

Services Management Communication Bulletin #2 (10/14/04)

Dear Case Responsible Providers:

This is a brief update about several issues which we have had questions about:

Restrictions on evaluations - With the loss of the behavioral health screening code (H0002), providers have asked about the frequency that the assessment codes may be used. Here is the policy:

90801 is used for an assessment by a CPT-code billable clinician. It may be used a second time (including on the same day) for the psychiatric (MD) evaluation.

H0031 (or H0001 for an SA assessment) is used for the assessment by a non-CPT-code billable clinician. Two assessments may be billed on the same day (or different days) if they are completed by different providers for different purposes. For example, a consumer may receive and an assessment from a mental health provider and a substance provider on the same day.

Are v-codes allowable in order to be reimbursed? - Yes. The IPRS Target Population Worksheet outlines the v-codes that are supported by particular Target Populations.

Assertive Outreach - We have received feedback on our recently published guidelines for the use of Assertive Outreach. Here is the final policy: For consumers who do not have an open case, Assertive Outreach (YP230) may be authorized for the following circumstances:

- Hospital discharge follow-up
- Follow-up for consumers on outpatient commitment
- Contacts associated with face-to-face Emergency evaluations
- Actual testimony in court - not for waiting (again, for unopened consumers)
- Management of consumers for whom Western Highlands Network's CEO is legal guardian, when the case still is not open
- Contacts associated with community outreach to high-risk populations which involve logistical challenges (telephone and field-based face-to-face)

YP230 can not be used for non-target populations. It is intended for more seriously impaired individuals who would fall within a target population and for whom where a case opening is simply not practical, usually because the care is being delivered in the community (i.e., not in the traditional office setting). Some examples are PATH Grant services and Perinatal Substance Abuse services. Normally, it would NOT be used for an outpatient commitment or commitment in an office setting, although occasionally a consumer may display extremely challenging behavior that would justify its use. It is absolutely not permissible to substitute YP230 for the loss of H0002.

These services typically will be authorized by the Access Department.

Case Support - We have received feedback on our recently published guidelines for the use of case support. Here is the final policy: For consumers who do have an open case, Case Support (YP215) may be authorized for the following circumstances:

- Hospital discharge follow-up (when case management has not been authorized or, if it has, the staff member is not the designated case manager)
- Follow-up for consumers on outpatient commitment (when case management has not been authorized or, if it has, the staff member is not the designated case manager)
- Contacts associated with face-to-face Emergency evaluations (typically involves an ancillary staff member)
- Actual testimony in court - not for waiting
- Management of consumers for whom Western Highlands Network's CEO is legal guardian
- ICF-MR discharge planning

These services typically will be authorized by the Services Management Department.

Which codes should be used for crisis intervention activities? - The attached document (also on our website), "Description of Coding for Crisis Intervention," outlines when to use particular codes for crisis services.

Change of Case Responsible Provider - If an active consumer changes his or her case responsible provider, the new case responsible provider should call the Access Department and "re-register" the consumer in the new agency. The Access Department will complete a new (brief) screening and authorize an initial package of services to the new case responsible provider. The authorization will be forwarded to Administrative Support for keying and changing the case responsible agency designation in the WHN system.

Pended SARs - There was confusion about the amount of time the SAR can remain pended before the request is administratively denied. 21 days is the time period that case responsible persons have to respond to a pended SAR. If more time is needed, the case responsible person can make a request for additional days.

Providing Multiple Services on the Same Day - You may bill more than one service on the same day, as long as they are different services. For example, you could bill for individual and group therapy on the same day, but you could not bill for an individual therapy session in the morning and another individual therapy session later in the day.

Does Medicaid Require a Target Population to Bill?- Yes, although it is an entitlement and consumer's needs must only meet the medical necessity criteria under the particular service definition, you must still submit an IPRS Target Population form in order to bill the LME. It is important to use the correct Target Population in the event that the consumer turns out to NOT have Medicaid.

When Does Services Management Require an OTR?

Adults

When the Services Management Department receives a request to authorize outpatient services for an adult Medicaid consumer, an OTR is required, unless the consumer also has Medicare. (Providers are responsible for tracking the exhaustion of the Medicare benefit and submitting an OTR when Medicaid funds will be needed.) Because the initial authorization for a consumer includes 8 events, an OTR should be needed by the time a SAR is submitted to the Services Management Department.

Children

When the Services Management Department receives a request to authorize outpatient services for a child Medicaid consumer, WHN will assume that the services are still in the "Value Options 26 unmanaged sessions," unless an OTR accompanies the SAR. It is a provider's responsibility to track the 26 sessions. If a provider fails to submit an OTR for session 27+, then Medicaid will not pay the claim and WNH will not reimburse the provider.

Please send the OTR to the Services Management Department only when it is necessary.

The Services Management Department will appraise Medicaid Eligibility by looking at the Medicaid checkbox on the Service Authorization Request (SAR) form.

Case Management with Initial Services Authorization - Effective November 1, when referring a high-risk consumer for assessment, the Access Department will authorize 20 units of case management to providers, in addition to the 8 events of 90801 and 32 units of H0000. Many of these consumers will require case management services. By including some case managements units in the initial authorization, it will enable providers begin case management immediately. However, providers are still required to meet all the requirements for billing case management (e.g., service order, case management included in PCP, meet medical necessity criteria, including the need to coordinate multiple services). High-risk consumers include:

1. Hospital discharge follow-up or consumer waiting for discharge
2. Follow-up for consumers on outpatient commitment
3. Consumer is homeless
4. Safety issues: Suicidal and/or homicidal ideation; consumer requires immediate psychiatric consult
5. Consumer has known transportation barriers that will prevent consumer from accessing office-based services.
6. Criminal justice and/or DSS involvement
7. Consumer has an SPMI which requires either the initiation or continuation of medication.
8. Imminent risk of educational placement disruption
9. Consumer in need of placement
10. Consumer at imminent risk for out-of-home placement

Medical Necessity Criteria for Case Management - The recipient is eligible for this service when:

A. There are two identified needs in the appropriate documented domains,

AND

B. There is an Axis I or II diagnosis present or the person has a condition that may be identified as a developmental disability as defined in *G.S. 122C-3(12a)*,

AND

C. Level of Care Criteria, Level A/NC-SNAP (NC supports/Needs Assessment Profile) ASAM (American Society for Addiction Medicine), or children under age 3 determined to be eligible for early intervention services through procedures documented in the North Carolina Infant Toddler Program Manual (Bulletins 16 and 22).

AND

D. The recipient is experiencing difficulties in at least one of the following areas:

1. Is at risk for institutionalization, or hospitalization or is placed outside the natural living environment.
2. Is receiving or needs crisis intervention services, intensive in home services - including wrap around or CBS services.
3. Has unmet identified needs from multiple agencies.
4. Needs advocacy and service coordination to direct service provision from multiple agencies.
5. DSS has substantiated abuse, neglect, or has established dependency.
6. Presenting with intense, verbal and limited physical aggression due to symptoms associated with diagnosis, which is sufficient to create functional problems in the home, community, school, job, etc.