

OPERATIONS MANUAL



Mecklenburg County
Area MH/DD/SA Services

July 1, 2010

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Introduction

This manual is a binding part of Agreements and Contracts between the Mecklenburg LME and providers of Medicaid and State Funded services. The intent of this manual is to provide the references and sources providers need to meet the requirements of Memorandums of Agreement and Contracts between Mecklenburg LME and provider agencies. The manual is organized into seven categories as indicated in the Table of Contents

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 and/or Contract, whichever applies. It does include a link to the DMH website where you can locate Endorsement information.

Information or procedures which pertain only to Medicaid providers or only to State Funded providers are identified. The absence of this designation means that the information or source document pertains to both types of providers.

AMH Vision Statement

“To be a community that supports individuals and families who are fully empowered to lead healthy and independent lives.”

LME Mission Statement

“To assist persons, families and communities affected by mental illness, substance abuse, or developmental disabilities to achieve their life goals.”

LME Values

- We are a Diverse Organization
- We see Partnerships
- We have Integrity
- We are accountable
- We are Consumer Driven
- We seek Quality
- We are Strength Based and Outcome Focused

Mecklenburg's Guiding Principles for Conducting Business

Ethics: We work with integrity

Planning: Consumers and families are fully involved in all aspects of the system's redesign and operations.

Customers: We serve consumers with dignity, respect and sensitivity to their cultural heritage.

Employees: We give our employees the respect, training and support to be successful.

Excellence: Our commitment is to quality improvement.

Accountability: We focus on system and consumer outcomes.

SECTION I

Provider Relations

This section of the Operations Manual directs providers to the appropriate procedures and contacts for various concerns they may encounter or with which they need assistance.

A. Licensure Questions

Division of Health Service Regulation (formerly Division of Facility Services): 919-855-3795 or <http://www.ncdhhs.gov/dhsr/index.html>

B. Notification of Change of Address

Formal notification of change of address of either party shall be given to the other. Providers must notify the Area Authority in writing of change of address at least thirty (30) calendar days prior to the relocation. Notice of other significant organizational changes should also be made in writing to the LME as soon as they are known.

C. Problem Resolution/Disputes and Appeals

If problems arise between the Provider and the LME in the delivery of services, the parties shall attempt whenever possible to resolve these problems informally in a reasonable and timely manner. In the event that informal resolution is not appropriate or is unsuccessful, the process outlined in GS 122C-151.4 shall be followed. Please follow the links below:

1. Medicaid Providers

- <http://www.ncdhhs.gov/mhddsas/stateplanimplementation/providerendorse/policy12-3-07endorsementprocedures.pdf> on Page 9.

2. Disputes Policies

- [Administrative Contract Appeals Policy \(link\)](#)
- [Reconsideration Procedures \(link\)](#)

D. Technical Assistance/Training Collaboration

1. Medicaid Providers

- See MOA, Article I – 1.6.

2. State Funded Providers

- State Funded Contract – Article II, 2.18

E. Monitoring Policies (link)

- [Local Monitoring Policy](#)
- [Requesting Plan of Correction](#)
- [Elements of a Functional 1st Responder System](#)

F. Who to Contact for Questions

Questions regarding contracts, Standard Agreements, monitoring and/or insurance requirements

1. Medicaid Providers

- <http://www.dhhs.state.nc.us/dma>

2. Contract and Endorsed Providers

- Provider Relations and Support Managers:

Angie Jackson	704-336-6954	Child and Adult Mental Health
Kimberly Alexander	704-336-2739	Developmental Disabilities, CAP MR/DD and Substance Abuse

- LME Leadership Team

<http://charmec.org/mecklenburg/county/AreaMentalHealth/AboutUs/Pages/home.aspx>

Billing and Payments

1. Contract Providers :

- Senior Fiscal Analysts
 - James Hamm 704-336-5625
 - Fran Neely 704-353-0270
 - Vermell Salmond 704-336-5469
 - Jelese Jones 704-336-2713
- Other LME Contacts
 - Balanced Scorecard QI Analyst Evelyn Cross 704-432-3058
 - DD UM Supervisor Steve Blanton 704-336-6980
 - Health Information Services Admin. Jan Sisk 704-621-1982
 - MH/SA UM Supervisor Paige Walther, LPC 704-336-3022
 - MeckLINK Intermim Supervisor Paige Walther, LPC 704-336-3022
 - NC-TOPPS Coordinator Paula Cox 704-432-4267

SECTION II

State and Federal Requirements and Policies with Access Information

The chart 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 and Article I, Section 1.1 of the State Contract. These documents change based on legislative action, change in federal and state policy, and state procedures.

There is a mutual responsibility for Providers and Area Authorities 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 Area Authority has concerns about how a change will be implemented, then the Area Authority 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 Area Authority for information.

If a Provider has problems obtaining or understanding the information referenced in this section, please contact the LME Provider Relations and Support Service Analyst.

REQUIREMENT	SUGGESTED CONTACTS	WEB SITE, IF AVAILABLE
APSM 30-1 (Rules for MH/DD/SA- Core rules for services and also includes State-covered services definitions) APSM 45-1 (Confidentiality) APSM 45-2 (Service Record Manual) APSM 45-2a (Service Records Resource Manual) APSM 95-2 (Client Rights) APSM 10-3 (Records Retention and Disposition Schedule) APSM 75-1 (Area Programs Budget Procedures Manual) 45 CFR Part 2 & 164 (HIPAA Standards for Privacy and Security of Health Information)	DMH MH/DD/SAS 3001 Mail Service Center, Raleigh, NC 27699-3001 (919) 733-7011	Contact Web Master for the NC Division of MH/DD/SA Services and NC Division of Medical Assistance http://www.dhhs.state.nc.us/mhddsas/statpublications/manualsforms/index.htm#manuals
CAP-MR/DD Manual and Clinical Coverage Policy – (CAP Providers and Core Competencies Training Requirements for MR/MI service providers)	DMH MH/DD/SAS 3001 Mail Service Center, Raleigh, NC 27699-3011 (919) 733-7011	http://www.ncdhhs.gov/mhddsas/cap-mrdd/index.htm http://www.dhhs.state.nc.us/dma/mp/8M.pdf
Medicaid-Related Documents Medicaid-covered services definitions Medicaid Services Guidelines Medicaid Communiqués	DMH MH/DD/SAS 3001 Mail Service Center, Raleigh, NC 27699-3011 (919) 733-7011 or (919) 851-8888	http://www.ncdhhs.gov/mhddsas/government.htm
Substance Abuse Services Cluster Requirements	DMH MH/DD/SAS 3021 Mail Service Center, Raleigh, NC 27699-3021	http://charmec.org/mecklenburg/county/AreaMentalHealth/ForProviders/Pages/ProviderDocuments.aspx Then scroll down to “Additional Policies”
Health Care Personnel Registry	2709 Mail Service	http://ncdhhs.gov/dhsr/hcpr/index.html and

REQUIREMENT	SUGGESTED CONTACTS	WEB SITE, IF AVAILABLE
	Center, Raleigh, NC 27699 (919) 855-3968	www.ncnar.org
<p>Monitoring of Providers SB 163- Monitoring of Providers</p> <p>House Bill 576</p> <p>House Bill 2077</p> <p>Provider Monitoring Tool (PMT)</p> <p>Provider Performance Report (PPR)</p>		<p>http://www.ncga.state.nc.us/sessions/2001/bills/senate/html/S163v6.html</p> <p>http://www.ncleg.net/Sessions/2009/Bills/House/PDF/H576v5.pdf</p> <p>http://www.ncga.state.nc.us/Sessions/2005/Bills/House/HTML/H2077v5.html</p> <p>http://www.ncdhhs.gov/mhddsas/provider_monitor_tool/index.htm</p> <p>http://charmbeck.org/mecklenburg/county/AreaMentalHealth/ForProviders/Pages/ProviderRatings.aspx</p>
Endorsement Policy and Procedures	DMH MH/DD/SAS 3001 Mail Service Center, Raleigh, NC 27699 (919) 733-7011	<p>http://www.dhhs.state.nc.us/mhddsas/stateplanimplementation/providerendorse/index.htm Then down to Communication Bulletin #44</p>

REQUIREMENT	SUGGESTED CONTACTS	WEB SITE, IF AVAILABLE
<p align="center">General Statutes</p> <p>122-C Mental Health, Substance Abuse, Developmental Disabilities Act of 1985</p> <p>Applicable sections include but are not limited to:</p> <ul style="list-style-type: none"> ▪ 122C-3 Definitions ▪ 122C-4 Use of phrase “client or his legally responsible person” ▪ 122C-51 Declaration of Policy on clients rights ▪ 122C-52 Right to confidentiality ▪ 122C-53-56 Exceptions... ▪ 122C-57 Right to treatment and consent to treatment ▪ 122C-58 Civil Rights and civil remedies ▪ 122C-59 Use of corporal punishment ▪ 122C-60 Use of physical restraints or seclusion ▪ 122C-61 Treatment rights in 24-hour facilities ▪ 122C-62 Additional rights in 24-hour facilities ▪ 122C-63 Assurance for continuity of care for individuals with mental retardation ▪ 122C-64 Human Rights Committees ▪ 122C-65 Offenses relating to clients ▪ 122C-66 Protection from abuse and exploitation; reporting ▪ 122C-67 Other rules regarding abuse, exploitation, neglect, etc. ▪ 122C-81 National Accreditation Benchmarks ▪ 122C-(116,141,142,146) Local Government Entity ▪ 122C-151.3 and 151.4 Resolving Disputes with Contractors, etc ▪ 90-21.4 Treatment of Minors ▪ 7A 517, 452-553 Abuse and Neglect of Minors ▪ 108A 99-111 Abuse and Neglect of Disabled Adults ▪ 122C-151.3 and 151.4 Resolving Disputes with Contractors, etc. 		<p>http://www.ncga.state.nc.us/EnactedLegislation/Statutes/HTML/ByChapter/Chapter_122C.html</p>
DHHS Disaster Preparedness, Response and Recovery Plan		http://www.ncdhhs.gov/mhddsas/disasterpreparedness/
Performance Agreement between DMH and Area programs		www.dhhs.state.nc.us/mhddsas/performanceagreement
Contract between the Area Authority and the NC Division of MH/DD/SAS – Results and information regarding Performance Measures		http://www.ncdhhs.gov/mhddsas/performanceagreement/index.htm
Drug Free Workplace Act of 1988 as revised	Library-Federal Laws	http://www.dol.gov/elaws/drugfree.htm
Section 503 and 504 of the Rehabilitation Act of 1973	Library-Federal Laws	http://www.dol.gov/dol/compliance/compliance-majorlaw.htm#eoc
Civil Rights Act of 1964	Library-Federal Laws	www.eeoc.gov http://www.eeoc.gov/policy/vii.html

REQUIREMENT	SUGGESTED CONTACTS	WEB SITE, IF AVAILABLE
Non-Profit Agencies-Conflict of Interest 1993 Session Laws: Chapter 321, Section 16	Library-Federal Laws	http://www.hhs.gov/ocr/privacy/hipaa/understanding/summary/introduction.pdf
Public Law 99-319, May 1986 Protection and Advocacy for Mentally Ill Persons	Library-Federal Laws	http://thomas.loc.gov/bss/d099/d099laws.html Search for 99-320
<ul style="list-style-type: none"> ▪ Subchapter I Protection and Advocacy Systems ▪ Subchapter II Reinstatement of Rights for Mental Health patients 	Cornell University Law School	http://www4.law.cornell.edu/uscode/42/ch114.html
Public Law 100-509 Protection & Advocacy for Mentally Ill Individual Amendments Act of 1988, October 1988	Library-Federal Laws	http://thomas.loc.gov/bss/d100/d100laws.html Search for 100-501 -- 100-550
Public Law 101- 496 Developmental Disabilities Assistance and Bill of Rights Act of 1990	Library-Federal Laws	http://thomas.loc.gov/bss/d101/d101laws.html Search for 101-451 – 101-500
42 CFR Part 2 Confidentiality Regulations for consumers with SA Diagnosis 45 CFR Part 160 & 164 HIPAA Standards for Privacy of Health Information	Library-Federal Laws	Federal Regulations search: http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&rgn=div5&view=text&node=42:1.0.1.1.2&idno=42
Office of the Inspector General	Library-Federal Laws	http://exclusions.oig.hhs.gov/
Pro-children Act 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
National Provider Information Number		https://nppes.cms.hhs.gov/NPPES/StaticForward.do?forward=static.npistart
North Carolina Council of Community MH/DD/SAS Programs		www.nc-council.org
Local Business Plan		http://www.charmeck.org/Departments/Area+Mental+Health/State+Reform/Home.htm
Local Policies and Procedures		http://charmeck.org/mecklenburg/county/AreaMentalHealth/ForProviders/Pages/ProviderDocuments.aspx
Local Resources		http://www.mecklenburgamha.org/local.php
Statewide and National Resources SAMHSA's National Mental Health Information Center National Mental Health Consumers' Self-Help Clearinghouse		http://www.mecklenburgamha.org/online_detail_all.php http://mentalhealth.samhsa.gov/ http://www.mhselfhelp.org/

REQUIREMENT	SUGGESTED CONTACTS	WEB SITE, IF AVAILABLE
<p>SAMHSA's National Registry of Evidence-Based Programs and Practices</p> <p>NC Practice Improvement Collaborative</p> <p>NC Peer Support Specialist Program</p>		<p>http://nrepp.samhsa.gov/</p> <p>http://www.ncpic.net/</p> <p>http://pss-sowo.unc.edu/index.php?q=pss</p>
<p>Mecklenburg County Community of MH/DD/SAS Providers</p>		<p>http://charmeck.org/mecklenburg/county/AreaMentalHealth/ForConsumers/Pages/FindaProvider.aspx Then scroll down to Find a Provider under Consumer Highlights</p>

SECTION III

MeckLINK and Authorization Processes

A. MeckLINK (formerly STR)

All MH/DD/SA consumers who receive state funded services and Medicaid consumers whose county of Medicaid eligibility is Mecklenburg must be registered with MeckLINK, formerly known as Screening, Triage and Referral. The phone number for MeckLINK is 704-336-6404 or Toll-free 877-700-3001. You can also access MeckLINK at <http://mecklink.charmeck.org>.

B. Clinical Information Data Submission

Once a provider conducts an assessment for a consumer of the LME, the provider will complete all of the designated sections of the **Standardized Consumer STR Interview and Registration Form** along with the **LME Admission and Discharge Form** and fax the forms to the LME at 704-432-3453.. Incomplete forms will be returned to the provider for missing required data elements.

1. [MeckLINK forms \(link\)](#)

- Standardized Consumer STR Interview and Registration Form (formerly the STR Fax Form)
- LME Consumer Admission and Discharge Form (formerly the PCP Admission Form)

2. [Authorization and UM Policies \(link\)](#)

- Screening, Triage and Referral Policy

C. Authorization process resources

1. Medicaid Providers

- www.dhhs.state.nc.us/dma/home.htm
-

2. State Funded Providers

[UM Manuals \(link\)](#)

Mecklink and Utilization Management Procedures – July 1, 2010

[Authorization and UM Policies \(link\)](#)

- Administrative Denial Policy
- Adolescent Transition to Adult Status
- Availability and Communication with UM Staff
- Consumer Eligibility Policy
- Denial Determination Policy
- Distribution of Medical Necessity Criteria
- Limitations in the Use of Non-Clinical Staff
- Lack of Clinical Information Policy

- Non-Medicaid Appeals Policy
- Medical Necessity Exceptions Policy
- Operational Procedures for Use of County Funds
- Out of State Placement Policy
- Provider Compliance with Screening, Triage and Referral Requirements
- Retrospective and Administrative Reviews
- Screening Triage and Referral Policy
- Standard Time Frames for UM Decisions

[UM Forms \(link\)](#)

Authorization Form ([PDF](#)) ([Word](#))

- [Discharge Event](#)
- [Non-Medicaid Appeal Request for Extension](#)
- [Out of State Placement of Child/Adolescent Forms](#)
- [PCP Form \(Complete\)](#)
- [PCP Manual](#)
- Target Pop Update
- [State Facility Referral Procedure](#)

SECTION IV

Finance Information

This section applies to Contract providers only. Medicaid Direct Bill providers obtain claims information from DMA.

A. Claims Filing Requirements and Adjudication

As outlined in your Contract, Article V 5.3 Billing, the Provider is responsible for billing for all first and third party payment. The provider must obtain information about all benefits from the consumer and providers must bill for third party payment when information is available.

1. State Funded Providers

[Finance Manuals and Guides \(link\)](#)

- 837 Instructional Document for Providers
- Claims Inquiry Process
- Claims Processing Tips
- eCura Adjudication Denial Crosswalk to HIPAA
- eCura Claims Process Flowchart
- HCFA Training Guide
- Sliding Scale Fee Schedule 2010-2011

B. LME Fee Collection Policy and Minimum fee/sliding scale fee schedule

1. State Funded Providers

[Finance Policies \(link\)](#)

- Claims Recoupment for Medicaid Eligibility
- Sliding Fee Scale Policy-LME
- Sliding Fee Schedule 2010-2011

C. Electronic Connectivity Requirements

1. State Funded and Contract Providers

2. [Finance Manuals and Guides \(link\)](#)

- [Provider Connect Training Manual](#)

D. Payment Schedules

1. State Funded Providers Only

- *The LME processes claims on a weekly basis. Therefore, providers are strongly encouraged to submit claims often. Providers that submit claims every week will be mailed a check or receive Electronic Funds Transfer every week providing that claims are successfully matched and funds are available in the contract. Paper claims may take longer to process.*

[Finance Manuals and Guides \(link\)](#)

- eCura Claims Process Flowchart

Prompt Pay:

- Within 18 calendar days of receiving an invoice, Area Mental Health will approve payment, deny payment or request additional information. Payment will occur within 30 calendar days of approving the invoice, with the exception of those clients with Health Choice and private insurance.
- The Provider shall bill State and County services to Area Mental Health within 90 days from the date of service. Any bill received after this will be denied. At the end of the fiscal year, if funds are available, the claim may be reprocessed.

E. Billing for Residential Services

Residential services should be billed based on a midnight bed count. For example, if the consumer is in service at 11:59 pm, then the service can be billed for that day. Providers should bill for the date of admission and not the day of discharge.

F. Payment Information

Payment is by check or Electronic Funds Transfer.

Checks to contract providers and vendors will be mailed. Mecklenburg County does not allow checks to be held for pick up. It is imperative that requests for payment, including invoices, claims submission and any required backup documentation, be sent to AMH Financial Services with sufficient time (usually 3 weeks) to process the payment and mail the check.

Mecklenburg County encourages vendors to complete an authorization agreement for Electronic Funds Transfers (EFT). Once the provider's bank information is entered into the County's financial system, the provider will no longer receive paper checks for payment. During the check-writing cycle, the financial system will identify vendors who have requested EFT and create a file of the payment amounts rather than writing a check.

The Investment Officer transmits this file, and the associated dollars, to an Automated Clearing House (ACH) where the data and funds are distributed to the respective banks and provider accounts. The County Finance Department sends an email to the provider notifying them of the payment amount, date sent and items being paid.

An EFT Agreement will be provided to each new Provider.

G. Management of Accounts Receivable – Provider's Responsibility

The provider must take full responsibility for the management of their accounts receivable. Mismanagement of this function can lead to serious financial and legal problems. Area Mental Health will assist Providers by producing weekly remittance advices. In addition, available to providers is a weekly claims report found in Provider Connect, the web-based portal through which network providers are able to verify submitted claims (manual electronic or 837 file uploads) and check the status of any claim. Researching denials and resubmitting claims in a timely manner is strongly encouraged.

Section V

Quality Improvement and Performance Monitoring

A. Provider Monitoring

1. Medicaid and State Funded Providers

- Providers and their practitioners shall allow the LME access to treatment records.
- Providers shall maintain the confidentiality of LME consumer information and records.
- [Confidentiality Policies \(link\)](#)
 - [Release of Confidential Information](#)
 - [Confidentiality and Protection of Consumer Information](#)
 - [Notice of Privacy Practices](#)
 - [Request for Restriction of Use of PHI](#)
- [State Monitoring Rules \(link\)](#)
- [Monitoring Policies \(link\)](#)
 - [Local Monitoring Policy](#)
 - [Requesting Plan of Correction](#)
 - [Requesting an Exception to Community Support Enrollment Suspension](#)
- [Compliance Policies \(link\)](#)
 - [False Claims Act Compliance Policy](#)
 - [Provider Compliance with Screening, Triage, and Referral Requirements](#)
 - [Reporting and Investigating Compliance Concerns](#)

2. State Funded Providers

- The Provider and its practitioners shall cooperate with the Mecklenburg LME Quality Improvement activities.
- [Credentialing Policies \(link\)](#)
 - [Confidentiality of Credentialing and Re-credentialing Process for LIPs](#)
 - [Credentialing LIPs](#)
 - [Provider Standards and Credentialing of Agency Providers](#)
 - [Ongoing Monitoring of Sanctions Policy](#)
 - [Quality of Care Review, Notification of Authorities and Appeal Process for Contractors \(non-physicians\)](#)
 - [Quality of Care Review, Notification of Authorities and Appeal Process for Contractors \(physicians\)](#)
 - [Re-credentialing Licensed Independent Practitioners](#)
 - [Results of Primary Source Verification Policy](#)
 - [Review of Performance Data](#)
 - [Site Visits for LIPs](#)
- [Client Record Policies \(link\)](#)
 - [Collection and Coordination of Information](#)
 - [Exchange of Information and Continuity of Care Policy](#)

- Records Retention and Disposition Policy
- Special Protection of Protected Health Information

B. Client Rights Reporting

1. Medicaid and State Funded Providers

- [Client Rights Policies \(link\)](#)
 - Complaint Management
 - Consumer Choice Policy
 - Human Rights Policy
 - Referral of Complaints
- [Client Rights Handbooks \(link\)](#)
 - Rights Handbook
 - [Rights Handbook Spanish \(link\)](#)

2. State Funded Providers

- Informed Choice of Provider
In the instance of individual practitioners whose relationship is terminated with a provider organization, and who become an employee of another provider organization, and/or who open a private practice, the provider organization shall notify each individual consumer verbally and in writing of the consumer's freedom of choice, and document this notification in the consumer's record. The consumer will be offered assistance to retain or select another provider by contacting the LME's Consumer Representative.
- [Client Rights Policies \(link\)](#)
 - Complaint Management
 - Consumer Choice Policy
 - Human Rights Policy
 - Referral of Complaints
- [Consumer Choice Forms \(link\)](#)
 - Documentation of Choice Memo
 - Documentation of Consumer Choice Form
 - Consumer Request to Change Provider Procedure
 - Consumer Request to Change Provider Form

C. Incident Reporting

1. Medicaid and State Funded Providers

- All incidents pertaining to LME clients shall be reported to the LME and NC DHHS as required. **Please note that as of 7/1/2010 paper incident reports will no longer be accepted. Incidents should now be reported using the North Carolina Incident Response Improvement System (IRIS)**
- [IRIS Technical Manual \(link\)](#)

- [IRIS FAQ's \(link\)](#)
- [Incident Reporting Information \(link\)](#)
- [Consumer Safety Policies \(link\)](#)
 - Incident Management Policy
- Consumer Safety Forms
 - [Quarterly Incident Reporting Form \(link\)](#)
 - [Levels II and III Incident Reporting Form \(link\)](#)

2. State Funded Providers

- The provider must notify the LME if the agency is under investigation by a licensing, accrediting, local, state, or federal agency and will submit findings to the LME upon completion of such investigations. Copies of surveys, reviews, and audits performed by accrediting or regulatory authorities shall be provided to the LME upon receipt or completion.

D. Person-Centered Planning

1. Medicaid and State Funded Providers

- [Person Centered Information \(link\)](#)
 - Person Centered Plan (PCP)
 - PCP Update/Revision Supplemental Page
 - PCP Update/Revision Supplemental Signature Page
 - PCP Instruction Manual
- [For Psychosocial Rehabilitation Providers Only \(link\)](#)
 - PCP PSR Instruction Manual
 - PCP PSR Version
 - Supplemental Page Update/Revision
 - Supplemental Signature Page Update/Revision

E. Clinical Outcome Measures

1. Medicaid and State Funded Providers

- [NC TOPPS Operations Manual \(link\)](#)
- [NC TOPPS Information \(link\)](#)
- [Practice Guidance for Providers \(link\)](#)

SECTION VI

LME Specific Policies/Forms/Provider Documentation Submission Requirements/Local Governance Requirements

The LME develops and reviews policies on an ongoing basis. Changes to any of these policies will be posted on <http://charmec.org/mecklenburg/county/AreaMentalHealth/ForProviders/Pages/ProviderDocuments.aspx> under Provider Library. Please review the following additional policies which are applicable to your agency.

A. Medicaid, Federal, and State Funded Providers

- [Additional Policies \(link\)](#)
 - [Request for Proposal Policy](#)
 - [Dissemination of Information to the LME Community of Providers Policy](#)
 - [Provider Network Availability Standards](#)
 - [Provider Compliance with MeckLINK Call Center Requirements](#)
 - [Support for Provider Agency Education and Training Policy and Procedure](#)

B. State Funded Providers

- [Additional Policies \(link\)](#)
 - [Adolescent Transition to Adult Status](#)
 - [Delegation Policy](#)
 - [LME Disaster Plan](#)
 - [Payment of Services to Family Members](#)
 - [Representative Payee Services](#)

C. Regular Reports / Forms Due to Mecklenburg LME

Below you will find information about the monthly and quarterly reports which are due to the LME. These reports are required as follows:

1. Medicaid and State Funded Providers

Report / Form Name	Due Date	Contact
Provider Quarterly Incident Reporting Form	Quarterly (see Consumer Safety forms (link))	Linda Margerum 704-336-7187
Levels II and III Incident Reporting	<p><u>Please note that as of 7/1/2010 paper incident reports will no longer be accepted. Incidents should now be reported using the North Carolina Incident Response Improvement System (IRIS)</u></p> <p>Incident Reporting Information (link)</p>	Linda Margerum 704-336-7187

NC SNAP (DD consumers only)	As occurs - see the following link for complete info. (http://www.ncdhhs.gov/mhddsas/ncsnap/index.htm)	Martha Joslin 704-432-1978
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2. State Funded Providers

Report Name	Due Date	Contact
Quarterly Balanced Scorecard Data	Jan., April, July, Oct.	Evelyn Cross 704-432-3058

SECTION VII

Glossary of Terms

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 Area Authority 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 (Not to be confused with the Access Program) – 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.

ACT - Assertive Community Treatment

ADULT - means a person 18 years of age or older, unless the term is given a different definition by statute, rule, or policies. Medicaid considers a person an adult at age 21.

ADMINISTRATIVE SERVICES - means the services other than the direct provision of MH/DD/SA services (including case management) to eligible or enrolled persons, necessary to manage the MH/DD/SA system, including but not limited to: provider relations and contracting, provider billing accounting, information technology services, processing and investigating grievances and appeals, legal services (including any legal representative of the Contractor at Administrative hearings concerning the Contractors decisions and actions), planning, program development, program evaluation, personnel management, staff development and training, provider auditing and monitoring, utilization review and quality management.

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 fields.

AOC - Administrative Office of the Courts

APPEAL - means a formal request for review of a decision made by the Area Program 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. *PRE AUTHORIZATION/PRIOR AUTHORIZATION* is the process of approving use of certain resources in advance rather than after the service has been requested. Approval for admission to hospitals in an emergent situation is one example. *RE-AUTHORIZATION* is the process of submitting a request for services for a consumer who has already received authorized services. The request shall specify the scope, amount and duration of service requested and shall indicate the consumer’s progress toward outcomes, the use of natural and community

supports, and how the requested services will support the outcome the individual is seeking. *RETROSPECTIVE AUTHORIZATION* is authorization to provide services after the services have been delivered.

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* are 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*.

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. It is an administrative Service Management Function performed by the Area Program for individuals not enrolled or not meeting target population definitions.

CARF – Commission on Accreditation of Rehabilitation Facilities

CATCHMENT AREA - The geographic part of the State served by a specific Contractor. The *GEOGRAPHIC AREA* can be a specific county or defined grouping of counties that are available for contract award. The Contractor is responsible to provide 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).

CERTIFICATION – A Statement of approval granted by a certifying agency confirming that the program/service/agency has met the standards set by the certifying agency. The Area Program or the NC Council may be the certifying agency for subcontracted providers.

CFAC – (see **CONSUMER and FAMILY ADVISORY COMMITTEE**)

CHILD - means a person who is under the age of 21, unless the term is given a different definition by statute, rule or policies. IPRS defines a child as a person under the age of 18.

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 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.

COA - Council on Accreditation

CO-MORBID CONDITION - CO-OCCURRING DISORDERS, DUAL DIAGNOSIS – Terms that reflect 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 and FAMILY ADVISORY COMMITTEE (CFAC) – A Board appointed group of persons receiving services, families of persons receiving services, who 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 Area Program 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. The Contract in this case is the Performance Agreement between the Department of MH/DD/SAS 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 persons 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 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.

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-4th edition (DSM IV) – A book, published by the American Psychiatric Association, that identifies and describes MH/DD/SA disorders, and lists specific codes for each.

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.

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 applies: The individual can reasonably be expected within the near future to physically injure himself, herself, or another individual, either intentionally or unintentionally. 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 – This term is a synonym for LEGAL.

FORMULARY – A reference guide to pharmaceutical products; items can be included in the formulary or not.

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.

GACPD - Governor’s Advocacy 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.

GRIEVANCE – A formal complaint by a service recipient that shall be resolved in a specified manner.

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 (**See Above**)

HUD - Housing and Urban Development

HUMAN RIGHTS COMMITTEE – The body established by statute for hearing grievances and appeals related to violation of rights guaranteed by law and 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 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 (**See Above**)

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 ensuring 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 MANAGEMENT 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 in 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 and 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 the 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 (NCQA) - 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.

NCQA - NATIONAL COMMITTEE FOR QUALITY ASSURANCE (see above)

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.

OUTREACH - Programs and activities to identify and encourage enrollment of individuals in need of MH/DD/SA services and/or to encourage people who have left service prematurely to return.

PATIENT PLACEMENT CRITERIA (PPC) - Standards of, or guidelines for, alcohol, tobacco and other drug (ATOD) abuse treatment that describe specific conditions under which patients should be admitted to a particular level of care (admission criteria), under which they should continue to remain in that level of care (continued stay criteria), and under which they should be discharged or transferred to another level (discharge / transfer criteria). PPC generally describe the settings, staff, and services appropriate to each level of care and establish guidelines based on ATOD diagnosis and other specific areas of patient assessment.

PCP - Person Centered Plan

PCPM – Per Citizen Per Month. The basis on which the Contractor is paid for administrative functions under the terms of some contracts.

PEER REVIEW – The analysis of clinical care by a group of that clinician’s professional colleagues. The provider’s care is generally compared to applicable standards of care, and the group’s analysis is used as a learning tool for the members of the group.

PENETRATION – The extent to which the system serves those individuals expected to have a specific medical condition, in this case persons with developmental disabilities, persons with mental illnesses and persons with substance abuse disorders.

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 individuals selected by the consumer who are committed to supporting the person in pursuit of desired outcomes. Planning includes discovering strengths and barriers, establishing time limits, 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.

PRINCIPAL 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.

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 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**. *QUALITY IMPROVEMENT (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. *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 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.

SERIOUSLY 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.

SERIOUSLY 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.

SEVERELY 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 or 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 the presence of tolerance, withdrawal, and/or continuous, compulsive use of a substance over a 1 year period.

SUBCONTRACT - means any contract between the 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 should 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 practice in the service area; they are not primarily for the convenience of the consumer or a provider; and they are the most appropriate level 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 ACCREDITATION COMMISSION (URAC) – is a non-profit organization that promotes continuous improvement in the quality and efficiency of health care management through processes of accreditation, education and measurement.

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 assures 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 concurrently with the care being provided, retrospectively, or in some cases prospectively if there are questions about the authorization requested.

SECTION VIII
Change Notices

Mecklenburg County Area MH/DD/SA Services

OPERATIONS MANUAL CHANGE NOTICES

Change Number	Issue Date	Location	Description of Change
1	7/9/10	Page 8	Updated links to CAP Manual and Clinical Coverage Policy
2	7/9/10	Page 15	Repaired links to Finance Manuals and Guides and Finance Policies
3	8/10/10	Manual	Updated links to AMH website
4	9/2/10	Page 7	Added Functional Elements of a 1 st Responder System to the Monitoring Policies