



Provider Operations Manual

July 1, 2011

*Managing Behavioral Healthcare for the citizens of Duplin, Lenoir,
Sampson, and Wayne Counties*

www.eastpointe.net

Eastpointe Mission Statement

“Eastpointe will work together with individuals, families, providers, and communities to manage and continually improve our behavioral healthcare system to ensure accessibility, accountability, and empowerment of people to achieve valued outcomes.”



Managing Behavioral Healthcare for the citizens of Duplin, Lenoir, Sampson and Wayne Counties

Administration: 800-513-4002
Access to Care: 800-913-6109
TTY Service: 888-819-5112

100 South James Street, Box B
Goldsboro, NC 27530
Fax: (910) 298-7180

2901 North Heritage Street
Kinston, NC 28501
Fax: (910) 298-7188

PO Box 369
Beulaville, NC 28518
Fax: (910) 298-7180

Dear Provider,

Welcome to the Eastpointe Provider Network! As a Provider for Eastpointe, you join a network of behavioral health service providers who are committed to providing quality services to the citizens of Duplin, Lenoir, Sampson, and Wayne Counties. We appreciate your dedication to enhance the quality of life for our citizens by assisting us in our mission to collaboratively work with consumers, families, providers, and communities to manage and continually improve a behavioral healthcare system that ensures accessibility, accountability and empowerment of people to achieve valued outcomes.

Eastpointe is a Local Management Entity (LME), which provides management of comprehensive community services for mental health, developmental disabilities, and substance abuse to the citizens of Duplin, Lenoir, Sampson and Wayne counties. The total population for Eastpointe's catchment area is 293,943.

As a Local Management Entity, Eastpointe is managed by a Board of Directors that is appointed by the County Commissioners from each of the four counties of Eastpointe. In accordance with G.S. 122C-118.1, the Eastpointe Board of Directors is comprised of citizen participation, representation of all disability groups, County Commissioners from each county, individuals with financial expertise, an individual with expertise in management or business, and an individual representing the interests of children. The link for the current Eastpointe Area Board Members is <http://www.eastpointe.net/aboutus/lmeboard/boardmembers.aspx>

As a provider for Eastpointe, you are responsible for adhering to numerous requirements: the Eastpointe policies and procedures outlined in this Manual, the appropriate clinical coverage policies for the particular service(s) your agency provides, as well as the information outlined in the "Rules for Mental Health/Developmental Disabilities and Substance Abuse Facilities and Services", "Confidentiality Rules", "Client Rights Rules in Community Mental Health, Developmental Disabilities, and Substance Abuse Services", and the "Records Management and Documentation Manual". We hope you find the information in this manual helpful to you as you strive to fulfill your obligations for compliance in service provision.

Once again, we thank you for your interest and commitment in working with us to meet the needs of consumers in the Eastpointe catchment area. If you have questions, need additional information, or require technical assistance, please do not hesitate to contact any of the Eastpointe staff.

Sincerely,

Ken Jones, MPA
Chief Executive Officer
Eastpointe Human Services

Kenneth E. Jones, MPA
Area Director/CEO

An Equal Opportunity/Affirmative Action Employer

Lee Smith
Board Chairperson

"Renewing the mind, restoring the spirit"

www.eastpointe.net

Eastpointe Provider Operations Manual

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OPERATIONS MANUAL

INTRODUCTION

This manual is a binding part of the Agreement or contract between Eastpointe and providers of Medicaid and State Funded services. The intent of this manual is to reference detailed information and where possible require the same statewide procedures as part of any agreement or contract between a Local Management Entity/County Program and a provider agency.

This manual does not include information about DHHS endorsement procedures that take place prior to any agreement with a Medicaid Provider. Rather, it includes only information pertinent to the performance of the Agreement or contract, whichever applies.

Information or procedures which pertain only to Medicaid providers or only to State Funded providers are identified. References to Eastpointe's policy and procedures means that Eastpointe has inserted our own information and statewide applications do not apply at this time.

All state-funded services (Integrated Payment and Reporting System-IPRS) are provided within a closed Qualified Provider Community (QPC). Eastpointe has selected a limited number of providers who are able to be paid for IPRS services. The relationship between Eastpointe and these providers is governed by a Contract.

The relationship between Eastpointe providers of Enhanced Medicaid services is governed by a Memorandum of Agreement (MOA).

SECTION I

Provider Relations

Entrance into the Qualified Provider Community (QPC): (NM 9b)

All providers who serve consumers falling into the IPRS population will provide and bill these services through a contract with Eastpointe. Eastpointe contracts a limited number of providers to serve IPRS consumers. For endorsable services, the state has established “Policy and Procedures for Endorsement of Providers of Medicaid Reimbursable MH/DD/SA Services.”.

<http://www.ncdhhs.gov/mhddsas/stateplanimplementation/providerendorse/index.htm>

Prior to initiating a contract for state funded services, the endorsement process must be completed for all endorsable services. Once endorsement is completed, the provider is eligible to begin the contract process. Providers who are interested in contracting with Eastpointe should contact the Provider Relations Department.

Participating Provider Criteria:

- Be Endorsed and/or Contracted w/ the LME to provide services
- Be a Qualified Professional or have doc. of required training/supervision
- Have relevant state licensure/board certification
- Agree to participate in Person Centered Planning
- Be fiscally stable, ethical, and adhere to all laws, rules and safety requirements
- Evidence of current DEA Certificate
- Complete Certificate of Insurance

Problem Resolution/Disputes and Appeals: (NM 14 a-g)

A provider agency has the right to dispute actions taken by the LME and can submit a request in writing to the Eastpointe Complaints Department. (NM 14 C)

The provider must include:

- Nature of the Problem
- Any previous attempts to resolve it
- Any other pertinent information

The provider may submit additional information in writing, either by electronic mail, surface mail, special delivery or other source of written communication. (NM 14 b)

Upon receipt of the dispute, Eastpointe will review the dispute and determine if the dispute is Administrative or related to Professional Conduct/Competency as this will determine the review process. If the dispute is related to Professional Conduct/Competency, a “Peer Review Panel” is formed and convened to review the dispute. Administrative cases are reviewed by a designated Eastpointe staff member who was not involved in the initial decision that is the subject of the

dispute. The findings and determination of the all disputes are summarized in writing and this notification is sent to the provided via mail within 20 (NM 14 e) business days of the receipt of the Dispute request. Providers may have additional dispute review options beyond this first level review, which will be outlined in the Dispute resolution notification. (NM 14 d)

For additional information please review the Eastpointe Policy on: Provider Violations and Disputes (NM f,g)

Technical Assistance/Training Collaboration:

For technical assistance/training references see links below:

Reference State Funded Contract Article II 2.18 [State Contract](#)
Reference Medicaid Funded MOA Article I 1.6 [MOA with LME](#)

Technical Assistance:

Eastpointe shall provide timely and reasonable technical assistance regarding new State initiatives, or as the result of monitoring activities as related to the services covered in the Agreement, subject to the State's timeliness and availability of the information necessary to provide the technical assistance.

Providers shall give reasonable notice to Eastpointe for any and all requests for technical assistance. Requests for technical assistance/training shall be submitted to the Quality Management Director by the appropriate provider agency administrator, using the Technical Assistance Request Form. This form can be found under "For Providers" and "Forms" on the Eastpointe website. Technical assistance is a limited service and is provided at the discretion of Eastpointe. Please note that the inability of Eastpointe to provide technical assistance does not release the provider of contract responsibilities.

Technical assistance may be offered and/or required as a result of monitoring site visit(s) made by Eastpointe or in conjunction with any Plan of Correction that may be required after any local, state, or federal audit or license review.

Training:

Refer to DMA Clinical Coverage Policies and Enhanced Services Implementation Updates regarding courses that satisfy the training requirements for service definitions. All course requirements for Medicaid services also apply to IPRS services.

New Provider Orientation [NM 6 (a. i.)]

Eastpointe has an orientation welcome packet for all new participating provider agencies. Topics include, but are not limited to:

- Authorization process for state-funded services
- Authorization process for Medicaid services
- Endorsement of Medicaid providers
- Routine monitoring
- Plans of Correction for out of compliance findings
- Eastpointe website
- IPRS admission and discharge forms

Eastpointe provides web based trainings and pre-recorded training sessions to educate providers about business practices.

Provider Updates [NM 6 (a. ii.)]

As often as deemed necessary, announcements will be posted on the main page under “announcements” on the Eastpointe website. The purpose of the website posting is to relay network activities and changes. This would include any changes in fee schedules or contracting provisions. [NM 6 (a. iii.)]

The Provider Manual

The Provider Manual provides comprehensive information to provider agencies regarding Eastpointe and the necessary information to successfully deliver services, which includes but is not limited to the following:

- How to obtain information on benefits, eligibility, formulary, and appeals processes. [NM 6 (a. iv.)]
- The process for communicating with providers and the community at large, including detailed instructions on how to access Eastpointe staff for technical assistance and problem resolution. [NM 6 (b)]

The Provider Manual is on the Eastpointe Website and the provider is informed of where to receive the manual at the time of contractual agreement. [NM 6 (a. v.)]

Provider Training

Eastpointe offers training to any participating provider on relevant policies and procedures, as well as other communications set forth by the Department of Health and Human Services or its entities. Other Eastpointe provider training opportunities include, but are not limited to the following:

- The development of quality improvement programs.
- The ability to navigate the state’s mental health system.
- Understanding expectations of Eastpointe, The Division of Medical Assistance (“DMA”), and the Division of Mental Health/Development Disability/Substance Abuses Services (“DMH/DD/SAS”)

Eastpointe maintains a “training calendar” on the Eastpointe website which communicates not only trainings offered by Eastpointe but also offered throughout the state. On-Line trainings are also

hosted on the Eastpointe website and offer a variety of trainings with continuing education credits for a discounted rate.

Provider Forums

Provider Forums or meetings are held at least quarterly as a mechanism to share and receive information pertinent to Eastpointe and Provider Agencies. These forums allow participating providers opportunity to share their suggestions and guidance on how to improve the provider network to best serve consumers. [NM 6 (c)]

Eastpointe Website

The Eastpointe website also offers providers an excellent source of comprehensive information that is continuously updated as processes change or new information is available. This website serves as a major part of the communication between the LME, the consumer community, and provider network. Posted within the website the consumer or provider has the ability to report a comment/suggestion/or complaint at any time. This may be reported anonymously or requesting a response to the report. In addition, as a mechanism of gaging provider and consumer satisfaction, Eastpointe quarterly posts on the Eastpointe website satisfaction surveys for input by any interested party. [NM 6 (c)]

Registration for training offered by Eastpointe may be accomplished by visiting our website at the following link: <http://www.eastpointe.net/providers/trainingcalendar/trainingcalendar.aspx>

Eastpointe also offers website training through Essential Learning via the Eastpointe CE Quick website under the “for providers” section and “links”. Registration fees may occur; however, staff may train in the comfort of their own environment and at their own pace. Upon completion of the on-line training, a certificate can be printed by the individual completing the training. Eastpointe will accept any required trainings obtained through Essential Learning if the individual can produce documentation of completion. Eastpointe does not have access to individual training records; therefore, each individual is responsible for keeping up with their own training records.

<u>Who to Contact for Questions:</u>	<u>Contact Information</u>
<u>Administration:</u> 100 South James Street, Suite B Goldsboro, NC 27530	800-513-4002
<u>Network Relations:</u> <ul style="list-style-type: none"> • Agreement Questions • Provider Relations • Endorsement • Monitoring • Letters of Support • Provider Meetings 	800-513-4002 option #4 Request Provider Relations Department
<u>Contracts Management:</u> <ul style="list-style-type: none"> • Agreement Questions • Liability Insurance Questions 	800-513-4002 option #4 Request Contract Manager/Finance Department
<u>Medical Records:</u> <ul style="list-style-type: none"> • Medical Records/Documentation • Record Requests 	800-513-4002 option #4 Request Medical Records
<u>Customer Services:</u> <ul style="list-style-type: none"> • General Concerns • Complaints/Grievances • Client Rights • Complaint Investigations • Consumer Advocacy • Incident Reporting • Appeals for IPRS funds 	800-513-4002 option #2
<u>Call Center:</u> <ul style="list-style-type: none"> • Screening, Triage, Referral <ul style="list-style-type: none"> ○ Access to Care ○ Appointments ○ Hospital Admissions 	800-913-6109
<u>Finance:</u> <ul style="list-style-type: none"> • Invoices/Billing • Payment/Direct Deposit • Financial Audits 	800-513-4002 Option #4 Request Business Department
<u>Information Technology:</u> <ul style="list-style-type: none"> • Client Data Warehouse (CDW) • ProviderConnect • NC-TOPPS (technical) • Eastpointe website 	800-513-4002 Option #4 Request Information Technology (IT)

<ul style="list-style-type: none"> • Technical Support • Confidentiality/HIPAA • Secure E-Mail • Calcium 	
<u>Housing</u> <ul style="list-style-type: none"> • Housing grants 	800-513-4002 Option #4 Request Housing Specialist
<u>System of Care- Adult MH/SA and Adult and Child I/DD:</u> <ul style="list-style-type: none"> • After-Care Appointments • Consumer Transition • Issues regarding DSS, Court, Jail, and Hospitalization • Collaboration with CCNC and high risk consumers • CAP I/DD prioritization 	800-513-4002 Option #4 Request Adult MH/SA or I/DD
<u>System of Care- Child MH/SA:</u> <ul style="list-style-type: none"> • Child and Family Team • Issues regarding System of care best practice resources and expectations • Issues regarding DSS, Court, Jail and Hospitalization • Collaboration with CCNC and high risk consumers 	800-513-4002 Option #4 Request Child MH/SA Care Coordinator
<u>Quality Management:</u> <ul style="list-style-type: none"> • QI Plans • NC-TOPPS • NC SNAP Registration • Outcomes and Performance Indicators • Training/Staff Development • Essential Learning/CE Quick • Data Analysis 	800-513-4002 option #4 Request Quality Management
<u>Utilization Management/Review:</u> <ul style="list-style-type: none"> • Authorization of state dollars/Medicaid services • Authorization questions 	800-513-4002 option #3

<u>Human Resources:</u> <ul style="list-style-type: none"> • Employment Applications • Credentialing Questions 	800-513-4002 option #4 Request Human Resources
<u>Corporate Compliance:</u> <ul style="list-style-type: none"> • Investigations concerning fraud and abuse as it relates to Eastpointe billing 	800-513-4002 option #4 (910) 298-7003 Request Corporate Compliance Office
<u>On-Line Resources:</u> <ul style="list-style-type: none"> • Provider choice data base • Training Opportunities • Forms • Links • Web submission forms • Eastpointe News 	www.eastpointe.net

Notification of Change of Address:

Formal notification of change of address of either party shall be given to the other.

Upon the change of all contractual information including the mailing address, phone number, Federal ID number, email address, and contact name, the Contract Provider will complete the Qualified Provider Network Application and forward it to the LME's Contract Administrator. Please forward all updates and/or changes to:

Eastpointe
Contract Administrator
PO Box 369
Beulaville, NC 28518

Upon receipt our contract administrator will ensure the updating of Eastpointe's database.

SECTION II

Comprehensive List of State and Federal Requirements for The Local Management Entity and Provider

The document below serves as sufficient and necessary direction to Providers for accessing pertinent rules, regulations, standards, and other information referenced in Article I, Section 1.2 of the Agreement.

These documents change based on legislative action, change in federal and state policy, and state procedures. There is a mutual responsibility for Providers and LMEs to each routinely check these items for updates on requirements. If a Provider is uncertain how a State or Federal change will be implemented, or if an LME has concerns about how a change will be implemented, then the LME shall make a good faith effort to get further information or resolution regarding implementation and share this with the Provider. However, the Provider shall not exclusively rely upon only the LME for information. If a Provider has problems obtaining or understanding the information referenced in this section, please contact the following department/individual at Eastpointe:

**Provider Relations
800-513-4002 option #4**

**Comprehensive List of State and Federal Requirements for
The LME and Provider**

REQUIREMENT	SUGGESTED ACCESS	WEB SITE, IF AVAILABLE
<p>APSM 30-1 (Rules for MH/DD/SA- Core rules for services and also includes State-covered services definitions) APSM 45-1 (Confidentiality) APSM 95-2 (Client Rights)</p>	<p>Contact: Mail Service Center, 3015 Raleigh, NC 27699 (919) 715-1294</p>	<p>Contact Web Master for the NC Division of MH/DD/SA Services and NC Division of Medical Assistance</p> <p>Manuals</p> <p>Records Management Resources</p>
<p>CAP-MR/DD Manual –(CAP Providers and Core Competencies Training Requirements for MR/MI service providers)</p>	<p>Contact: Mail Service Center, 3015 Raleigh, NC 27699 (919) 715-1294</p>	<p>CAP-MR/DD Webpage</p>
<p>Medicaid-Related Documents Medicaid-covered services definitions <u>Medicaid Services Guidelines</u> Medicaid Communiqués</p>	<p>Contact: Mail Service Center, 3015 Raleigh, NC 27699 (919) 715-1294</p>	<p>Division of Medical Assistance</p>
<p>Residential Licensure Requirements</p>	<p>(919) 855-3750</p>	<p>Division of Health Service Regulation Webpage (DHSR)</p>
<p>Health Care Personnel Registry</p>	<p>(919) 733-8500 or (919) 715-0562</p>	<p>NC Health Care Registry</p>
<p>SB 163- Monitoring of Providers</p>		<p>APSM 30-1</p> <p>See section .0600 Local Management Entity Monitoring of Facilities and Services</p>
<p>CMH and SAPTBG Funding Requirements</p>	<p>NC State Treasurer</p>	<p>http://www.nctreasurer.com/LGC/compsup2007/federal/93.959-1CL-2007.pdf</p> <p>http://www.nctreasurer.com/compsup2005/sectionb/93.958-cl-2005.pdf</p> <p>http://www.eastpointe.net/providers/manuals/SAPTBG-CMHSBG Restrictions on Expenditure.pdf</p>

STATE LEVEL

<p>General Statutes 122-C Mental Health, Substance Abuse, Developmental Disabilities Act of 1985</p>		<p>All of the NC general statutes can be located on-line at the following site. Just type in the statute number you wish to review in the search box that is in this site.</p> <p>www.ncleg.net</p> <p>NC General Statute 122C</p>
<p>DHHS Disaster Preparedness, Response and Recovery Plan</p>		<p>Disaster Preparedness Division Webpage</p>
<p>Performance Agreement between DMH and Local Management Entity (LME)</p>		<p>Performance Agreement Webpage</p> <p>See FY 09 LME Contract section 4.1</p>

FEDERAL LEVEL

<p>Drug Free Workplace Act of 1988 as revised</p>	<p>Library-Federal Laws</p>	<p>http://www.dol.gov/elaws/drugfree.htm</p>
<p>Section 503 and 504 of the Rehabilitation Act of 1973</p>	<p>Library –Federal Laws</p>	<p>http://www.dol.gov/dol/compliance/compliance-majorlaw.htm#eoo</p>
<p>Civil Rights Act of 1964</p>	<p>Library-Federal Laws</p>	<p>www.eeoc.gov http://www.eeoc.gov/policy/vii.html</p>
<p>Non-Profit Agencies-Conflict of Interest 1993 Session Laws: Chapter 321, Section 16</p>	<p>Library-Federal Laws</p>	<p>www.dol.gov</p>
<p>Public Law 99-319, May 1986 Protection and Advocacy for Mentally Ill Persons</p>	<p>Library-Federal Laws</p>	<p>http://thomas.loc.gov/bss/d099/d099laws.html</p> <p>Search for 99-320</p>
<ul style="list-style-type: none"> ▪ Title I Protection and Advocacy Systems ▪ Title II ReinStatement of Rights for Mental Health patients 		<p>http://www4.law.cornell.edu/uscode/42/ch114.html</p>
<p>Public Law 100-509 Protection & Advocacy for Mentally Ill Individual Amendments Act of 1988, October 1988</p>	<p>Library-Federal Laws</p>	<p>http://thomas.loc.gov/bss/d100/d100laws.html Search for 100-509 http://www.oxfordhouse.org/fairhouse.html</p>
<p>Public Law 101– 496 Developmental Disabilities Assistance and Bill of Rights Act of 1990</p>	<p>Library-Federal Laws</p>	<p>http://thomas.loc.gov/bss/d101/d101laws.html Search for 101-496</p>

42 CFR Part 2 Confidentiality Regulations 45 CFR Part 160 & 164 HIPAA Standards for Privacy of Health Information	Library-Federal Laws	Federal Regulations search: http://www.gpoaccess.gov/cfr/index.html
Office of the Inspector General (Exclusions - “Lower-tier Transactions and disbarment”) Pro-children Act	Library – Federal Laws	http://oig.hhs.gov/fraud/exclusions.html
Section 1041-1044 of the Educate America Act of 1994 prohibiting smoking in areas used by children.	Library – Federal Laws	http://www.ed.gov/legislation/GOALS2000/TheAct/intro.html
Americans with Disabilities Act	Library – Federal Laws	http://www.usdoj.gov/crt/ada/adahom1.htm
OTHER		
North Carolina Council of Community MH/DD/SAS Programs		www.nc-council.org
Service Definitions		DHHS- Service Definitions Webpage
Provider Endorsement Information		DHHS- Endorsement webpage
Incident Reporting Manual and Forms (IRIS)		DHHS- Incident Reporting (IRIS) Webpage
NC TOPPS instructions, training, forms, and web application		DHHS- NC TOPPS Webpage
NC Division of Medical Assistance		Division of Medical Assistance
NC Division of Health Service Regulation		Division of Health Service Regulation
Contract for state funded (IPRS) services		Provider Contract Template for State Funded Services
National Provider Identifier (NPI) website		NPI Website
EASTPOINTE		
Eastpointe Local Business Plan		Eastpointe Local Business Plan
Eastpointe Policies and Procedures		Eastpointe Website
Eastpointe Provider Announcements		Eastpointe Website
Eastpointe Provider Meeting/Training Information		Eastpointe Training Calendar

SECTION III-A

IPRS Authorization Process

Medical Necessity

Eastpointe UR operates under Medical necessity defined as those procedures, products, and services that are provided to recipients that are necessary and appropriate for the prevention, diagnosis, palliative, curative, or restorative treatment of a mental health or substance abuse condition when the procedure, product, or services are:

- Consistent with N.C. DHHS-defined standards, DMA Clinical Coverage Policies, State Funded Service Definitions, and national or evidence-based standards verified by independent clinical experts at the time the procedures, products, or services are provided.
- Individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the recipient's needs.
- Able to be safely furnished, and no equally effective and more conservative or less costly treatment is available statewide (this should be linked with network development in the catchment area).
- Furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.
- Not for experimental, investigational, unproven or solely cosmetic purposes.
- 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 federal and state laws and regulations, the Medicaid State Plan, the North Carolina Administrative Code, DMA Clinical Coverage Policies, and other applicable federal and state directives.
- Sufficient in amount, duration and scope to reasonably achieve their purpose.
- Reasonably related to the diagnosis for which they are prescribed regarding type, intensity, duration of service and setting of treatment.

For additional information, processes, and forms:

<http://www.eastpointe.net/providers/iprs/iprs.aspx>

Access to Services (Screening, Triage, and Referral):

Screening for services will occur telephonically within the Access Department of Eastpointe. (1-800-913-6109) The Access Department will collect demographic and clinical information as well as facilitate consumer choice to a clinical home within the Eastpointe Qualified Provider Network (QPN). Services with the clinical home should begin based upon the needs of the individual and within the guidelines given by the state for emergent, urgent, and routine appointments.

Person Centered Planning (excludes basic outpatient and crisis services):

The clinical home, provider, consumer, and other involved individuals are expected to follow the person centered planning process as outlined by the Division of MH/DD/SAS.

<http://www.ncdhhs.gov/mhddsas/pcp.htm>

IPRS (Integrated Payment Reporting System) Target Populations:

The IPRS pop group determines funding eligibility for state dollars. Each population group determines the services that are available to the consumer.

Authorization Process:

Prior to seeking authorization a consumer must be enrolled as a member into the Eastpointe Network via the LME Consumer Admission/Discharge form (LCAD). Eastpointe is responsible for the authorization of state funded services. Eastpointe does not approve care retrospectively utilizing state funding. All services require prior approval. It is recommended for concurrent requests that requests are submitted at least ten days prior to the expiration of the current authorization.

Utilization Management Timeliness Standards

The timeframe within which the determination is made is dependent upon:

- State-Funded utilization requirements,
- The type of request (prospective/initial or concurrent),
- The “completeness” of the request, and
- The clinical urgency of the consumer’s situation.

Service Authorization Request Documentation

The service provider initiates the authorization/re-authorization process by completing and submitting the required IPRS Service Authorization Request form. The IPRS Service Authorization Request form is the approved Service Authorization Request forms and must be used without modification. Providers are encouraged to submit supporting documentation that demonstrates medical necessity.

Types of Utilization Reviews

A. Prospective/Initial Reviews

Prospective/Initial reviews are completed for requests of service where, typically, the recipient is new to the service being requested or the request is submitted after a break in service from the last date of authorized service.

Note: If a request for re-authorization of services for a recipient is submitted by a new service provider, it is considered to be an initial request.

B. Concurrent Reviews for Re-authorization of Service

Concurrent reviews are required when:

- The service provider requests authorization for care beyond the dates of service initially authorized.
- The service provider requests a revision to the units of service initially authorized.

The purpose of a concurrent review is to determine if the authorized service continues to be appropriate at the current level. Eastpointe must assure that the least restrictive and most cost-effective service option that appropriately addresses the need, for which the original service was authorized, is being utilized. Requests for re-authorization must be submitted to Eastpointe prior to the end of the current authorization period. If a request for re-authorization is submitted **AFTER** the end of the previous authorization period, it will be handled as an initial request.

Note: If a request for re-authorization of services for a recipient is submitted by a new service provider, it is considered to be an initial request.

C. Requests for Additional Units

Following an Initial or Concurrent Authorization, a provider may request additional units of service within the original authorization period to meet unforeseen client circumstances. When this occurs, the provider must clearly identify the request as such on a new request form and include new information which supports the medical necessity of the request. Eastpointe shall evaluate these requests as a separate review and issue a new authorization or adverse determination letter notifying the recipient of the decision.

When a non-urgent (routine) UM request successfully passes the screening process, it is ready for the UM clinician to conduct the initial clinical review. If the UM clinician, upon reviewing the case, determines that there is insufficient information to make a sound utilization management determination, the clinician refers to the policy and procedure, “Insufficient Clinical Information.” Otherwise, these are the timeframes to which Eastpointe adheres as part of the utilization management process: **[HUM 17 (a & b), 18 (a), & 19 (a & b)]**

Eastpointe Timeliness Standards for UM Decision-Making			
Type of Non-Urgent Request		State-Funded	
		Decision	Notification
Prospective- ITR,ORF2		14 calendar days	1 business day from decision
Concurrent- ITR, ORF2		14 calendar days	1 business day from decision
Retrospective- ITR, ORF2, CTCM		n/a	n/a
Initial- CAP-MR/DD- CTCM		14 calendar days	1 business day from decision
Concurrent- CAP-MR/DD- CTCM		14 calendar days	1 business day from decision
Type of Urgent Request		State-Funded	
Prospective		24 hours	1 business day from decision
Concurrent		24 hours	1 business day from decision
Retrospective		N/A	N/A

Receipt of UM Request

Authorization requests are received via the electronic managed care system.

Authorization requests are defined as routine or urgent. Eastpointe defines urgent care as the type of care needed when a clinical situation exists where there is potential for the situation to become a life-threatening emergency in the absence of treatment. Therefore, requests for the following levels of care are deemed to be “urgent” requests: inpatient, crisis bed, and detoxification treatment. Eastpointe defines non-urgent care as ambulatory care that is routine. However, if a physician with knowledge of the consumer's condition believes that failure to treat the request as "urgent" would jeopardize the health of the consumer, Eastpointe defers to the physician.

Eastpointe accepts and takes into account relevant information from any reasonably reliable source, such as treating providers, other providers on the treatment team, consumers or their family members, when making utilization management determinations. [HUM 26 (a)]

Authorization requests received via the electronic managed care system are date and time stamped by the system in reportable fields that are used to calculate turn-around times (TAT) for decision-making.

Unable to Process-(No Appeal Rights)

There are six conditions that meet the criteria for returning a Request for Authorization to the provider with no action taken. They are:

1. Improper/Invalid Request

When a service provider’s request for authorization does not contain the required data elements to be considered a proper or valid authorization request, the request shall be returned to the service provider as “unable to process”. For all recipients the following information is required:

- the recipient's name,
- address,
- IPRS Target Population,
- date of birth,
- attending provider name
- billing provider name
- date of request, and
- service requested.

2. Services that are currently authorized to Another Provider

Eastpointe shall not authorize a service for a recipient during any active authorization period for this same service with another service provider.

Eastpointe must receive the completed Discharge LCAD (LME Consumer Admission/Discharge) Form from the service provider with the active authorization. In situations where there is controversy regarding the legitimate provider of services and there is an appearance that medical necessity is present, Eastpointe's UR staff shall contact Eastpointe's Customer Services for assistance.

3. Duplicate Requests

If it is determined that the authorization request is a duplicate of a request already received and:

- If no action has been taken on the initial request, return the duplicate request and indicate that no action was taken because the request was a duplicate and that action on the original request will be forthcoming.
- If the request has been reviewed and approved, return the duplicate request to the provider and indicate that no action was taken because the request was a duplicate.
- If the request has been reviewed, adverse action taken, and the recipient's appeal rights have not expired, review the request to see if additional information is contained in the request that would change the adverse decision. If there is no change in the adverse action, return the duplicate request to the service provider indicating that the initial decision stays; no appeal rights shall be granted.

4. Ineligible Recipient

When a Request for Authorization is received for an individual who is not a current enrolled consumer, the Request shall be returned to the provider as "unable to process".

Approval

If the requested service is determined to be medically necessary, Eastpointe shall authorize services issuing a written authorization/decision letter to the service provider within one (1) business day. All written authorization/decision letters shall be uploaded to the LME “Provider Connect” system where the provider will be able to download and print for their records.

Insufficient Clinical Information (appeal rights):

If a State-funded case is missing necessary information to make a medical necessity determination, the UM reviewer contacts the requesting provider to request the needed clinical information as soon as possible. The clinician informs the provider of the specific information needed to process the request and allows the provider time to provide the missing information but must render a decision in accordance with turnaround time requirements for initial decision-making. The table below indicates the timeliness standards based on line of business: [HUM 29 (a)]

	Type of Non-Urgent Request	State-Funded	
		Decision	Notification
	Prospective & Concurrent	14 calendar days	1 day from decision
	Retrospective	NA	NA

If the timeframe to complete the review begins to draw near and the provider has not submitted the requested clinical information, the UM reviewer will either administratively deny the case based on lack of information, or if there is sufficient information to process a request and determine medical necessity, the initial reviewer will process the request according to the relevant policy and procedure. [HUM 29 (a) (b) & (c)]

Denials (appeal rights):

Eastpointe may deny, reduce or terminate a request for services if it is determined that:

- medical necessity criteria is not met for the specific service requested
- medical necessity criteria is not met for the volume or duration of the specific service requested
- the services would be ineffective
- a more cost-effective alternative that otherwise satisfies the standards for medically necessary services is available
- the services exceeds benefit limits (if 21 years of age or older only)
- the service provider failed to provide a complete authorization request form or failed to provide additional information as requested or
- other administrative reasons.

Provider Assistance

Eastpointe shall provide staff representatives who will handle provider complaints and problems.

The Eastpointe staff provider representative shall be readily available during working hours (Monday through Friday, 8:00 a.m. to 6:00 p.m.) to receive calls and take actions to solve problems. All calls shall be returned within two (2) business hours of receipt. The staff provider representative shall maintain a call log that includes the following items:

- Name of provider agency
- Name and contact information of caller
- Date and time of call
- Nature of the problem/complaint
- Disposition of LME representative(s)
- Date and time of LME response
- Resolution of the problem/complaint
- Date and time of the resolution
- Was inquirer satisfied with response process

For additional information review the Eastpointe Policy:

- First Level (Initial) Clinical Review
- Insufficient Clinical Information
- Clinical Appeals
- UM Review Criteria/Clinical Decision Tools

Section III-B

Medicaid Authorization Process

Eastpointe is responsible for utilization review of Medicaid-funded behavioral health, intellectual disabilities, and substance abuse treatment services for individuals with Medicaid originating from Duplin, Sampson, Lenoir or Wayne Counties. In addition, Eastpointe is responsible for CAP I/DD utilization review for consumers from the following counties: Beaufort, Bertie, Bladen, Brunswick, Camden, Carteret, Chowan, Columbus, Craven, Cumberland, Currituck, Dare, Duplin, Edgecombe, Gates, Greene, Hertford, Hyde, Johnston, Jones, Lenoir, Martin, Nash, New Hanover, Northampton, Onslow, Pamlico, Pasquotank, Pender, Perquimans, Pitt, Robeson, Sampson, Scotland, Tyrrell, Washington, Wayne, Wilson

Medical Necessity

Eastpointe UR operates under Medical necessity defined as those procedures, products, and services that are provided to Medicaid recipients that are necessary and appropriate for the prevention, diagnosis, palliative, curative, or restorative treatment of a mental health or substance abuse condition when the procedure, product, or services are:

- Consistent with N.C. DHHS-defined standards, Medicaid clinical coverage criteria, and national or evidence-based standards verified by independent clinical experts at the time the procedures, products, or services are provided.
- Individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the recipient's needs.
- Able to be safely furnished, and no equally effective and more conservative or less costly treatment is available statewide (this should be linked with network development in the catchment area).
- Furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.
- Not for experimental, investigational, unproven or solely cosmetic purposes.
- 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 federal and state laws and regulations, the Medicaid State Plan, the North Carolina Administrative Code, Medicaid clinical coverage policies, and other applicable federal and state directives.
- Sufficient in amount, duration and scope to reasonably achieve their purpose.
- Reasonably related to the diagnosis for which they are prescribed regarding type, intensity, duration of service and setting of treatment.

Additionally, Eastpointe UR must follow the medical necessity criteria delineated in the service definitions for a particular service and appropriate Medicaid clinical coverage policies to determine the appropriateness of the following services for eligible populations. Refer to the link listed below for access to the services definitions and clinical coverage policies.

Types of Utilization Reviews

A. Initial Reviews

Initial reviews are completed for requests of service where, typically, the recipient is new to the service being requested or the request is submitted after a break in service from the last date of authorized service.

Note: If a request for re-authorization of services for a recipient is submitted by a new service provider, it is considered to be an initial request.

B. Concurrent Reviews for Re-authorization of Service

Concurrent reviews are required when:

- The service provider requests authorization for care beyond the dates of service initially authorized.
- The service provider requests a revision to the units of service initially authorized.

The purpose of a concurrent review is to determine if the authorized service continues to be appropriate at the current level. Eastpointe must assure that the least restrictive and most cost-effective service option that appropriately addresses the need, for which the original service was authorized, is being utilized. Requests for re-authorization must be submitted to Eastpointe prior to the end of the current authorization period. If a request for re-authorization is submitted AFTER the end of the previous authorization period, it will be handled as an initial request.

Note: If a request for re-authorization of services for a recipient is submitted by a new service provider, it is considered to be an initial request.

C. EPSDT Reviews

EPSDT reviews are defined as reviews for service authorization requests for recipients under the age of twenty-one (21) when the service(s) requested exceed unit or visit limitations or age exclusions as delineated in the service definitions or clinical coverage policies for the service. As documented in the EPSDT requirements (42 U.S.C. 1396d(r) {1905(r)} of the Social Security Act), requests for services beyond the established limitations or exclusions must be considered if they are medically necessary to correct or ameliorate the condition.

Service authorization requests must be reviewed under Early Periodic Screening, Diagnosis and Treatment (EPSDT) requirements if adverse action is to be taken on a request because the request exceeds policy limitations. If all EPSDT criteria are met, the service request should be approved even if policy limitations are exceeded. For further information see the guidelines published in the EPSDT Policy Instruction Update on DMA's website at <http://www.ncdhhs.gov/dma/epsdt/>.

D. Requests for Non-Covered Services

Requests for mental health or substance abuse treatment services for recipients under the age of twenty-one (21) that are not covered by Medicaid must also be reviewed and recommendations must be sent to DMA's Assistant Director for Clinical Policy and Programs Section for a final decision. Eastpointe must notify the service provider in writing that the request was referred to DMA for disposition.

E. Retrospective Reviews

Medicaid Eligibility

Retrospective reviews may be performed if the recipient did not have Medicaid at the time the service was provided but obtains Medicaid eligibility with an effective date that encompasses the dates that the service was provided. The LME must verify with DMA the date that the eligibility was entered into the Recipient Eligibility file to assure the authenticity of the provider request.

The records must be submitted with the Service Request Form and the authorization documentation specific to the service being requested. 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. Where Medicaid eligibility was approved after the service was provided, authorization for inpatient, outpatient or enhanced services typically should not exceed 365 days from the date of eligibility (depending on the authorization increments delineated in the service definition or clinical coverage policy for the service). However, there may be circumstances that require additional time for determining eligibility. Additional retrospective reviews for enhanced services may be requested by DMA due to provider or client specific situations.

F. Requests for Additional Units

Following an Initial or Concurrent Authorization, a provider may request additional units of service within the original authorization period to meet unforeseen client circumstances. When this occurs, the provider must clearly identify the request as such on a new ITR, ORF or CTCM and include new information which supports the medical necessity of the request. Eastpointe shall evaluate these requests as a separate review and issue a new authorization or adverse determination letter notifying the recipient of the decision.

Authorization Process:

Eastpointe shall accept secure transmissions from the service provider electronically via Eastpointe's ProviderConnect system. The ITR, ORF and CTCM are the approved Service Authorization Request forms and is utilized within the ProviderConnect system.

Eastpointe cannot authorize services for dates of service prior to the receipt of the authorization request unless the request meets the criteria for a retrospective reviews.

Eastpointe shall use the established turn around times for initial authorizations and re-authorizations indicated below:

Request Type	Turn Around Time	Written Notice
Emergent/Urgent Residential or Inpatient Assessments	4 business hours	Within 1 business day after decision
Routine Requests (Initial or Concurrent)	5 business days	Within 1 business day after decision
Criterion 5	5 business days	Within 1 business day after decision
Out-of State	5 business days	Within 1 business day after decision
CAP-MR/DD and Targeted Case Management	10 business days	Within 1 business day after decision
EPSDT	15 business days	Within 1 business day after decision
Retrospective Reviews	30 calendar days	Within 1 business day after decision

Eastpointe’s Clinical Director shall ensure that authorization reviews are conducted by appropriate staff with experience relevant to the disability of the individual for whom services are being reviewed. At any point during the authorization process the service provider may request to speak to the physician rendering an adverse decision.

Service Authorization Request Documentation

The service provider initiates the authorization/re-authorization process by completing and submitting the required Service Request Forms of Inpatient Treatment Report (ITR), Outpatient Review Form-2 (ORF-2) or CAP/Targeted Case Management (CTCM) form. The ITR, ORF2, and CTCM are the approved Service Authorization Request forms and must be used without modification. The following services are requested on the stated forms:

- Inpatient Treatment Report (ITR)- ALL Medicaid funded MH/SA Services except Mobile Crisis and Outpatient Services (Basic Benefits).
- Outpatient Review Form-2 (ORF-2)- ONLY Medicaid funded Mobile Crisis and Outpatient Services (Basic Benefits).
- CAP/Targeted Case Management (CTCM)- All Medicaid funded Targeted DD Case Management and CAP-MR/DD Services.

Unable to Process-No Appeal Rights

There are six conditions that meet the criteria for returning a Request for Authorization to the provider with no action taken. They are:

1. Improper/Invalid Request

When a service provider's request for authorization does not contain the required data elements to be considered a proper or valid authorization request, the request shall be returned to the service provider as "unable to process". For all recipients the following information is required:

- the recipient's name,
- address,
- Medicaid identification number,
- date of birth,
- attending provider name and Medicaid number
- billing provider name and Medicaid number
- date of request, and
- service requested.

2. Services that are currently authorized to Another Provider

Eastpointe shall not authorize a service for a recipient during any active authorization period for this same service with another service provider.

Eastpointe must receive the completed Discharge from Treatment Form from the service provider with the active authorization. In situations where there is controversy regarding the legitimate provider of services and there is an appearance that medical necessity is present, Eastpointe's UR staff shall contact Eastpointe's Customer Services for a determination. If this cannot be resolved, then Eastpointe will contact DMA who will coordinate the determination of client choice and associated dates of service and inform the UR Department.

3. Duplicate Requests

If it is determined that the authorization request is a duplicate of a request already received and:

- If no action has been taken on the initial request, return the duplicate request and indicate that no action was taken because the request was a duplicate and that action on the original request will be forthcoming.
- If the request has been reviewed and approved, return the duplicate request to the provider and indicate that no action was taken because the request was a duplicate.
- If the request has been reviewed, adverse action taken, and the recipient's appeal rights have not expired, review the request to see if additional information is contained in the request that would change the adverse decision.

If there is no change in the adverse action, return the duplicate request to the service provider indicating that the initial decision stays; no appeal rights should be granted.

4. Ineligible Recipient

When a Request for Authorization is received for an individual who is not a current Medicaid recipient, the Request shall be returned to the provider as “unable to process”.

When a Request for Authorization is received which exceeds the benefit limit for the following services, it may also be returned as Unable to Process:

- CAP-MR/DD Cost Summary indicates a request in excess of \$17,500 for the Supports Waiver; or
- CAP-MR/DD Cost Summary indicates a request in excess of \$135,000 for the Comprehensive Waiver.

5. Requested Service Exceeds Maximum Policy Guidelines

If the UR Department determines that the request exceeds the maximum allowable amount, duration or combination between services, the clinician may reduce the request to the maximum as follows:

1. When a request is received that exceeds the allowable *authorization period* for that service, the clinical care manager may automatically authorize the maximum authorization period if medically necessary.
2. When a request is received for an Adult age 21 and older that exceeds the maximum allowable *amount of service*, the clinical care manager may reduce the authorization to the maximum allowable units if medically necessary.

NOTE: When a request is received for a Child under age 21 that exceeds the maximum allowable *amount of service*, the request is reviewed under EPSDT to determine medical necessity.

Approval

If the requested service is determined to be medically necessary, Eastpointe shall authorize services issuing a written authorization/decision letter to the service provider within one (1) business day. All written authorization/decision letters shall be uploaded to the LME “Provider Connect” system where the provider will be able to download and print for their records.

Pended Requests

When a service provider's request for authorization contains the required data elements for a valid authorization request, however there is inadequate information to make a determination of medical necessity, the request is pended and Eastpointe notifies the service provider that additional information is required to complete the service authorization review.

The request for additional information must be made in written format within one (1) business day. All written authorization/decision letters shall be uploaded to the LME "Provider Connect" system where the provider will be able to download and print for their records.

If the provider does not respond to the request within fifteen (15) business days following the issuance of the request by submitting the needed information or requesting a time extension, Eastpointe must deny the request for lack of information. Eastpointe shall issue a letter of denial informing the recipient and service provider that the service authorization request was denied due to the service provider's failure to provide the additional information.

Incomplete request:

When a service provider's request for authorization contains the required data elements for a valid authorization request, however the required documentation/information is not included the request is processed as an incomplete request. Incomplete decisions may be appealed through the appeals process.

Denial/Reduction

In addition to the required information listed above, the following must be submitted to the Eastpointe to be able to process the request for authorization:

- A signed Request for Authorization form (ITR, ORF, CTCM)
- The signed applicable Person Centered Plan
- Signatures must be present for the recipient, legally responsible person (if applicable), person responsible for the plan and clinician signing the service order indicating medical necessity;
- Signatures cannot be dated in excess of one year from the start date of the request;
- Signatures must be updated in conjunction with the review of Action Plan/Goals.
- The service order checkboxes which designate whether or not the clinician completed a face-to-face interview and reviewed the assessment must be checked for MH/SA recipients;
- The Person Centered Plan contains information in the following sections to be considered a complete plan for review: Action Plan/Goals, page 2 of the Crisis Plan and the Observation and Assessment page.

Eastpointe may deny, reduce or terminate a request for services if it is determined that:

- medical necessity criteria is not met for the specific service requested

- medical necessity criteria is not met for the volume or duration of the specific service requested
- the services would be ineffective
- a more cost-effective alternative that otherwise satisfies the standards for medically necessary services is available
- the services exceeds benefit limits (if 21 years of age or older only)
- the service provider failed to provide a complete authorization request form or failed to provide additional information as requested or
- other administrative reasons.

If the denial is appealed, Eastpointe shall issue Maintenance of Service authorization within the timeframes designated by the appeal process.

Eastpointe shall notify the individual and/or his/her legal representative (if any) by UPS track-able mail. All written authorization/decision letters shall be uploaded to the LME “Provider Connect” system where the provider will be able to download and print for their records.

An explanation of the individual’s appeal rights and a statement of the manner in which the individual may appeal the adverse determination must be included in the letter.

More information about the DMA Medicaid appeals process:
<http://www.ncdhhs.gov/dma/provider/URVendorInstruct.pdf>

Provider Assistance

Eastpointe shall provide staff representatives who will handle provider complaints and problems.

The Eastpointe staff provider representative shall be readily available during working hours (Monday through Friday, 8:00 a.m. to 6:00 p.m.) to receive calls and take actions to solve problems. All calls shall be returned within two (2) business hours of receipt. The staff provider representative shall maintain a call log that includes the following items:

- Name of provider agency
- Name and contact information of caller
- Date and time of call
- Nature of the problem/complaint
- Disposition to Contractor representative(s)
- Date and time of Contractor response
- Resolution of the problem/complaint
- Date and time of the resolution
- Was inquirer satisfied with response process

For additional information review the Eastpointe Policy:

- First Level (Initial) Clinical Review

- Insufficient Clinical Information
- Clinical Appeals
- UM Review Criteria/Clinical Decision Tools

SECTION IV

Claims

I. IPRS Claims

Claims Filing and Adjudication:

The LME shall honor Provider billings that are filed in time to meet DHHS billing requirements. For services covered by funds allocated by the DMH/DD/SAS, billings shall be honored in accordance with the IPRS timely filing provisions. See Claims filing schedule.

If the Provider bills in accordance with the Claims Filing Schedule, the LME will pay claims in line with the Division of Mental Health, Developmental Disabilities and Substance Abuse prompt pay requirements set forth as follows: within eighteen (18) calendar days after the LME receives a claim from a Provider, the LME shall either (a) approve payment of the claim, (b) deny payment of the claim, or (c) determine that additional information is required for making an approval or denial. If the LME approved payment, the claim shall be paid within (30) calendar days after making approval.

The LME shall disallow claims in the event and to the extent the claim is incomplete, does not conform to the applicable service authorization, or is otherwise incorrect. Any claim disallowed shall be returned to the provider with an explanation for the disallowance. The LME shall allow providers to re-submit a disallowed billing for re-consideration, so long as the re-submission occurs within the general claims filing timeframes outlined above. The LME shall cooperate with its contract providers in the prompt reconciliation of disallowed billings.

The LME shall not pay claims submitted after the time period allowed by DHHS billing requirements.

All payments for services to Providers shall be provisional and subject to review and audit for their conformity with DHHS requirements and those of any applicable subcontract.

The LME claims system, as well as its prior authorization and concurrent review process shall minimize the likelihood of having to recoup paid claims. The DHHS shall be notified with thirty (30) days of any recoupment of \$50,000 or more per Provider within a contract year.

The LME and its Providers shall not charge or receive any payment from an eligible Medicaid person for covered services except for co-payments and sums payable by third party payers under coordination of benefits provisions.

The LME shall work with its Providers to pursue all applicable first and third party payments for service in order to maximize the use of public resources. The Provider shall be responsible for the adoption, assessment, collection, and disposition of fees in accordance with G.S. 122C-146 and all subsequent revisions. The Provider shall be responsible for coordination of benefits and determination of third party liability. The Provider may retain first and third party revenue

collected for services authorized by the LME up to the extent that such revenue does not exceed the total cost of services for the consumers for whom services have been authorized by the LME.

The LME shall obtain, and require its contracted Providers to obtain, all relevant payer information from each consumer to be served, his/her guardian and/or family. This information should be collected at the consumer's first encounter with the contract Provider, but no later than the submission of the first claim for service. Claims for service will not be paid or "clean" until such information is provided. The LME shall provide available information to each Provider involved with the consumer and require the Provider to collect the remaining information, if applicable.

The Provider agrees to provide the LME with the Physician's Service Order for authorized services, the LME's Service Authorization Request, and other documentation specified in the ProviderConnect manual. The ProviderConnect manual may be found on the LME website at www.eastpointe.net

The LME agrees to compensate the Provider only for authorized services based on the Division's rate schedule. The LME is not responsible for compensating the Provider for services provided outside of an approved service authorization or for services billed outside the terms of the contract. Payments by the LME for services delivered by the Provider are expressly conditioned upon the availability of funds.

The Provider and LME agree that accurate data on the Provider's services are necessary for the LME to fulfill its statutory responsibilities pursuant to North Carolina General Statute 122C-146 and to further its ability to find sources of funding for the program, and that an expeditious exchange of information is necessary for the effective and efficient operation of the program.

1. The LME will process "clean claims" in accordance with the Division's Prompt Pay Provision.

The following data elements may be required on a claim for payment:

- a. Provider Name
- b. Provider Number
- c. Attending Provider Name
- d. Attending Provider Number
- e. Referring Provider Number
- f. Date of Claim
- g. Date of Service
- h. Consumer Name
- i. LME Consumer ID
- j. Consumer ICD9 Diagnosis
- k. Service Authorization Number
- l. Number of Units Delivered/and duration of minutes delivered
- m. Name of Service
- n. Service Billing Code
- o. Service Rate Billed
- p. Target Population Code
- q. Total Net Billed for Service
- r. Invoice Total
- s. Location of Service

2. Items that may be required to be attached to a claim for payment:
 - a. EOB from consumer's primary insurance only for those services for which DMA has a third party liability edit in the MMIS.
3. Allowable Claims Format (All to be submitted electronically)
 - a. Electronically via Eastpointe's ProviderConnect system
 - b. CMS-1500 form (only for claims who require EOB's attached to prove third party billing)
 - c. Eastpointe electronic Medicaid Submission Form will be accepted for any Medicaid billable claims that must be processed by the LME. State funded claims will not be accepted in this format.
4. Allowable Reasons to Request Additional Information or Deny a Claim
 - a. One of the required elements in #1 is missing or is inaccurate
 - b. EOB is not attached in accordance with #2
 - c. Claim is not on one of the three standardized methods forms per item #3
 - d. LME has delegated to Provider the responsibility to update IPRS Target Population designations for the consumer and the Target Population designation has been allowed to expire.

Submission of notes with the claim is not required. However, the LME reserves the right to request such documentation from the Provider. By submitting the claim, the Provider represents that all of the services submitted to the LME conform to all service delivery requirements, including documentation.

5. Failure by the Provider to properly document their services will result in recoupment of payments for those services where documentation does not meet the standards specified in this contract. The Provider will not have the opportunity to correct insufficient and/or incorrect documentation.
6. The LME reserves the right to withhold payment for services if it is determined by the LME Director or his/her designee that services and/or documentation of services do not meet requirements specified in this contract. The Provider must utilize a current service plan or Person-Centered Plan, staff privileging, staff supervision, or required licensure, accreditation or certifications.
7. The LME will not be responsible for payment of services not authorized by Utilization Management. Refer to the Utilization Management section of the Operations Manual for authorization processes for Medicaid and non-Medicaid services. Additional information regarding authorization of Medicaid services may be found at the Eastpointe website at: <http://www.eastpointe.net/providers/MedicaidUR/mur.aspx>
8. Failure by the Provider to submit an invoice within sixty (60) days of the date of service shall exempt the LME from the time periods imposed by the Prompt Pay Provision for approving, denying, requesting additional information, and paying the invoice.
9. The LME will not be responsible for payment of services rendered by a Provider who has not been credentialed/privileged in accordance with the Provider Agency's policies and procedures.
10. Upon request, data may be required by the LME in order to accurately verify the kind and amounts of services provided in the program which is the subject of this contract and for the

purpose of audit by state authorities, as required by law. The LME may require reports mandated as part of the implementation of the Division initiatives. The LME shall provide the procedures and format for reporting such data and information to the Provider in writing as soon as such are known.

11. Specific claims filing instructions may be found in the ProviderConnect manual located on the LME website www.eastpointe.net

Claims Filing Schedule:

To see the current claims filing schedule please see the following link:

<http://www.ncdhhs.gov/dma/provider/calendar.htm>

- Division deadlines require that the LME receive the April-June invoices within 30 days from the end of the month of providing services.

Payments by the LME for services delivered by the Provider are expressly conditioned upon the availability of funds.

The LME shall not pay claims submitted after the time period allowed by DHHS or DMA billing requirements.

Prompt Pay Provision from Performance Agreement between Division of MHDDSAS and LMEs:

Definition:

As used in this section, "Provider" means any qualified public, or private, Provider, agency, institution, or resource that contract with the LME for the provision of services pursuant to G.S. 122C-141 (a).

Invoice Processing Period Requirements:

Within eighteen (18) calendar days after the LME receives an invoice from a Provider, the LME shall either: (a) approve payment of the invoice, (b) deny payment of the invoice, or (c) determine that additional information is required for making an approval or denial. The foregoing requirement is further specified in the following bullets:

- If the LME approves payment of an invoice, the LME shall pay the invoice within thirty (30) calendar days after making the approval.
- If the LME denies payment of an invoice, the LME shall return the invoice to the Provider and include notice specifying the full and complete good faith reasons for the denial within eighteen (18) calendar days after the LME received the invoice. The LME will have been deemed to have complied with this requirement if, on or before the eighteenth calendar day, the LME electronically transmits the invoice and notice to the Provider, places the

invoice and notice in the U.S. mail, first class postage prepaid, properly addressed to the Provider, or makes actual delivery of the invoice and notice to the Provider.

- If the LME determines that additional information is required for making the approval or denial of an invoice, the LME shall provide the Provider with notice of the same. The notice shall contain the good faith reasons why the invoice has not been paid and furnish a complete itemization, or description, of all of the information needed by the LME to complete the processing of the invoice. The LME shall provide such notice to the Provider within eighteen (18) calendar days after the LME receives the invoice. The LME will be deemed to have complied with this requirement if, on or before the eighteenth calendar day, the LME electronically transmits the invoice and notice to the Provider, places the invoice and notice in the U.S. mail, first class postage prepaid, properly addressed to the Provider, or makes actual delivery of the invoice and notice to the Provider. Upon the LME's receipt of the additional information from the Provider, the LME shall process the invoice within the time periods stated above for approving, denying, and paying invoices.
- The LME is not limited to paying an invoice in full, denying an invoice in full, or requesting additional information for an entire invoice. Rather, as appropriate, the LME may approve an invoice in part, deny an invoice in part, and/or request additional information for only a part of the invoice, as long as the LME either approves, denies, or requests additional information for each part of the invoice within the required eighteen (18) calendar day period. If the LME partially approves, denies, or requests additional information for an invoice, the LME shall take the appropriate further actions on the invoice within the applicable time periods stated above. For instance, if an invoice is denied in part and approved in part, the LME shall pay the approved portion of the invoice within thirty (30) calendar days after the approval and shall send the notice of denial for the denied portion of the invoice within eighteen (18) calendar days after the LME's receipt of the invoice.
- The LME is presumed to have received a mailed invoice five business days after the invoice has been placed in the United States mail, first-class postage prepaid, properly addressed to the LME, or an invoice transmitted electronically, or by facsimile transmission, to the LME or a designated clearinghouse, on the day the invoice is transmitted.
- All references to the term "invoice" in this Section, IV.A.3. "Prompt Pay Provision" shall include invoices for Medicaid services and invoices for non-Medicaid services. Except for the references to "invoice" in the provision below captioned, "Submission of Non-Medicaid Invoices to LME," which shall include only invoice for non-Medicaid services.
- In calculating any period of time prescribed by this section, IV.A.3. "Prompt Pay Provision," the day of an act, or event, after which a designated period of time begins to run is not to be included. For instance, in calculating the eighteen (18) calendar days after an LME receives an invoice, the day the LME receives the invoice is not included or counted, and the first of the eighteen (18) calendar days is the calendar day that follows the day on which the invoice was received.

Funds Availability Provision:

The payment of funds by the Division to the LME, as specified by this Agreement, is conditioned upon the appropriation, allocation, and availability of the funds to the Division for this purpose. To this end, if it appears that the payments from the Division to the LMEs will be disrupted due to a statewide reduction in funding, the Division Director shall provide Providers and LMEs with

prior notice of the reduction. This notification shall give direction to LMEs about the appropriate course of action regarding payments to Providers. In addition, in instances where the LME submits evidence to the Division that reasonably demonstrates that the LME's late payment of invoices is the direct result of errors or delays by the State, or its contract vendors, the LME shall be exempt from the time periods imposed by this section for approving and paying such invoices. In such circumstances, the LME shall approve and pay the invoices within a time period that is reasonable under the circumstances. If, for any reason, the LME anticipates that it will be unable to make payment on an individual invoice within the time periods required by this section, and the LME and Provider are unable to reach a resolution, the LME must obtain the prior approval of the Division in order to delay payment. Such requests will be reviewed on a case-by-case basis. Notwithstanding any of the foregoing, the LME's duty to pay an approved claim within thirty (30) calendar days after approval is not conditioned upon the LME first having received payment from the State for the services covered by the invoice.

Submission of Non-Medicaid Invoices to LME:

LMEs shall include in their contracts with Providers provisions concerning the submission of non-Medicaid invoices that comport with the following:

- The Provider shall submit invoices for non-Medicaid services in the appropriate form within the shorter of: (a) the time period stated in the contract between the LME and Provider and (b) 15 calendar days after the end of the month in which the service(s) was rendered, or in which the consumer was discharged from service. Failure to submit an invoice within the time period shall exempt the LME from the time periods imposed by this section the time period stated in the contract between the LME and Provider and. In such circumstances, the LME shall process and pay the invoice within a reasonable time under the circumstances. If the LME denies payment of an invoice, the Provider must resubmit the invoice, with full and complete information, as specified by the LME, within the shorter of (a) the time period stated in the contract between the LME and Provider and (b) thirty (30) calendar days after Provider's receipt of the denied invoice, unless the Provider has received from the LME a waiver of the re-submission time period. Provider's failure to resubmit the invoice within forty-five (45) calendar days after Provider's receipt of the denied invoice (absent a waiver from the LME) shall exempt the LME from the time periods imposed by this section for approving, denying, requesting additional information for, and paying the invoice. In such circumstances, the LME shall process and pay the invoice within a reasonable time period under the circumstances.

Interest:

Payment due on an invoice that is not made within the time period required by this Section IV.A.3. shall bear interest at the annual percentage rate of eight percent (8%) beginning on the date following the day on which the payment should have been paid. A payment is considered made on the date upon which a check, draft, or other valid negotiable instrument is placed in the United States mail, first class postage prepaid, properly addressed to the Provider, or if not mailed, on the date of the electronic transfer, or other actual delivery, of the payment to the Provider. In paying any interest it owes to a Provider under this provision, the LME shall use funds other than funds allocated to pay for services rendered to clients.

Third Party Beneficiary:

Any Provider who submits invoices to the LME for services rendered shall be an intended third-party beneficiary of this Section.IV.A.3, and without limitation, the duties imposed upon the LME through this section are likewise duties owed to such Provider, and such Provider may enforce the performance of the duties.

Electronic Connectivity Requirements:

In order to utilize Eastpointe’s ProviderConnect billing system the provider must have an Internet connection (high speed is preferred but not required). Utilization of Internet Explorer version 5.5 or greater is required.

For specific information about how to use the ProviderConnect system providers review the training posted on the Eastpointe website at:

<http://www.eastpointe.net/providers/meetingsandtrainings/meetingtrainingdocs.aspx>

Click on the System Trainings option to see the trainings available.

ProviderConnect Manual is also maintained on the Eastpointe website at: www.eastpointe.net.

Payment Schedules:

- Medicaid Provider DMA website www.dhhs.state.nc.us/dma/home.htm
- See prompt pay requirements listed above for Eastpointe.

Claims Adjudication:

- State Funded Provider– Reference State Contract

II. Medicaid Claims

SUBMITTING PASS-THRU MEDICAID CLAIMS

Medicaid providers who are not eligible to directly enroll in Medicaid may bill through Eastpointe via a contract. Providers who wish to bill through Eastpointe for these type claims should contact the Contracts Administrator to request a contract. After the contract is approved, the Contracts Administrator will contact the provider to give them the link they will utilize in order to submit claims. The “Medicaid Billing Submission Form” is utilized for these type claims and can be found at the following link: <https://fd9.formdesk.com/eastpointe/medicaidbilling> .

A Web-Based LME Admission form must be submitted in order to enroll the client into our billing system prior to billing. This form can be found at:

<https://fd9.formdesk.com/eastpointe/admissionform>

SECTION V

Provider Documentation Submission Requirements

IPRS Funded Consumers

Documentation:

All contracted services are required to adhere to state and federally mandated clinical documentation. Guidance can be found in the following:

- APSM 45-2
<http://www.ncdhhs.gov/mhddsas/statspublications/manualsforms/rmd09/rmdmanual-final.pdf>
- Medicaid/IPRS Service Definitions
<http://www.dhhs.state.nc.us/mhddsas/servicedefinitions/index.htm>
- Licensure Rules
<http://facility-services.state.nc.us/>
- DMA Clinical Coverage Policy
<http://www.dhhs.state.nc.us/dma/>

In addition to clinical record documentation, state funded providers are also required to complete and submit other documentation required by the state.

Information to be submitted is as follows:

- LCAD- LME Consumer Admission and Discharge Form
- Financial Information, sliding fee scale, all payers
- NC TOPPS- MH and SA Consumers
- NC SNAP- DD Consumers
- Incident Reports- Through State Electronic System Only (IRIS)
- National Core Indicators-DD Consumers based on sample provided by Division of MH/DD/SAS
- Perception of Care Surveys (Consumer Satisfaction)
- Other items may be added based on contract requirements

Provider Reporting Requirements for Services		
Reporting Requirement /Due Date:	Who is required to Submit:	Responsible Department to submit to:
Consumer Complaint- Due at time of occurrence	All	800-513-4002 option #3 Request Customer Services
NC SNAP- due annually or at time of change in functioning	All DD Providers	800-513-4002 Request Medical Records
Admission info- required for all new admissions to your agency	All	IPRS- http://www.eastpointe.net/providers/iprs/iprs.aspx Medicaid- LME Admission Form Link for Medicaid Consumers
National Core Indicators-annually at time of Division request	DD Providers	800-513-4002 Request DD Care Coordination
Division Perception of Care Survey- per division requirements	MH/SA Providers	800-513-4002 Request Customer Services
MAJORS Report- Monthly	MAJORS	800-513-4002 Request Provider Relations
TANF Work First Initiative Report- Quarterly	TANF-SA	800-513-4002
SAPTBG Compliance Report- bi-annually	SA Block Grant Funding	800-513-4002 Request Provider Relations, Block Grant Liaison
NC TOPPS- at admission, 3 months, 6 months, 12 months, and bi-annually thereafter.	MH/SA Providers of consumers over age 6 years- See Matrix for more details	Submit directly to Division through NC TOPPS web based submission. Verify Compliance with Individual agency Super-user. NC TOPPS Website
Incident Reporting Level II, III- at time of occurrence	All	Submit via web based form at: IRIS Website If you have questions contact 800-513-4002 Request Consumer Liaison
Incident Report Level Aggregate report for Levels I, II, III- quarterly	All	Submit electronically 800-513-4002 Request Consumer Liaison
Quality Improvement Plan-annually with signed contract	All	Submit with annual contract 800-513-4002 Request Quality Management
QI Projects-3 projects due annually	All	Submit with annual contract

by June 1 prior to the end of the contract.		800-513-4002 Request Quality Management
Disaster Plan- annually with signed contract	All	Submit with annual contract 800-513-4002 Request Quality Management
DWI Assessment- Oct 1 st for previous year	DWI Providers	Submit directly to the state.
Annual Financial statement (unaudited)-due Aug 30 th	All	800-513-4002 Request Business Department
Annual statement (audited)-after each official audit	Providers receiving financial assistance over \$500,000 annually	800-513-4002 Request Business Department
Certificate of Insurance showing Eastpointe as additionally Insured- Annually at expiration of current COI.	All IPRS contract providers and Medicaid MOA providers	800-513-4002 Request Business Department

SECTION VI

Quality Improvement and Performance Monitoring

Provider Monitoring:

Eastpointe will monitor/audit according to the mandate set forth in Senate Bill 163 (also known as SB 926). [APSM 30-1](#) This review includes but is not limited to: medical records, facility review, training information, personnel records, quality improvement processes, policy and procedure, billing compliance, and consumer rights. See Eastpointe's policies and procedures at www.Eastpointe.net.

Quality Improvement:

According to 10a NCAC 27g .0201, "The governing body responsible for each facility or service shall develop and implement written policies for the following:

- composition and activities of a quality assurance and quality improvement committee;
- written quality assurance and quality improvement plan;
- methods for monitoring and evaluating the quality and appropriateness of client care, including delineation of client outcomes and utilization of services;
- professional or clinical supervision, including a requirement that staff who are not qualified professionals and provide direct client services shall be supervised by a qualified professional in that area of service;
- strategies for improving client care;
- review of staff qualifications and a determination made to grant treatment/habilitation privileges;
- review of all fatalities of active clients who were being served in area-operated or contracted residential programs at the time of death;
- adoption of standards that assure operational and programmatic performance meeting applicable standards of practice. For this purpose, "applicable standards of practice" means a level of competence established with reference to the prevailing and accepted methods, and the degree of knowledge, skill and care exercised by other practitioners in the field."

Quality Improvement Plan Submission:

All providers applying for an IPRS funding contract with Eastpointe are required to submit a Quality Improvement Plan to the Quality Management Department upon receipt of the signed contract. The QM Director of Eastpointe will provide plan review oversight. A suggested *QI Plan Template* can be found at: [QI Plan Template](#) If a provider chooses to utilize their own format, all elements of the Eastpointe QI Plan Template must be present.

Providers shall demonstrate a Continuous Quality Improvement (CQI) process by identifying a minimum of 3 quality improvement projects acted upon per year. Projects and results will be reported to the Quality Management Director in any quarter of completion. All projects are due June 1 prior to the end date of the contract.

Client Rights:

The goal of the consumer rights function is to assure the basic human rights of consumers receiving mental health, developmental disabilities, and substance abuse services within the network of community providers. Consumers shall be informed of their rights upon initial contact and as requested thereafter. It is the responsibility of all providers to develop and implement a consumer rights function and coordinate this function with the Local Management Entity. It is also the responsibility of all providers to provide training on consumer rights and ensure employees are knowledgeable of and uphold consumer rights.

Client Rights Reporting:

The Client Rights Committee may review grievances regarding incidents that occur within a contract agency after the governing body of the agency has reviewed the incident and had the opportunity to take action.

Incidents of actual or alleged client rights violations, the facts of the incident and the action, if any, made by the contract agency shall be reported to the Eastpointe director for further disposition, if indicated, within 30 days of the initial report of the incident and to the Eastpointe Board within 90 days of the initial report of the incident.

The Client Rights Committee shall serve as Eastpointe's Behavior Intervention Advisory Committee.

Contract providers are required to establish a client rights committee and to register committee membership and meeting dates with the Eastpointe liaison.

At the beginning of a new contract, the contract provider may request that the Committee serve as the provider's client rights committee for two (2) months to allow time to develop a client rights committee. Client rights committees of contract providers must meet all required standards, including provisions to utilize Intervention Advisory Committees, as applicable.

Incident Reporting:

All incidents pertaining to Eastpointe clients shall be reported to the Local Management Entity and NC DHHS as required in APSM 95-2(Client rights) and APSM 30-1 (Quality Assurance/Improvement), and 10A NCAC 27G.0603. All Level II and III incident reports shall be submitted via the Department of Health and Human Services Incident Response Improvement System (IRIS). IRIS is a web-based incident reporting system for reporting and documenting

responses to Level II and III incidents involving consumers receiving mental health, developmental disabilities, and substance abuse services. Providers of publically funded services licensed under NCV General Statutes 122C (Category A Providers), except hospitals, and publically funded non-licensed periodic or community based MH/DD/SA Services (Category B Providers) are required to report these incidents. [IRIS Website](#)

Level I quarterly reports are due to the Client Rights Coordinator as stated below:

- 1st Quarter- (July-Sept)- Due Oct 10
- 2nd Quarter- (Oct-Dec)- Due Jan 10
- 3rd Quarter- (Jan-March)- Due April 10
- 4th Quarter- (April-June)- Due July 10

Clinical Outcome Measures:

Each provider shall, under the terms of the performance contract, conduct an Initial NC TOPPS Interview on every new MH and/or SA consumer (aged 6 years old or older) who receives services. (See NC TOPPS Grid to determine requirement for NC TOPPS) [List of Services that Require NC TOPPS](#)

The Initial Interview should be conducted as part of the PCP process and should be entered into the web-based system within 30 days of the first service. The Initial Interview should not be completed prior to a consumer's formal date of admission to the LME or enrollment in a target population. All consumers who are active in services and have not had an Initial Interview should have one as soon as possible. Update interviews, including Transfer or Episode Completion Interviews, should be completed on schedule as specified in the NCTOPPS Implementation Guidelines.

NC-TOPPS: Implementation Guidelines:

[DHHS- NC TOPPS Webpage](#)
[NC TOPPS Guidelines 2010-11](#)

SECTION VII

Local Management Entity Specific Policies/Forms/Local Governance Requirements

Disaster Planning and Preparedness, Response and Recovery:

Eastpointe will ensure a Comprehensive Disaster Preparedness, Response and Recovery Plan exists for both the LME and the Qualified Provider Community. For endorsed providers of Medicaid services, the MOA addresses Disaster Planning and Response. For contracted providers, the expectation of the LME is: all contracted providers will maintain and annually update a Disaster Plan to cover disaster preparedness response and recovery and the provider will maintain trained staff to respond to the LME in time of shelter coverage requests. Disaster Plans are due with submission of the signed contract. *A Disaster Plan Template is available on the Eastpointe website under "for provider community and forms".* You are not required to utilize our format, however; all disaster plans should include the following required items:

- Policies and Procedures to address staff expectations during natural and manmade disasters. Procedures should include what processes staff would follow to assure their safety, the safety of the consumer, and the protection of health information and confidentiality. Attention should be given to addressing the interruption of services, evacuation, and prioritizing the needs of consumers receiving services. Preparation for natural disaster should also be addressed- for example, fire drills, fire extinguisher training, etc.
- Location of emergency/first aid kits to deal with loss of power, water supply, heat, or minor injury.
- Training requirements of staff including blood borne pathogens, first aid, CPR, crisis intervention, Critical Incident Stress Debriefing, etc. Training plans should indicate the renewal cycle of trainings. There should be evidence of on-going training with staff to prepare them for emergencies.
- Communication plans among the agency and responsible parties for communicating during a disaster. Plans for communicating with the LME during a disaster.
- Safety and communication plans to facilitate open communication with consumers, their families, and others in preparation in case of a disaster.

All plans must adhere to state requirements (Critical Incident Reporting) and Federal Laws/regulations (OSHA). Eastpointe encourages providers to enhance upon the items listed above to meet their needs and in preparation for disaster. All disaster plans should be submitted with the annual contract renewal for IPRS.

National Accreditation:

If applicable, it is the responsibility of the contracted provider to achieve and maintain National Accreditation through an accrediting agency as approved by DMH/DD/SAS and DMA, for the service definitions which require national accreditation that are in the provider's contract.

Provider Demographic Information:

It is the responsibility of the contracted provider to keep Eastpointe informed of all changes, updates, and deletions applicable to the provider's agency. For example: Physical address, phone numbers, e-mail addresses, personnel. See Section I Provider Relations for more information on how to update the LME.

Professional Competency and Credentialing:

The performing provider's status (i.e. Qualified Professional, Associate Professional, and Paraprofessional) shall be clearly delineated. The performing provider shall meet all skills, knowledge, abilities, experience, educational, and/or licensure status to demonstrate competency in the service area as defined by the scope of services in the contract and 10NCAC 27G 0202, 0203, and 0204. Provider documentation and personnel records shall ensure that this provision is met. Supervision is mandated for both Associate Professional and Paraprofessional as outlined in 27G 0203 and 0204 and must be addressed by the Provider's policy.

See also: APSM 30-1, Staff Definitions, [APSM 30-1](#)

Criminal Record Background Checks:

Prior to providing direct care services, all providers must assure that criminal background checks are completed on all employees who will interact with consumers as specified in G.S. 122C-80 and SB 41. In the event that an employee has a criminal history that includes a relevant offense and later commits an illegal act against an Eastpointe consumer, the contract provider shall assume all legal liability since they were responsible for screening the employee. Failure to complete the criminal record background checks in accordance with G. S. 122C-80 and SB 41, current and subsequent revisions, additions or other applicable rules, may result in immediate termination of the contract.

As outlined in GS 122C-80 relevant offense means a county, state, or federal criminal history of conviction or pending indictment of a crime, whether a misdemeanor or felony, that bears upon an individual's fitness to have responsibility for the safety and well-being of persons needing mental health, developmental disabilities, or substance abuse services. These crimes include the criminal offenses set forth in any of the following Articles of Chapter 14 of the General Statutes: Article 5, Counterfeiting and Issuing Monetary Substitutes; Article 5A, Endangering Executive and Legislative Officers; Article 6, Homicide; Article 7A, Rape and Other Sex Offenses; Article 8, Assaults; Article 10, Kidnapping and Abduction; Article 13, Malicious Injury or Damage by Use of Explosive or Incendiary Device or Material; Article 14, Burglary and Other Housebreakings; Article 15, Arson and Other Burnings; Article 16, Larceny; Article 17, Robbery; Article 18, Embezzlement; Article 19, False Pretenses and Cheats; Article 19A, Obtaining Property or Services by False or Fraudulent Use of Credit Device or Other Means; Article 19B, Financial Transaction Card Crime Act; Article 20, Frauds; Article 21, Forgery; Article 26, Offenses Against Public Morality and Decency; Article 26A, Adult Establishments; Article 27, Prostitution; Article 28, Perjury; Article 29, Bribery; Article 31, Misconduct in Public Office; Article 35, Offenses Against the Public Peace; Article 36A, Riots and Civil Disorders; Article 39, Protection of

Minors; Article 40, Protection of the Family; Article 59, Public Intoxication; and Article 60, Computer-Related Crime. These crimes also include possession or sale of drugs in violation of the North Carolina Controlled Substances Act, Article 5 of Chapter 90 of the General Statutes, and alcohol-related offenses such as sale to underage persons in violation of G.S. 18B-302 or driving while impaired in violation of G.S. 20-138.1 through G.S. 20-138.5.

First Responder:

The First Responder/Provider is considered the lead provider for purposes of crisis response 24/7 365 days a year, originating current service plans, coordinating services, obtaining appropriate authorizations, and other functions vital to delivery and payment of consumer services. If the consumer/family does not have a First Responder/Provider, the therapist is responsible for treatment planning and collaboration with other involved parties. If there is no therapist or First Responder/Provider, and the only provider is a physician, the physician is responsible for service planning, coordinating services, and obtaining authorization.

The following service providers and CABHAs (Critical Access Behavioral Health Agencies) are required to have first responder capabilities:

- Community Support Team
- Intensive In Home Services
- Multi-Systemic Therapy
- Assertive Community Treatment Team
- Substance Abuse Intensive Outpatient Program
- Substance Abuse Comprehensive Outpatient Treatment
- Targeted Case Management- Developmental Disabilities
- Targeted Case Management- Mental Health/Substance Abuse

Medical Records:

<http://www.ncdhhs.gov/mhddsas/recordsmgmt/index.htm>

Ownership and Retention:

Record Retention

The Records Management and Documentation Manual for Providers of Publicly Funded MH/DD/SA Services, CAP-MR/DD Services, and Local Management Entities (APSM 45-2) effective April 1, 2009, details the responsibilities of Providers and the LME regarding record maintenance and retention. This Manual may be accessed on the Division of MH/DD/SAS website <http://www.ncdhhs.gov/mhddsas/statspublications/manualsforms/index.htm>

In the event that a Provider agency ends services or dissolves for any reason, the provider is required to make arrangements to continue safeguarding clinical and reimbursement records in accordance with the record retention guidelines. Please be reminded that your agency is responsible for any future financial and/or clinical record audits, and that if there are discrepancies or deficiencies, that you will be expected to repay any amounts due.

The two schedules that address the retention and disposition requirements for publicly-funded MH/DD/SA services are the *DHHS Records Retention and Disposition Schedule for Grants* (based on funding source) and the *Records Retention and Disposition Schedule for State and Area Facilities* (APSM 10-3), organized by record type. Providers are subject to the applicable standards outlined in both schedules.

- The clinical records of children must be maintained for twelve (12) years after the age of majority (i.e., until the person reaches age 30)
- The clinical records of adults must be kept for 11 years after the last encounter
- When more than one retention schedule applies to certain records, the stricter of the retention schedules must be applied.

Service provider agencies have the responsibility of fulfilling the record retention and disposition requirements for all the records generated within their agency. This includes responsibility for maintaining custody of the records for the duration of the retention period. Each provider must develop a retention and disposition plan outlining how the records are stored, who will be the designated records custodian, and how the records custodian is going to inform Eastpointe of what their process is and where the records will be located. The provider should send Eastpointe a copy of the storage logs identifying each individual served within the catchment area, the dates of service and into which box a record is stored. The storage log can be used for all record types including service records, personnel records, etc.

In the event that your agency ends services or dissolves for any reason, you must notify us of your process. We also request that you complete the Eastpointe Record Retention and Disposition Form and submit it to us along with your storage logs. You may send these completed forms to the Medical Records Director at 100 South James Street, Box B Goldsboro, North Carolina 27530.

<http://www.eastpointe.net/providers/PESDA/Eastpointe%20Records%20Retention%20and%20Disposition%20Form%2011142011.doc>

<http://www.eastpointe.net/providers/PESDA/Record%20Storage%20Log%20Sample.doc>

When a consumer changes providers, relevant clinical and consumer-specific information should be copied and sent to the new provider in a timely manner with the appropriate written consent when such consent is required] to ensure continuity of care. Custody of the original record generated by the provider shall be retained by the provider organization.

Transferring Records:

In order to transfer a consumer's record information to another provider follow the following steps:

1. The receiving provider is responsible for obtaining authorization for services. For example, Provider A is transferring a case to Provider B. Provider B would complete an authorization request.
2. The new provider is responsible to ensure that all required forms, authorizations, etc., are complete prior to initiating services.
3. The receiving provider should revise the Person Centered Plan as needed to comply with the change in services. Any changes to the service plan would require the involvement of the treatment team.
4. The receiving provider should also review to ensure the proper pop group is documented in order to provide the change in services.
5. The transferring agency is responsible for providing the receiving agency with any paper documentation to the receiving provider that they may need.

Discharging Consumers:

The provider should complete a discharge summary when the client is no longer in need of services from your agency but will receive services from another agency. For example: A consumer is being discharged from Case Management because they no longer need it from Agency A, but will receive services from Agency B for outpatient therapy. The record will remain open since Provider B will provide services.

The New Member Enrollment/LCAD is utilized for this purpose for state funded services. For Medicaid the LME Consumer Admission and Discharge Form would be utilized.

Terminating Records:

A Termination summary is only completed when the client is no longer receiving services from any company. The report should be completed by the clinical home provider. This process will close the record for all service providers and in order to initiate services again the client would have to start the process again through the Access Department. The clinical home should verify with the consumer that they are no longer in need of service prior to terminating the record.

The New Member Enrollment/LCAD is utilized for this purpose for state funded services. For Medicaid the LME Consumer Admission and Discharge Form would be utilized.

Persons who may Sign Consent for Release:

State Law:

10A NCAC 26B .0203 PERSONS WHO MAY SIGN CONSENT FOR RELEASE

The following persons may sign consent for release of confidential information:

- a competent adult client;
- the client's legally responsible person;

- a minor client under the following conditions:
- pursuant to G.S. 90-21.5 when seeking services for venereal disease and other diseases reportable under G.S. 130A-135, pregnancy, abuse of controlled substances or alcohol, or emotional disturbances;
- when married or divorced;
- when emancipated by a decree issued by a court of competent jurisdiction;
- when a member of the armed forces; or
- personal representative of a deceased client if the estate is being settled or next of kin of a deceased client if the estate is not being settled.

10A NCAC 26B .0204 VERIFICATION OF AUTHORIZATION IN CASES OF DOUBT

Whenever the validity of an authorization is in question, an area or state facility employee shall contact the client or the client's legally responsible person to confirm that the consent is valid. Such determination of validity of the consent shall be documented in the client record.

Federal Law:

Federal Substance Abuse Law: [42 CFR Federal Substance Abuse Law](#)

If the patient is a minor: [42 CFR Part 2B 2.14-Minor Patients](#)

Release of Information for Disclosure/Re-disclosure:

State Law:

10A NCAC 26B .0208 PROHIBITION AGAINST REDISCLOSURE

- Area or state facilities releasing confidential information shall inform the recipient that re-disclosure of such information is prohibited without client consent.
- A stamp may be used to fulfill this requirement.

Federal Law:

42 CFR Part 2, 2.32 PROHIBITION ON REDISCLOSURE:

Notice to accompany disclosure. Each disclosure made with the patient's written consent must be accompanied by the following written statement:

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Financial Paybacks:

The contracted provider is responsible for appropriate delivery of services and proper billing to the LME. Any payback as a result of audit or monitoring by the LME will be the responsibility of the contracted provider. Providers should ensure that all required elements for services are present prior to billing the LME. See Article V Section 5.6 of your service contract.

Appeals:

The contracted provider has the right to appeal any findings from monitoring by the LME to the Quality Improvement Appeal Committee. All appeals must be received by stated deadline in monitoring notice in order to be considered for appeal. Any appeals received after the deadline will not be reviewed and should not be appealed on any additional level. Appeals must be directed to the Quality Management Director.

System of Care(SOC) for Children :

System of Care Handbook: [System of Care for Children- Handbook](#)

System of Care Concept and Philosophy

A system of care for children with emotional disorders is a comprehensive spectrum of mental health and other necessary services which are organized into a coordinated network to meet the multiple and changing needs of and their families.

The core values of the system of care philosophy specify that services should be community based, child centered and family focused and culturally and linguistically competent. The guiding principles specify that services should be:

- Comprehensive, incorporating a broad array of services and supports,
- Individualized,
- Provided in the least restrictive, appropriate setting,
- Coordinated both at the system and service delivery levels,
- Involve families and youth as full partners, and
- Emphasize early identification and intervention.

The system of care concept holds that all life domains and needs should be considered rather than addressing mental health treatment needs in isolation, and so systems are organized around eight overlapping dimensions: the system of care framework has child and family in the center surrounded by (1) mental health, (2) social services, (3) educational services, (4) health services, (5) substance abuse services, (6) vocational services (7) recreational services, and (8) operational services. It is essential that all services are developed cooperatively and are coordinated in a Child And Family Team. The team shares responsibility, expertise, and mutual support while designing creative services that meet an individual's strengths and needs across home, school and community.

Eastpointe Community Collaborative promotes the System of care approach to organize services supports. System of care is a process not a program. The Eastpointe Community Collaborative bring families members, public and private agencies together to make decision about services in their communities. The Community Collaborative is a forum for the discussion of issues regarding how agencies, community members and families can work together to produce better outcomes for children and families.

The functions may include, but not limited to:

- Oversight of service implementation
- Coordination and communication of related information
- Monitoring SOC implementation and practice change
- Advocates for children
- Plan developers: i. e. Training, cultural competency, service gaps, etc.

In addition to the above, the Community Collaborative takes referrals from providers and other child serving agencies that are having difficulty identifying appropriate services for any child or youth. We will do a Care Review, looking closely at the PCP and outcomes. Other action steps maybe recommended to the providers or by the Collaborative . If you are having difficult challenges with a particular case, please contact a child care coordination coordinator at 800-513-4002.

System of Care for Adults:

Care Coordination provides the function of linking, coordinating and monitoring services for those people who arrive at psychiatric units or hospitals. This would also include the State ADATC Centers, and those being released from Department of Corrections. Ongoing liaison is provided to both acute and long term patients.

Care coordinators schedule appointments with providers, for the continuing care of those people being discharged from in patient services to community services. Additionally they follow up with providers on the disposition of the scheduled appointment, in order to promote the continuity of care.

Training Information through Eastpointe:

[Eastpointe Training Calendar](#)

Cultural Competence:

The LME shall:

- Ensure and promote a service system that is culturally competent, relevant and sensitive through providing standards, criteria and training to staff and the provider community
- Ensure that the system of care exists which recognizes diversity (i.e. racial, ethnic, linguistic, etc.) of the consumers, families, staff and the provider community;
- Ensure that staff and the provider community adhere to the criteria and standards established by the LME through its monitoring mechanisms.

Title VI of the Civil Rights Act of 1964 prohibits discrimination based on the grounds of race, color or national origin by any entity receiving Federal financial assistance. Administrative methods or procedures, which have the effect of subjecting individuals to discrimination or defeating the objectives of these regulations, are prohibited. Individuals with Limited English Proficiency must be provided meaningful access to benefits and services.

Continuity of Care:

When a Provider Surrenders Services:

If a provider withdraws from the endorsement process or gives notice of termination of the contract or MOA the provider must:

1. Inform the LME in writing with a letter addressed to the Provider Relations Director: 2901 N. Heritage Street, Kinston, NC 28501.
2. Provide to the Eastpointe Customer Services Department a complete list of current consumers and the services they receive from the departing provider.
3. Contact the clinical home provider of all consumers currently served by the departing provider.
4. Assist the clinical home providers with facilitating Consumer Choice process.
5. Complete all program discharge processes that are appropriate, including the submission of the discharge summary to the LME and discharging from electronic assessments such as the NC TOPPS. Any information that might identify/tie that consumer back to your agency.
6. Notify all active consumers in writing of the decision to terminate service provision in language that the individual can understand.
7. If the departing provider is the clinical home for consumers, the departing provider is responsible for facilitating the choice process for all individuals for whom they provide that service.
8. Maintain all consumer rights during the process of the provider's departure.
9. Upon written communication, the Provider Relations Director (or designee) will inform the Eastpointe Leadership Team members. The Team members will be responsible for actions to be taken within their department.
10. LME Customer Services Staff will monitor the transition of consumers to another provider and assure that all active consumers are transitioned to an appropriate provider of their choosing.
11. The LME Director will inform the Eastpointe Board and Eastpointe Attorney.

When an individual chooses another provider:

Consumer Choice of Service Provider

The ability of a consumer to exercise choice of service providers will have a major impact on his/her willingness to continue engagement in services. Consumers who are not afforded that right often discontinue services before recovery or stability can be achieved. If a Provider Agency is planning to end services or dissolve, consumers should be notified in advance, and should be offered choice of service providers in order to ensure continuity of care. Once consumers have selected new providers and appropriate written consents are obtained, all relevant clinical and person-specific information should be copied and sent to the new provider in a timely manner. Eastpointe's Customer Services Staff are available to assist in this process and may be reached at (800) 513-4002. Service providers are required to notify Eastpointe when an individual changes service providers or ends a service that the LME has previously authorized. You may meet this LME requirement by sending Customer Services a copy of the signed Acknowledgement of Consumer Choice form. Signed Acknowledgement of Consumer Choice Forms may be faxed to the attention of Customer Services. Fax #:(910) 298-7186

All individuals have the right to choice of provider within their benefit source. If an individual chooses to change from their current provider to a new provider the following process should be followed:

1. The individual may contact their current service provider, clinical home, or Eastpointe Customer Services Department to begin the transfer/transition process.
2. Once it is determined that the individual would like to continue the services that they are currently authorized for, the individual should be offered choice from the Eastpointe Provider Choice Database on the Eastpointe website. www.Eastpointe.net
3. The person assisting the individual with provider choice should keep in mind the individual's payer source and only offer choices that are viable options.
4. A provider choice form should be signed and sent to the Customer Services Department of Eastpointe. The person assisting with the completion of the process should also keep a copy of the form for their records.
5. The person assisting the individual with the choice of new service provider should contact the newly chosen provider to begin the referral process.
6. The new receiving service provider would then be expected to begin the admission process, completing all necessary release forms for copies of medical records as well as completing the person centered plan and requesting authorization for services.
7. The transferring service provider should complete all necessary discharge information including the discharge summary being sent to the LME and discharging the person from NC TOPPS or other assessments which would tie that consumer to your agency.
8. A letter is sent to the consumer from the transferring provider stating the closure of their services from their agency.

Note: For a listing of all providers who contract with Eastpointe and the services that they provide please refer to the website at www.Eastpointe.net and review the "Provider Choice Database".

When the consumer chooses additional services:

1. When it is determined through the assessment and person centered planning process that an individual needs additional services that are justified, available through their IPRS POP Group, and available within the community, the clinical home should initiate the referral process to the additional provider. For example- an individual currently receives community support and the assessment stated that this individual could benefit from outpatient therapy as well- the clinical home would assist in linking the individual to the new services.
2. The clinical home offers choice to the individual through the Eastpointe Provider Database. This is found on the website- www.Eastpointe.net The individual assisting the person should ensure that all viable options are offered.
3. A provider choice form is signed and sent to the provider relations department. The clinical home should also keep a copy.
4. The clinical home contacts the new provider of services. The assist the consumer with the application process for services.
5. The new/additional provider completes request for information forms and requests any records that they need.
6. The clinical home assists in arranging transportation to the new service, the appointment date, etc.
7. The new service provider is responsible for all authorizations for their services.
8. Both parties should communicate and complete one person centered plan, including all services. The clinical home is the responsible party for the completion of the person centered plan, however; the clinical home should not write goals for services they are not receiving authorizations for.

SECTION VIII

Glossary of Terms

For Acronyms See: [DHHS Listing of Acronyms](#)

Please Note: *Definitions included in this section are primarily for clarification of terms used in the body of this Agreement, its attachments and manual. However many of these definitions are also used in existing state and Local Management Entity documents and are included here to be helpful but are not to be considered comprehensive. Where similar definitions apply to multiple terms, the terms are grouped. Broad categories are defined with specific elements detailed as a part of the entire definition.*

ACCESS – An array of treatments, services and supports is available; consumers know how and where to obtain them; and there are no system barriers or obstacles to getting what they need, when they are needed.

ACCREDITATION – Certification by an external entity that an organization has met a set of standards.

ACTT-Assertive Community Treatment Team

ADULT- for state funded services means a person 18 years of age or older, and for Medicaid 21 years of age, unless the term is given a different definition by statute, rule, or policies.

ADVOCACY – Activities in support of, or on behalf of, people with mental illness, developmental disabilities or addiction disorders including protection of rights, legal and other service assistance, and system or policy changes.

AMERICAN SOCIETY OF ADDICTION MEDICINE (ASAM) - An international organization of physicians dedicated to improving the treatment of people with substance use disorders by educating physicians and medical students, promoting research and prevention, and informing the medical community and the public about issues related to substance use. In 1991, ASAM published a set of patient placement criteria that have been widely used and analyzed in the alcohol, tobacco and other drug field.

APPEAL- means a formal request for review of a decision made by the Contractor or a subcontracted provider related to eligibility for covered services or the appropriateness of treatment services provided.

APPEALS PANEL - The State MH/DD/SA appeals panel established under NC. G.S.371.

ASSESSMENT – A comprehensive examination and evaluation of a person’s needs for psychiatric, developmental disability or substance abuse treatment, services and/or supports according to applicable requirements.

AUTHORIZATION - The process by which Utilization Management agrees to a medically necessary specific service or plan of care based upon best practice. The granted request of a provider is assigned a number for tracking and linked to the subsequent claim that will be made for reimbursement.

BASIC SERVICES – Mental health, developmental disability or substance abuse services that are available to North Carolina residents who need them whether or not they meet criteria for target or priority populations.

BENEFIT PACKAGE OR PLAN – An array of treatments, services and/or supports intended to meet the needs of target or priority populations.

BENEFIT LIMITATIONS- are any provision, other than an exclusion, which restricts coverage, regardless of medical necessity. *Covered Benefits* medically necessary services that are specifically provided for under the provisions of Evidence of Coverage. A covered benefit shall always be medically necessary, but not every medically necessary service is a covered benefit. For example, some elements of custodial or maintenance care, which are excluded from coverage, may be medically necessary, but are not covered.

BEST PRACTICE (S) – Interventions, treatments, services or actions that have been shown by substantial research or professional consensus to generate the best outcomes or results. The terms, *EVIDENCE-BASED*, or *RESEARCH-BASED* may also be used.

BLOCK GRANT – Funds received from the federal government (or others), in a lump sum, for services specified in an application plan that meet the intent of the block grant purpose. Also referred to as *CATEGORICAL FUNDING*.

CABHA- Critical Access Behavioral Health Agency that has been certified by the Department of Health and Human Services as meeting all requirements of 10A NCAC 22P.0100.

CARE COORDINATION – The methods utilized to notify other providers of significant events in the course of care and to enable multiple providers to give integrated care to an individual. Professionals with a broad knowledge of the resources, services and programs supported by the public MH/DD/SA system and the community at-large advocate for access and link individuals to entitlements and services.

CARF - Council on Accreditation of Rehabilitation Facilities

CATCHMENT AREA - The geographic part of the State served by a specific LME. The *GEOGRAPHIC AREA*- can be a specific county or defined grouping of counties that are available for contract award. The LME is responsible to manage covered services to eligible residents of their area.

CENTERS FOR MEDICAID AND MEDICARE SERVICES (CMS) - The federal agency responsible for overseeing the Medicaid and Medicare programs. Formerly, it was known as the Health Care Financing Administration, (HCFA).

CFAC – Each LME has a Consumer Family Advisory Committee which is comprised of consumers and family members representing all disability groups. CFACs meet on a regular basis in their communities to support and communicate their concerns and provide advice and comment on all state and local plans.

CHILD-means an eligible person who is under the age of 18, unless the term is given a different definition by statute, rule or policies.

CLAIMS MANAGEMENT – The process of receiving, reviewing, adjudicating, INVESTIGATING, paying, and otherwise processing service claims submitted by network and facility providers.

CLAIM – An itemized Statement of services, performed by a provider network member or facility, which is submitted for payment.

CLEAN CLAIM- means a claim that successfully passes all adjudication edits.

CLIENT - An individual who is admitted to or receiving public services. “Client” includes the client’s personal representative or designee and the terms *CONSUMER*, *RECIPIENT* and *PATIENT* are often used interchangeably.

CLIENT OUTCOMES INVENTORY (COI) – DMH/DD/SAS measurement system for assessing treatment/services outcomes of mental health and substance abuse service consumers.

CLIENT DATA WAREHOUSE(CDW) - The DHHS’s source of information to monitor program, clinical and demographic information on the clients served. The data are also used to respond to Departmental, Legislative and Federal reporting requirements.

CLINICAL PRACTICE GUIDELINES – Utilization and quality management mechanisms designed to aid providers in making decisions about the most appropriate course of treatment for a specific clinical case. The guidelines or *TREATMENT PROTOCOLS* are summaries of best practice research and consensus. They include professional standards for providing care based on diagnostically related groups. NC has adopted protocols for MH and DD. NC uses ASAM Guidelines for substance abuse.

COA -Council on Accreditation

CO-MORBID CONDITION- CO-OCCURRING DISORDERS, DUAL DIAGNOSIS – Term that reflects the presence of two or more disorders at the same time (e.g. substance abuse and mental illness; developmental disability and mental illness; substance abuse and physical health conditions, etc and require specialized approaches.

COMPLAINT – A report of dissatisfaction with some aspect of the public MH/DD/SA system. The term *DISPUTE* is used to indicate a specific complaint about a service or a provider that requires attention and joint resolution.

CONFLICT OF INTEREST – A situation where self interest could negatively impact the best interests of the person being served or the system.

CONSENSUS - Majority opinion regarding a group decision. It is not the same as total agreement.

CONSUMER- An individual who is admitted to or receiving public services. “Consumer” includes the consumer’s personal representative or designee and the terms *CLIENT*, *RECIPIENT* and *PATIENT* are often used interchangeably.

CONSUMER/FAMILY ADVISORY COMMITTEE – A Board appointed group of persons receiving services, families of persons receiving services, advocates and other stakeholders that participate in meaningful decision making relative to the local program. The group shall meet at least monthly in a public forum to review data, practices, policies and plans of the Contractor and make recommendations to the Board from the consumer/family perspective.

CONTRACT- A legal agreement between a payer and a subscribing group or individual which specifies rates, performance covenants, the relationship among the parties, schedule of benefits and other pertinent conditions. The contract usually is time limited. A contract is defined as a document that governs the behavior of a willing buyer and a willing provider. In this case the Contract is the 2004 Performance Agreement between the Department and the LME.

CONTRACTOR - an organization or entity agreeing by signature to provide the goods and services in conformance with the Stated contract requirements, NC statute and rules and federal law and regulations.

CONTRACT YEAR-a period from July 1 of a calendar year through and including June 30 of the following year.

COPAYMENT- The portion of the cost of services which the enrolled person pays directly to the Contractor or the subcontracted providers at the time-covered services are rendered.

CORE SERVICES – *BASIC SERVICES* such as screening, assessment, crisis or emergency services available to any person who needs them whether or not they are a member of a target or priority population. The term also includes universal services such as education, consultation and prevention activities intended to increase knowledge about mental illness, addiction disorders, or developmental disabilities, reduce stigma associated with them and/or prevent avoidable disorders.

CORPORATE COMPLIANCE – The systematic local governance plan for detection of fraud and abuse as defined in the Balanced Budget Act.

CREDENTIALING – The process of approving providers for membership in a network to provide services to consumers. This term can also refer to a peer competency-based credential such as a license for professionals.

CRISIS – Response to internal or external stressors and stressful life events that may seriously interfere with or compromise a person’s ability to manage. A crisis may be emotional, physical, or situational in nature. The crisis is the perception of and response to the situation, not the situation itself.

CRISIS RESPONSE is the immediate action to assess for acute MH/DD/SA service needs, to assist with acute symptom reduction, and to ensure that the person in crisis safely transitions to appropriate services. These services are available 24 hours per day, 365 days per year. These services may be referred to as *EMERGENCY* services as well. NC requires

a *CRISIS PLAN* for consumers to promote recovery and to lessen the trauma of emergency events.

CULTURAL COMPETENCE/PROFICIENCY –A process that promotes development of skills, beliefs, attitudes, habits, behaviors and policies which enable individuals and groups to interact appropriately, showing that we accept and value others even when we may disagree with them.

CUSTOMER – Customers may be *ULTIMATE CUSTOMERS* who are the intended and actual recipients of the services provided by the public system, *INTERNAL CUSTOMERS* are those individuals internal to the system who rely on each other to provide the service to the ultimate customer; and *EXTERNAL CUSTOMERS* are those groups and individuals outside the system that have a take in the outcomes and products produced by the system. The concept is critical to proper implementation of

DD - Developmental Disability

DEFAULT – The breach of conditions agreed to in this Contract and/or failure to perform based upon defined terms and conditions the scope of work specified in the Contract.

DE-INSTITUTIONALIZATION – Release of people from institutions to care, treatment and supports in local communities. De-institutionalization became national policy with the Community Mental Health Centers Act of 1963. The 1997 Supreme Court decision in *OLMSTEAD V. LC* has given new momentum to development of community based services for individuals who have remained in State hospitals and mental retardation centers because community services were not available. This movement is often referenced as movement to least restrictive care or to lower levels of care where safety and community integration are balanced and supported through the community system of services.

DEPARTMENT OF HEALTH AND HUMAN SERVICES, (DHHS) – North Carolina agency that oversees State government human services programs and activities.

DEVELOPMENTAL DISABILITY - A severe, chronic disability of a person which:

- a) is attributable to a mental or physical impairment or combination of mental and physical impairments;
- b) is manifested before the person attains age 22, unless the disability is caused by a traumatic head injury and is manifested after age 22;
- c) is likely to continue indefinitely and,
- d) results in substantial functional limitations in three or more of the following areas of major life activity: self-care, receptive and expressive language, capacity for independent living, learning, mobility, self-direction and economic self sufficiency; and
- e) reflects the person’s need for a combination and sequence of special interdisciplinary, or generic care, treatment, or other services which are of a lifelong or extended duration and are individually planned and coordinated; or f. when applied to children from birth through four years of age, may be evidenced as a developmental delay.

DHHS- Department of Health and Human Services.

DIAGNOSTIC AND STATISTICAL MANUAL (DSM IV) – A book, published by the American Psychiatric Association, of special codes that identify and describe MH/DD/SA disorders.

DISASTER – A disaster is any natural or human-caused event, which threatens or causes injuries, fatalities, widespread destruction, distress, and economic loss. Disasters result in situations that call for a coordinated, multi-agency response. A disaster calls for a response and resources that usually exceed local capabilities.

DIVERSION – Choosing lower cost and/or less restrictive services and/or supports. For example, choosing a community program instead of sending a person to a State hospital. The term is also used when preventing arrest or imprisonment by providing services that restore functioning and avoid detention. In North Carolina diversion programs are in place in response to SB859 that prohibits admission of persons with mental retardation to public psychiatric hospitals.

DIVISION OF MENTAL HEALTH, DEVELOPMENTAL DISABILITIES AND SUBSTANCE ABUSE SERVICES (DMH/DD/SAS) - A division of the State of North Carolina, Department of Health and Human Services responsible for administering and overseeing public mental health, developmental disabilities and substance abuse programs and services.

DJJDP - Department Of Juvenile Justice and Delinquency Prevention.

DOMAINS - Major areas of concern to the NC public MH/DD/SA system and its mission, goals, and strategies and for which indicators and measures are developed to examine outcomes of service in the lives of people served.

DPI -Department of Public Instruction

DSS - Department of Social Services

EARLY PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT SERVICES (EPSDT) – Early and Periodic Screening, Diagnosis and Treatment is a Medicaid program for Title XIX individuals under the age of 21. This mandatory preventive child health program for Title XIX children requires that any medically necessary health care service identified in a screening be provided to an EPSDT recipient. The MH/DD/SA component of the EPSDT diagnostic and treatment services for Title XIX members under age 21 years are covered by this contract.

EASTPOINTE-A Local Management Entity (LME) of Behavioral Health Services serving individuals who live in Duplin, Lenoir, Sampson, and Wayne counties.

EDUCATION – Activities designed to increase awareness or knowledge about any and all aspects of mental health, mental illness, developmental disability or substance abuse to individuals and/or groups. Education and training are also activities or programs delivered to staff to ensure that service providers are competent to provide services identified as best practices.

ELIGIBILITY – Determination of the service and/or benefit package an individual may be entitled to or determination of a class membership that allows entry to certain services and

supports. The determination that individuals meet prescribed criteria for a particular program, set of services or benefits.

EARLY INTERVENTION - The provision of psychological help to victims/survivors within the first month after a critical incident, traumatic event, emergency, or disaster aimed at reducing the severity or duration or event-related distress. For mental health service providers, this may involve psychological first aid, needs assessment, consultation, fostering resilience and natural supports, and triage, as well as psychological and medical treatment.

EMERGENCY- Means a situation in which an individual is experiencing a serious mental illness or a developmental disability, or a child is experiencing a serious emotional disturbance, and one of the following apply: o The individual can reasonably be expected within the near future to physically injure himself, herself, or another individual, either intentionally or unintentionally. o The individual is unable to provide himself or herself food, clothing, or shelter, or to attend to basic physical activities such as eating, toileting, bathing, grooming, dressing or ambulating, and this inability may lead in the near future to harm to the individual or to another individual. The individual's judgment is so impaired that he or she is unable to understand the need for treatment and, in the opinion of the mental health professional, his or her continued behavior as a result of the mental illness, developmental disability, or emotional disturbance can reasonably be expected in the near future to result in physical harm to the individual or to another individual.

ENROLLED – Individuals are admitted for service and have been provided at least one service and assigned a unique identifying number.

FAIR HEARING RIGHTS – Advance and Adequate Notice - The Contractor notice in accordance with DHHS policy and procedure using prescribed forms when denying, reducing, suspending or terminating covered services that require prior authorization. The Contractor shall comply with all notice, appeal and continuation of benefits requirements specified by State and federal law and regulations.

FEE FOR SERVICE – A method of payment for health care. A payer pays the Contractor or a service provider for each reimbursable treatment, upon submission of a valid claim, and according to agreed upon business rules. The *FEE SCHEDULE* is a list of reimbursable services and the rate paid for each service provided.

FEMA - Federal Emergency Management Agency

FORENSIC – Term used to describe a person with mental illness, developmental disability or substance abuse who is involved in the criminal justice system. This includes persons found Not Guilty by Reason of Insanity (NGRI), those who are Incompetent to Stand Trial, or who are in jails or prisons or referred to the mental health system by criminal courts for evaluation and treatment.

FORMULARY – A list of drugs that are considered preferred therapy for a given condition and cost effective and are to be used by providers in prescribing medications.

FUNCTIONAL OUTCOMES - The extent to which individuals receiving services and supports reach their goals. These outcomes generate from *DOMAINS* as defined earlier related to desirable life developments that all people wish to achieve, such as safe and affordable housing,

employment or a means of support, meaningful relationships, participation in the life of the community, etc.

GAPCD - Governor's Advisory Council for Persons with Disabilities

GENERAL FUND – State funds used by the General Assembly for public programs and initiatives.

GEOGRAPHIC ACCESSIBILITY – A measure of access to services, generally determined by drive/travel time or number and type of providers in a service area. The Contract standard is 30 minutes/30 miles.

GRIEVANCES – A formal complaint by a service recipient that shall be resolved in a specified manner detailed in this Contract.

HEALTH CHOICE – The health insurance program for children in North Carolina that provides comprehensive health insurance coverage to uninsured low-income children. Financing comes from a mix of federal, State, and other non-appropriated funds.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) – Public Law 104-191, 1996 to improve the Medicare program under title XVIII of the Social Security Act, the Medicaid program under title XIX of the Social Security Act, and the efficiency and effectiveness of the health care system, by encouraging the development of a health information system through the establishment of standards and requirements for the electronic transmission of certain health information. The Act provides for improved portability of health benefits and enables better defense against abuse and fraud, reduces administrative costs by standardizing format of specific healthcare information to facilitate electronic claims, directly addresses confidentiality and security of patient information - electronic and paper-based, and mandates “best effort” compliance.

HIPAA - Health Insurance Portability and Accountability Act

HUD - Housing and Urban Development

HUMAN RIGHTS COMMITTEE – The body established by statute for hearing grievances and appeals related to rights violations guaranteed by law and under this contract.

INCURRED BUT NOT REPORTED (IBNR)- means liability for services rendered for which claims have not been received. Refers to claims that reflect services already delivered, but, for whatever reason, have not yet been reimbursed. Failure to account for these potential claims could lead to inaccurate financial estimates.

INTEGRATED PAYMENT AND REPORTING SYSTEM (IPRS) - An electronic, web-based system for reporting services and making payments that will eventually replace the Willie M., Thomas S., and Pioneer systems of claims processing. The IPRS system will be built on the existing Medicaid Management Information System (MMIS) currently processing Medicaid claims for the

Division of Medical Assistance, (DMA). The goal of the IPRS project is to replace the existing UCR systems with one integrated system for processing and reporting all MH/DD/SAS and Medicaid claims.

IPRS-Integrated Payment Reporting System

JOINT COMMISSION ON ACCREDITATION OF HEALTHCARE ORGANIZATIONS (JCAHO) –Agency that reviews the care provided by hospitals and determines whether accreditation is warranted.

LBP - Local Business Plan

LEAST RESTRICTIVE CARE – The service that can be provided in the most normative setting while insuring the safety and well being of the individual.

LENGTH OF STAY (LOS) – The amount of time that a person remains in a service program, including hospitals, expressed in days.

LEVEL OF CARE (LOC)- A structured system for evaluating acuity and *INTENSITY OF NEED* against the amount, duration and scope of service required by a consumer. For substance abuse programs, As used in the ASAM criteria for substance abuse, this term refers to four broad areas of treatment placement, ranging from inpatient to outpatient.

LICENSURE – A State or federal regulatory system for service providers to protect the public health and welfare. Licensure of healthcare professionals and hospitals are examples.

LME - Local Management Entity

LOCAL BUSINESS PLAN – In the reformed MH/DD/SA system, a comprehensive plan required of local management entities for mental health, developmental disabilities and substance abuse services in a certain geographical area.

LOCAL MANAGING ENTITY (LME) - The local administrative agency that plans, develops, implements and monitors services within a specified geographic area according to the terms of this Contract including the development of a full range of services and/or supports for both insured and uninsured individuals.

LOCAL QUALITY MANAGEMENT COMMITTEE – A cross system group of stakeholders including the LME, providers, consumers, and family members that reviews data and trends to make recommendations for continuous improvement in the system of care and supports.

MANAGEMENT REPORTS – Collections of data that are benchmarked to enable the agency to compare performance against standards and to seek continuous improvement. The reports should be comprehensive incorporating timeliness, utilization and penetration rates, customer satisfaction, functional outcomes and compliance with various standards and terms inherent in this Contract.

MEDICAID – A jointly Funded federal and State program that provides medical expense coverage to low-income individuals, certain elderly people and people with disabilities. The Federal government requires that the State/local government match the federal government funds.

In North Carolina, this is approximately 60% federal/40% State/local match. People qualifying for Medicaid are “entitled” to supports and services based upon a State Medicaid Plan that is approved by the Federal Government. That Plan describes the services and benefits the individual is entitled to receive and the conditions of service provision.

MEDICAL DIRECTOR – A Board Certified Psychiatrist responsible for establishing and overseeing medical policy throughout the system under the terms of this Contract.

MEDICAL NECESSITY - Criteria established to ensure that treatment is essential and appropriate for the condition or disorder for which the treatment is provided. The criteria reference the scope, amount and duration of service appropriate for levels of acuity and rehabilitative care.

MEDICARE – A federal government hospital and medical expense insurance plan primarily for elderly people and people with long term disabilities.

MEMBER HANDBOOK – A document developed and disseminated by the Contractor according to parameters established in this Contract to inform potential eligibles, eligibles, and enrolled persons of their rights, responsibilities and treatment coverages.

MEMORANDUM OF AGREEMENT (MOA) or MEMORANDUM OF UNDERSTANDING (MOU) – A written document, signed by two or more parties, containing policies and/or procedures for managing issues that impact more than one agency or program.

MH - Mental Health

MMIS - Medicaid Management Information System.

MST - Multi-Systemic Therapy

NATIONAL COMMITTEE FOR QUALITY ASSURANCE (NCOA)-A non-profit organization created to improve patient care quality and health plan performance in partnership with system management plans, purchasers, consumers, and the public sector.

NATIONAL PRACTITIONER DATA BANK (NPDB) – A database maintained by the federal government that contains information on physicians and other medical practitioners against whom medical malpractice claims have been settled or other disciplinary actions that have been taken.

NATURAL AND COMMUNITY SUPPORTS - Places, things and, particularly, people who are part of our interdependent community lives and whose relationships are reciprocal in nature.

NCOA - National Council for Quality Assurance

NEEDS ASSESSMENT - A process by which an individual or system (e.g., an organization or community) examines existing resources to determine what new resources are needed or how to reallocate resources to achieve a desired goal.

NORTH CAROLINA SUPPORT NEEDS ASSESSMENT PROFILE (NC-SNAP) –

Assessment instrument used to determine the care or supports needed by a person with developmental disabilities.

OAH- Office of Administrative Hearings

PCP - Person Centered Plan

PERFORMANCE INDICATORS - Measurable evidence of the results of activities related to particular areas of concern as indicated in this Contract. The measures are quantitative indicators of the quality of care provided that consumers, payers, regulators and others could use to compare the care or provider to other care or providers.

PERFORMANCE STANDARDS- Benchmarks an agency or provider is expected to meet. The standards define regulatory expectations and in meeting them the agency or provider may meet a required level for “certification” or “accreditation”.

PERSON-CENTERED PLANNING - A process focused on learning about an individual’s whole life, not just issues related to the person’s disability. The process involves assembling a group of supporters selected by the consumer who are committed to supporting the person in pursuit of desired outcomes. Planning includes discovering strengths and barriers, establishing time-limited and identifying and gaining access to supports from a variety of community resources prior to utilizing the community MH/DD/SA system to assist the person in pursuit of the life he/she wants. Person-centered planning results in a written plan that is agreed to by the consumer and that defines both the natural and community supports and the services being requested from the public system to achieve the consumer’s desired outcomes. The plan is used as the basis for requesting an authorization for services.

PHYSICAL DEPENDENCE - A condition in which the brain cells have adapted as a result of repeated exposure to a drug and consequently require the drug in order to function. If the drug is suddenly made unavailable, the cells become hyperactive. The hyperactive cells produce the signs and symptoms of drug withdrawal.

PLAN OF CORRECTION – A written response to findings of an audit or review that specify corrective action, time frames and persons responsible for achieving the desired outcomes.

PP - Primary Provider

PREVALENCE – The estimated degree of incidence of a condition in a given population.

PREVENTION – Activities aimed at teaching and empowering individuals and systems to meet the challenges of life events and transitions by creating and reinforcing healthy behaviors and lifestyles and by reducing risks contributing mental illness, developmental disabilities and substance abuse. Universal Prevention programs reach the general population; Selective Prevention programs target groups at risk for mental illness, developmental disabilities and substance abuse; Indicated Prevention programs are designed for people who are already experiencing mental illness or addiction disorders.

PSR - Psychosocial Rehabilitation

RESPONSIBLE CLINICIAN - An assigned professional deemed competent and credentialed by the Contractor to serve as a fixed point of accountability for the consumer's PCP, monitoring and outreach.

PRIMARY CARE- (a) Basic or general health care usually rendered by general practitioners, family practitioners, internists, obstetricians and pediatricians—often referred to as primary care practitioners. (b) Professional and related services administered by an internist, family practitioner, obstetrician-gynecologist or pediatrician in an ambulatory setting, with referral to secondary care specialists, as necessary.

PRIMARY SOURCE VERIFICATION – A process through which an organization validates credentialing information from the organization that originally issued the credential to the practitioner.

PRINCIPLE DIAGNOSIS-The medical condition that is ultimately determined to have caused the consumer to seek care. The principal diagnosis is used to assign every consumer to a diagnosis-related group. This diagnosis may differ from the admitting diagnosis.

PRIORITY POPULATIONS – Groups of people within target populations who are considered most in need of the services available within the system.

PRIVILEGING – Process for determining, usually through training and supervision that an individual provider has the necessary skills and knowledge to offer designated services and can provide them without supervision.

PROMPT SERVICES - Services provided when needed. For target or priority populations, routine appointments within 14 days, initial hospital discharge visits within 3 days, urgent visits within 2 days, emergent visits immediately and no later than 24 hours qualify as prompt.

PROVIDER – In this Contract, a person or an agency that provides MH/DD/SA services, treatment, and supports under a subcontract to the LME.

OPERATIONS MANUAL – A document attached to a subcontract for the purpose of explaining how to work with the local system, the requirements for service delivery, authorization, claims submission, etc.

PROVIDER PROFILING – The process of compiling data on individual provider patterns of practice and comparing those data with expected patterns based on national or local statistical norms. The data may include medication prescribed, hospital length of stay, size of caseload, and other services. Some data may be compiled for use by consumers in choosing preferred providers based on performance indicators.

PUBLIC MENTAL HEALTH, DEVELOPMENTAL DISABILITIES AND SUBSTANCE ABUSE SERVICES SYSTEM – The network of managing entities, service providers, government agencies, institutions, advocacy organizations, and commissions and boards responsible for the provision of publicly Funded services to consumers.

QA - Quality Assurance

QI - Quality Improvement

QIC - Quality Improvement Committee

QM - Quality Management

QPN - Qualified Provider Network

QUALIFIED PROVIDER COMMUNITY/NETWORK – The group of subcontractors subcontracted by a Contractor to provide supports and services to persons for whom the Contractor authorizes care.

QUALITY MANAGEMENT (QM)- The framework for assessing and improving services and supports, operations, and financial performance. Processes include: QUALITY ASSURANCE, and QUALITY IMPROVEMENT.

QUALITYIMPROVEMENT (QI)- is a process to assure that services, administrative processes, and staff are constantly improving and learning new and better ways to provide services and conduct business. As distinct from QA, the purpose of QI, also referred to as continuous quality improvement (CQI), is to continuously improve the process and outcome (quality) of treatments, services, and supports provided to consumers and administrative functions.

QUALITY ASSURANCE (QA)- involves periodic monitoring of compliance with standards.

RECOVERING STAFF - Counselors with and without educational degrees working in the substance abuse treatment fields who are in recovery.

RECOVERY – A personal process of overcoming the negative impact of a disability despite its continued presence. Like the victim of a serious accident who undergoes extensive physical therapy to minimize the impact of damaging injuries, people with active addictions as well as serious, disabling mental illnesses and developmental disabilities can also make substantial recovery through symptom management, psychosocial rehabilitation, other services and supports, and encouragement to take increasing responsibility for self.

REFERRAL - Establishing a link between a person and another service or support by providing authorized documentation of the person’s needs and recommendations for treatment, services, and supports. It includes follow-up in a timely manner consistent with best practice guidelines.

REGISTER – The process of gathering initial data and entering an individual into the service system.

REVENUES – Money earned through reimbursements paid for covered services or other local sources, grants, etc.

SA - Substance Abuse

SAPT - Substance Abuse Prevention and Treatment

STATE-means the State of North Carolina.

STATE PLAN- Annual (each fiscal year) updated comprehensive MH/DD/SAS systems reform plan derived from the systems reform statute and titled “Blueprint for Change”.

STATE PLAN (MEDICAID)- The written agreements between the State of NC and CMS which describe how the NC DMH/DD/SAS programs meet all CMS requirements for participation in the Medicaid program and the Children’s Health Insurance Program.

SCREENING/TRIAGE – An abbreviated assessment or series of questions intended to determine whether the person needs referral to a provider for services based on eligibility criteria and acuity level. A screening may be done face-to-face or by telephone, by a clinician or paraprofessional who has been specially trained to conduct screenings. Screening is a core or basic service available to anyone who needs it whether or not they meet criteria for target or priority populations.

SEAMLESS - Treatment system without gaps or breaks in service, such that persons being served transition smoothly and with ease from one treatment component to another.

SELF-DETERMINATION – The right to and process of making decisions about one’s own life.

SENTINEL EVENT – CRITICAL INCIDENT, UNUSUAL INCIDENT, ETC. A sentinel event may include any type of incident that is clinically undesirable and avoidable. Sentinel events signal episodes of reduced quality of care. Many organizations monitor medication errors, review of deaths, accidents, evacuation drill responses, rights violations, medical emergencies, use of restraint or seclusion, behavior management etc. The purpose of sentinel event monitoring is to discover root causes and implement a continuous improvement process to prevent further events.

SEVERELY EMOTIONALLY DISTURBED (SED) – A designation for people less than 18 years of age who, because of their diagnosis, the length of their disability and their level of functioning, are at the greatest risk for needing services. **SEVERELY MENTALLY ILL (SMI)** – Refers to adults with a mental illness or disorder that is described in the Diagnostic and Statistical Manual of Mental Disorders, 4th Edition, that impairs or impedes functioning in one or more major areas of living and is unlikely to improve without treatment, services and/or supports. People with serious mental illness are a target or priority population for the public mental health system for adults.

SERIOUSLY AND PERSISTENTLY MENTALLY ILL (SPMI) – Refers to people with a mental illness or disorder so severe and chronic that it prevents or erodes development of functional capacities in primary aspects of daily life such as personal hygiene and self care, decision-making, interpersonal relationships, social transactions, learning and recreational activities.

SERVICE MANAGEMENT – An administrative function that includes Utilization Management and Care Coordination under this Contract. The service is carried out by experienced professionals with broad knowledge of the services and programs supported by the public system, managing a set of services by advocating for access and linking the person to the services. At the system level, this means activities such as implementing and monitoring a set of standards for

access to services, supports, treatment; making sure that people receive the appropriate level and intensity of services; management of State facilities' bed days, making sure that networks create consumer choice in service providers.

SPECIALIST REVIEW – A consultation or second opinion rendered by a member of the UM staff when an authorization request falls outside the defined criteria for service selection, amount or duration.

STANDARD OF CARE – A diagnostic and/or treatment consensus that a clinician should follow when providing care based upon the discipline's peer group organization, such as the APA or NASW.

STATE MENTAL HEALTH AUTHORITY – The single State agency designated by each State's governor to be responsible for the administration of publicly Funded mental health programs in the State. In North Carolina that agency is the Department of Health and Human Services.

STATE MENTAL HEALTH, DEVELOPMENTAL DISABILITIES AND SUBSTANCE ABUSE SERVICES PLAN – Plan for Mental Health, Developmental Disabilities and Substance Abuse Services in North Carolina. This Statewide plan forms the basis and framework for MH/DD/SA services provided across the State.

STATE OR LOCAL CONSUMER ADVOCATE - The individual carrying out the duties of the State Local Consumer Advocacy Program Office
SUBSTANCE ABUSE – The DSM IV defines substance abuse as occurring if the person 1) uses drugs in a dangerous, self defeating, self destructive way and 2) has difficulty controlling his use even though it is sporadic, and 3) has impaired social and/or occupational functioning all within a one year period.

THE SUBSTANCE ABUSE AND MENTAL HEALTH ADMINISTRATION OF THE FEDERAL GOVERNMENT (SAMHSA) - SAMHSA is an agency of the U.S. Department of Health and Human Service. It is the federal umbrella agency of the Center for Substance Abuse Treatment, Center for Substance Abuse Prevention, and the Center for Mental Health Services.

SUBSTANCE ABUSE PREVENTION AND TREATMENT BLOCK GRANT (SAPTBG) - A federal program to provide funds to States to enable them to provide substance abuse services.

SUBSTANCE DEPENDENCE - DSM IV defines substance dependence - as requiring the presence of tolerance, withdrawal, and/or continuous, compulsive use over a 1 year period.

SUBCONTRACT-means any contract between the Contractor (Contractor) and a third party for the performance of all or a specified part of this Contract. The *SUBCONTRACTOR* means any third party engaged by the Contractor, in a manner conforming to the se contract requirements for the provision of all or a specified part of covered services under this Contract.

SYNAR AMENDMENT – Section 1926 of the Public Health Service, is administered through the Substance Abuse Prevention and Treatment (SAPT) Block Grant and requires States to conduct specific activities to reduce youth access to tobacco products. The Secretary of the US Department of Health and Human Services is required by statute to withhold SAPT Block Grant funds (40% penalty) from States that fail to comply with the SYNAR Amendment.

TARGET POPULATIONS –Groups of people with disabilities with attributes considered most in need of the services available within the system; populations as identified in federal block grant language.

NON-TARGET POPULATION are those individuals with less severe disorders that can be adequately and most cost effectively treated by the private sector, primary physicians or by using generic community resources.

TRANSITION – The time in which an individual is moving from one life/development stage to another. Examples are the change from childhood to adolescence, adolescence to adulthood and adulthood to older adult.

UM - Utilization Management

UNIFORM PORTAL ACCESS - The standardized process and procedures used to ensure consumer access to, and exit from, public services in accordance with the State Plan.

UTILIZATION MANAGEMENT (UM)- is a process to regulate the provision of services in relation to the capacity of the system and needs of consumers. This process should guard against under-utilization as well as over-utilization of services to assure that the frequency and type of services fit the needs of consumers. The administration of services or supplies which meet the following tests: they are appropriate and necessary for the symptoms, diagnosis, or treatment of the medical condition; they are provided for the diagnosis or direct care and treatment of the medical condition; they meet the standards of good medical practice within the medical community in the service area; they are not primarily for the convenience of the plan member or a plan provider; and they are the most appropriate level or supply of service which can safely be provided. This function is carried out by professionals qualified in disciplines related to the care being authorized and requires their use of tools such as service definitions, level of care criteria, etc.

UTILIZATION-is the use of services. Utilization is commonly examined in terms of patterns or rates of use of a single service or type of service. Use is expressed in rates per unit of population at risk for a given period such as the number of admissions to the hospital per 1,000 persons per year, or the number of services provided per 1,000 persons by a system of care annually.

UTILIZATION REVIEW (UR)- is an analysis of services, through systematic case review, with the goal of reviewing the extent to which necessary care was provided and unnecessary care was avoided. The examination of documents and records to assure that services that were authorized were in fact provided in the right amount, duration and scope, within the time frames allotted; and that consumers benefited from the service. The review also examines whether the actual request for authorization was valid in its assessment of the consumer and the intensity of need. There are a variety of types of reviews that may occur concurrent with the care being provided, retrospectively or in some cases prospectively if there are questions about the authorization requested.

APPENDIX A

Electronic Systems Instruction Manual

Please see the following link to view or download the Eastpointe electronic systems manual:

<http://www.eastpointe.net/providers/manuals/LME%20ProviderConnect%20Manual.pdf>