Abuse Services-December 15, 2019
- Assertive Community Treatment (ACT)-December 15, 2019
- Facility-Based Crisis Service for Children and Adolescents-December 15, 2019
- Community Support Team (CST) December 15, 2019
- Peer Support Services (PSS)-December 15, 2019
- Inpatient Behavioral Health Services-December 15, 2019
- Individual Placement & Support (IPS) for AMH/ASA-December 15, 2019
- Transition Management Services (TMS)-December 15, 2019
- Critical Time Intervention-December 15, 2019
- Developmental Therapy Service- December 15, 2019



Enter your search terms here Q SEARCH

Provider Alert: Provider Manual, Revised Manual SAR Form, CST Benefit Limits
Provider Bulletin: Provider Communication Bulletin #99

Provider News (7)

- Provider Webinars & Forums
- Orientation Packet and Provider Operations Manual
- Bulletins, Alerts, and Training
- Request for Services
- Continuously Recruited Services
- Community Behavioral Health Needs Analysis
- Provider Council

Provider Tools (7)

- Provider Credentialing and Enrollment
- AlphaMCS, ZixMail and Billing Set Up
- Cultural Competency
- Provider Monitoring
- Provider Contracting
- Provider Disputes
- ACORN

Access to Care and Utilization Management (8)

- Access to Care, Member Eligibility and Enrollment
- Utilization Management
- Hospitals Working with Partners
- Referrals to Specialty Treatment
- Service Authorization Requests
- Clinical Criteria Check Sheets

Care Coordination (8)

- Mental Health and Substance Use Disorders
- Transitions to Community Living Initiative
- Intellectual and Developmental Disabilities
- Registry of Unmet Needs
- NC Innovations
- Relative as Direct Support Employee

Finance, Claims and Billing (3)

- Finance Documents and Forms
- Claims and Rates Information
- E-Verify

Clinical Tools (7)

- Whole Person Integrated Care
- Benefit Grids
- Service Definitions
- CANS Training
- Clinical Practice Guidelines
- EPSDT
- Evidence-Based Practices

Quality Management and Corporate Compliance (7)

- Quality Management and Global CQI
- NC-TOPPS
- Incident Reporting
- Regulatory Compliance
- Health Information Management
- Program Integrity
- Applicable Laws and Regulations for Regulatory Compliance

Additional Resources (7)

- Licensed Independent Practitioner Collaborative
- IVC Designated Facilities
- Consumer Relations, CFAC
- File a Concern or Grievance
- System of Care and Family Partners
- Housing Resources
- Transportation Resources



PARTNERS Provider Knowledge Base

▶ <https://providers.partnersbhm.org/>



Clinical Tools (7)

- Whole Person Integrated Care
- Benefit Grids
- Service Definitions
- CANS Training
- Clinical Practice Guidelines
- EPSDT
- Evidence-Based Practices

Records Management and Documentation Manual (APSM 45-2)

- ▶ Records Management and Documentation Manual APSM 45-2 (Chapter 3: Clinical Assessments and Evaluations, Chapter 4: Individualized Service Planning, and Chapter 5: Medical Necessity, Service Orders and Service Authorization)
 - <https://www.ncdhhs.gov/divisions/mhddsas/reports/records-management-and-documentation-manual-rmdm>

Service Orders

APSM 45-2 states the following...

- ▶ Services reimbursed by Medicaid must be ordered prior to, or on the day of the service and re-ordered, at a minimum, on an annual basis
- ▶ The dated signature of the appropriate professional in the designated service order section of the PCP for the services outlined in the PCP becomes the service order
- ▶ All service orders must be renewed annually



Service Orders

- Providers of Medicaid-covered outpatient treatment services must also follow the specific requirements outlined in CCP 8C for service orders

CCP 8C states the following...

- A written service order by a Physician, Licensed Psychologist (doctorate), Nurse Practitioner (NP) or physician assistant (PA) is required for Associate Level Professionals prior to or on the first date of treatment
- Licensed professionals do not require a separate written service order
- The provider's signed treatment plan serves as the service order



Comprehensive Clinical Assessment (CCA)

- ▶ General Statute 10A NCAC 27G .0205(a), requires that a CCA be completed by a licensed professional prior to provision of outpatient therapy services
- Must include ALL of the following elements:
 - a. description of the presenting problems, including source of distress, precipitating events, and associated problems or symptoms;
 - b. chronological general health and behavioral health history (including both mental health and substance abuse) of the beneficiary's symptoms, treatment, and treatment response;
 - c. current medications (for both physical and psychiatric treatment);
 - d. a review of biological, psychological, familial, social, development and environmental dimensions to identify strengths, needs, and risks in each area;



Comprehensive Clinical Assessment (CCA)

- e. evidence of beneficiary and legally responsible person's (if applicable) participation in the assessment;
- f. analysis and interpretation of the assessment information with an appropriate case formulation;
- g. diagnoses from the DSM-5, including mental health, substance use disorders, or intellectual/developmental disabilities, as well as physical health conditions and functional impairment; and
- h. recommendations for additional assessments, services, support, or treatment based on the results of the CCA.
- i. The CCA must be signed and dated by the licensed professional completing the assessment.



Person-Centered Plan (PCP)

- ▶ Required for most Medicaid-funded mental health, intellectual or developmental disabilities, and substance use services
- ▶ A PCP is required for all services delineated in CCP 8A
- ▶ Plan must be developed and written by a QP or a LP according to the requirements of the specific service definition
- ▶ APSM 45-2 speaks to some of the components of the PCP, primarily those related to authorization, content, and documentation
- ▶ Person-Centered Planning Instructions Manual delineates the required content and documentation requirements



Person-Centered Plan (PCP)

- ▶ There are four required components of the PCP, each of which is required, and when combined together, comprises the whole PCP
- ▶ The Signature Page consists of four parts with various attestations as applicable in each section
- ▶ The date of the plan [PCP Completion Date] is the date that the QP or the LP [per the service definition] completes the PCP and signs and dates the signature page
- ▶ All signatures must contain the appropriate credentials/degree/licensure



Person-Centered Plan (PCP)

- ▶ Dated signatures are required
- ▶ The person receiving the services, if he individual is his or her own LRP, is required to sign and date the PCP in Part I; LRP signs and dates the PCP in Part I
- ▶ QP or LP responsible for developing the PCP must sign and date the plan
- ▶ Medicaid-covered services, one of the following professionals must sign and date the PCP in Part III, Section A of the PCP signature page



Person-Centered Plan (PCP)

- ▶ State-funded services, it is recommended that one of the four professionals above sign the PCP in Part III, Section A of the Service Order section
- ▶ A PCP is valid for billing when the last of the three required signatures is in place
 1. Dated signature of the person whom plan belongs
 2. Dated signature of the QP or LP that wrote plan
 3. Dated signature of the person ordering the service(s).



Conclusion

It is the Provider's responsibility to stay abreast of the requirements for delivering the medical services they are credentialed and contracted to provide in the Partners' Provider Network.



Contact Information

How to Report Fraud or Abuse

Help us fight health care fraud and abuse. Reporting Medicaid fraud or financial abuse will not interfere with an enrollee's access to health care. If you suspect billing for a service, a conflict of interest, a violation of Medicaid or Medicare rules, or conduct violation might be illegal, please report your concerns to:

- Partners Regulatory Compliance Alert Line at 1-866-806-8777 or
- Partners Online Alert Line at <https://partnersbhm.alertline.com>

You do not have to provide your name or contact information. However, we can often conduct a more effective investigation if you let us contact you. Your name will not be shared with anyone investigated.

Note: In rare cases involving legal proceedings, your identity may have to be revealed.

Joy Chestnut, MHA, CLEAR
Certified

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Incident Response Improvement System (IRIS) Overview/Training

What is an incident

Any happening which is not consistent with the routine operation of a facility or service or the routine care of a member and that is likely to lead to adverse effects upon a member.



Types of Incidents and Levels of Responses

- There are three levels-the response level depends on the potential or actual severity of the incident. (See the Incident Grid in your IRIS Manual. The grid begins on Page 20, Appendix B.)
- There are nine categories of incidents. (See the incident category section on pages 8-12 in your IRIS Reporting Manual.)



Incident Levels

Level I

- Incidents that, if happen infrequently, do not significantly threaten the health or safety of an individual, but could indicate systemic problems
- Recorded on the providers internal Quality Management (QM) Form/Process

Level II

- Incidents that involve a threat to an individual's health or safety or a threat to the health or safety of others
- Deaths due to natural causes or terminal illness
- Reported to IRIS using the web-reporting portal
- Report within 72 hours of learning about the incident



Incident Levels (continued)

Level III

- Incidents that result in permanent physical or psychological impairment
- Media attention
- Significant danger to community
- Report to the LME/MCO as soon as possible upon learning of the incident, but no later than 24 hours:
 - iris@partnersbhm.org
 - (704) 884-2501 option 4 then option 8
- Submit IRIS report within 72 hours of learning of the incident



Who Should Report

Under a Provider's Care:

*** See pg. 4 of the IRIS reporting manual***

- The definition for “a consumer under the care of a provider” refers to an individual who has received any service in the 90 days prior to the incident
- Crisis providers are expected to report incidents that occur during the provision of crisis services
- Mobile crisis providers are expected to report any crises that occur between the time they receive the request for crisis service and during their face-to-face contact with the individual
- Facility-based crisis providers are expected to report incidents that occur when an individual is on their premises or in their care



Who Should Report (continued)

- Providers of crisis, day, and periodic services should report all deaths and errors in self-administration of medications upon learning of the incident, even if it did not happen while consumers were actively engaged in their services.

***Out-of-state providers should fax their IRIS reports to Partners Consumer Rights Officers (CRO) at (704) 884-2620**



Notification of Critical Agencies

The provider must notify all other parties as appropriate and document that notification in IRIS:

- Parent/Guardian
- DSS (CPS or APS)
- Law Enforcement
- Division of Health Services Regulation
- Health Care Personnel Registry
- Service Plan Team
- IRIS automatically notifies the Host and Home LMEs and DMH/SS/SAS
- Host LME/MCO-County where individual receives the services referred to in incident report
- Home LME/MCO-County where individual's Medicaid is established or county where the individual first entered services or county of individual's family's residence
- DMH/IDD/SAS – IRIS goes to Advocacy and Customer Service and the Quality Management departments within the Division



Key Report Sections

Incident Comment:

- Describe what happened? How staff responded? (Who, What, When, Where, How)

Supervisor Actions:

- Describe Cause of Incident: sequence of events, individual factors/triggers, systemic issues.
- Incident Prevention: What interventions did staff make and what will staff do in future to prevent incident from recurring? What changes will agency make to decrease likelihood of adverse effects for anyone?



Web Submission Tips

- The person with the most knowledge about the incident should complete the incident report
- Always print a copy of the report for your records
- Always maintain the incident report number assigned by IRIS
- Save your data after entering it in each tab



Late Submissions

Reviews:

- Reports must be entered within 72 hours
- Each provider must meet 85% on time submission per contract
- CRO's will attend monitoring visits to review Level I incident reports
- Last incident report submitted in IRIS



Resubmitting an Incident Report

Once you have made your updates and saved the report in IRIS, follow the steps below to resubmit the report:

- Go to the Supervisor Actions section
- Click on the Incident Submission tab
- Enter a reason for resubmission in the text box
- Make sure the attestation box is checked
- Click “SUBMIT.” Do not click “Save” here
- You should see a picture of a thumbs up indicating you report has been successfully resubmitted to the LME/MCO



Confidentiality

- All incident reports are confidential and protected by G.S. 122C-30, G.S. 122C-31, G.S. 122C-191, G.S. 122C-192
- Incident reports are quality assurance administrative forms and should not be filed in a consumer's medical record



Other Resources

- IRIS Technical Manual:
<http://www.ncdhhs.gov/mhddsas/providers/NCincidentresponse/iris6-4-10dhhsmanual.pdf>
- IRIS Reporting Manual (refer to pp. 20-25, Appendix B for detail on incident categories):
<http://www.ncdhhs.gov/mhddsas/providers/NCincidentresponse/incidentmanual2-25-11.pdf>
- IRIS Website: <https://iris.dhhs.state.nc.us/>
- IRIS Test Site: <https://irisuat.dhhs.state.nc.us/>
- NC Medical Examiner/Document Request:
<http://www.ncdhhs.gov/mhddsas/providers/NCincidentresponse/index.htm>
- Death certificates: obtained by contacting the Dept. of Vital Statistics of the county where the person died. We do not need an official certificate. Copies are fine
- DHSR Complaint Line: 1-800-624-3004/ Fax: (919) 715-7724
- HCPR: 919-855-3968/Fax: (919) 733-3207
- Blank IRIS Forms per category of incident:
<http://www.ncdhhs.gov/mhddsas/providers/NCincidentresponse/index.htm>



QUESTIONS???

Partners Consumer Rights Officers:

Deborah Jackson

(704) 772-4294 (office)

Responsible counties: (Cleveland, Gaston, Lincoln, Rutherford)

Responsible for Level III's in all counties

Keshia Sandidge, LCSW, LCASA

(704) 884-2698 (office)

Responsible counties: (Iredell, Surry, Yadkin, Burke, Catawba)

Consumer Rights Officers Fax: (704) 884-2620

Consumer Rights Officers Email: iris@partnersbhm.org





Social Determinants Of Health (SDOH) Update

Danielle Sigmon, MA, LPC

SDOH Snapshot:

- ▶ Total number of completed SDOH Assessments: 9,590
- ▶ 1,052 of these have Medicaid numbers listed
- ▶ 3,811 out of 5,739 have 3 or more identified needs (66.4%- based on current 21 question SDOH assessment)



Current needs

- ▶ Insurance: 54.2
- ▶ Employment: 52.7
- ▶ Medications: 46.8
- ▶ Transportation: 42.5
 - ▶ Food: 38.5
- ▶ Food Gone Early: 35.8
 - ▶ Housing Risk: 33.8
 - ▶ Feels Unsafe: 28.3
 - ▶ Utilities: 24.1
- ▶ Emotional abuse: 13.8
 - ▶ Hit currently: 9.3



What's next?

Partners is currently transitioning to electronic submission of SDOH assessments. We are asking providers to utilize PROMS- our electronic database, or a data entry template on a monthly basis when submitting SDOH assessments.



SDOH contact

- ▶ If your agency is interested in learning more about our SDOH initiative please contact me:

Danielle Sigmon, MA, LPC
Population Health Specialist
828-244-3966

Dsigmon@partnersbhm.org



Provider Operations Manual

Update will be published in March Communication Bulletin and posted on the Provider Knowledge Base.

- Member Engagement: department updates including Member portal to the Partners website
- Program Integrity: Prepayment Claims review process when a provider is being reviewed.
- Access to Care: Process to request changes to an enrolled member record



Communication Bulletin #102

Community Needs Assessment Survey through 3/31/2020

Claims Information and updates

Social Determinants of Health data

State updates regarding transition

Joint Communication Bulletins

Program Integrity news regarding state of New Jersey
paybacks for ACTT

National Quality Forum information

Provider Alerts

Numerous training opportunities



Provider Training Opportunities

Provider Open House: Your chance to walk in and gain face to face technical assistance! Must register.

First Thursday of each month. 9-11am Gastonia

Person Centered Thinking: March course is full

April 15 & 16 Gastonia May 4 & 5 Hickory

Ethics: April 28 Gastonia (pending 6 CEU's)

Functional Elements of PCP's: April 29 Hickory



Thank you!

