MeckLINK®
BEHAVIORAL HEALTHCARE
Call. Connect. Care.

PROVIDER OPERATIONS MANUAL

March 1, 2013

URAC
ACCREDITED
HEALTH UTILIZATION MANAGEMENT
HEALTH NETWORK
HEALTH CALL CENTER

Updated 6.17.13

Table of Contents

Introduction to the Manual

This manual is a binding part of Agreements and Contracts between MeckLINK Behavioral Healthcare, Medicaid Providers and State Funded services. This manual provides the information and resources needed to meet the requirements of the Division of Medical Assistance (DMA) and contracts between MeckLINK Behavioral Healthcare and Provider Agencies. MeckLINK Behavioral Healthcare is a Department under Mecklenburg County Government. The service areas that make up MeckLINK are referred to as Divisions within the MCO. Those Divisions are broken down into Units.

Online Resources

A tremendous amount of useful information can be found on MeckLINK Behavioral Healthcare's website including: Community Resources, a searchable Provider Directory, Key Policies and Procedures and much more. The home page address is:
http://charmeck.org/mecklenburg/county/AreaMentalHealth/Pages/default.aspx

Polices and Notices of Policy Changes

Policies are updated annually and can be found on-line in the Provider Document Library at http://charmeck.org/mecklenburg/county/AreaMentalHealth/ForProviders/Pages/ProviderDocuments.aspx. In addition to other valuable information, a weekly **Hot Sheet** is posted online for Providers containing new, updated, and retired policies.

Key for Policy Prefixes

NC MH/IDD/SAS= North Carolina
Mental Health/Intellectual Developmental Disability/Substance Abuse Services

CA= Consumer Affairs
CC= Corporate Compliance
CO= Clinical Operations
CR= Credentialing
FS= Financial Services
HCC= Health Call Center
HR= Human Resources
IM= Information Management
LME or **AMH**= Administrative
PO= Provider Operations
UM= Utilization Management

Guiding Principles
NC State Agencies

A. DHHS Mission

The mission of the Department of Health and Human Services is to provide efficient services that enhance the quality of life of North Carolina individuals and families; so that they may have opportunities for healthier and safer lives resulting ultimately in the achievement of economic and personal independence.

B. DMA Mission

The mission of the Division of Medical Assistance is to provide access to high quality, medically necessary healthcare for eligible North Carolina residents through cost effective purchasing of healthcare services and products.

C. DHHS/DMA Vision

All North Carolinians will enjoy optimal health and well-being with better quality, cost effective, and easy access to behavioral health services.

1. Public and social policy toward people with disabilities shall be respectful, fair and recognize the need to assist all that need help.

2. The state's service system for persons with Mental Illness, Intellectual Developmental Disabilities, and/or Substance Abuse problems shall have adequate and stable funding.

3. System elements shall be seamless: consumers, families, policymakers, advocates and qualified providers shall unite in a common approach that emphasizes support, education/training, rehabilitation and recovery.

4. All human service agencies that serve people with Mental Illness, Intellectual Developmental Disabilities, and/or Substance Abuse problems shall work together to enable consumers to live successfully in their communities.

5. Consumers shall have:
    - Meaningful input into the design and planning of the service system
    - Information about services including how to access them and how to voice grievances
    - Opportunities for employment in the system
    - Easy, immediate access to appropriate services
    - Educational, personal responsibility, enjoyment of life, and employment or vocational experiences that encourage individual growth
    - Safe and humane living conditions in communities of their choice
    - Reduced involvement with the justice system
    - Services that prevent and resolve crises
    - Opportunities to participate in their community to pursue relationships with others
    - Opportunities to make choices that enhance their productivity, well being and quality of life
    - Satisfaction with the quality and quantity of services
    - Access to an orderly, fair, and timely system of arbitration and resolution of appeals/grievances

6. Within this vision, Providers and Care Managers shall have:
    - The opportunity to participate in the development of a state system that clearly identifies target groups, core functions and essential service components
    - Access to an orderly, fair, and timely system of arbitration and resolution of appeals/grievances
    - Documentation and reimbursement systems that are clear and that contain only those elements necessary to substantiate specific outcomes required
    - Accurately estimated costs associated with services and outcomes provided
    - Training in services that are provided

D. MeckLINK Behavioral Healthcare

1. Purpose:

To actualize the Missions and Visions of DHHS, DMA and MeckLINK Behavioral Healthcare in providing MH/IDD/SA services in Mecklenburg County.

2. Mission

MeckLINK Behavioral Healthcare is to assist persons, families, and communities affected by Mental Illness, Intellectual Developmental Disabilities, and/or Substance Abuse to achieve life goals.

3. Vision

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

4. Community Standards of Practice

a. **Ethics:** We work with integrity
b. **Planning:** Consumers and families are fully involved in all aspects of the behavioral healthcare system's redesign and operations.
c. **Customers:** We serve consumers with dignity, respect, and sensitivity to their cultural heritage. We are strength based and outcome focused.
d. **Employees:** We give our employees the respect, training, and support to be successful.
e. **Excellence:** Our commitment is to quality improvement.
f. **Accountability:** We focus on system and consumer outcomes.

5. MeckLINK Treatment Philosophy

We endorse a treatment philosophy that is recovery-oriented, multidisciplinary, and strength-based; with a focus on choice and self-determination for all populations served. We embrace evidenced based or best practices and the most updated clinical practice parameters in order to support our enrollees in achieving positive outcomes.

SECTION I
Overview of the 1915(b) and (c) Medicaid Waivers

A. The Medicaid Waiver: What is the NC MH/IDD/SAS Health Plan?

The NC MH/IDD/SAS Health Plan is a Pre-paid Inpatient Health Plan (PIHP) funded by Medicaid. Another name for Pre-paid Inpatient Health Plan is Managed Care. All Medicaid MH/IDD/SA services are authorized by and provided through the MeckLINK Behavioral Healthcare Provider Network in accordance with the risk contract between the Division of Medical Assistance, Department of Health and Human Services and MeckLINK Behavioral Healthcare. As a PIHP, MeckLINK Behavioral Healthcare is at financial risk for a discrete set of MH/IDD/SA services; including both NC Medicaid State Plan services and services included in the NC Innovations waiver.

The NC MH/IDD/SAS Health Plan is a combination of two types of waivers: a 1915(b) waiver generally known as a Managed Care/Freedom of Choice Waiver, and a 1915(c) waiver generally known as a Home and Community Based Waiver. Through the 1915(b) section of the Social Security Act, States are permitted to submit a request to waive some Medicaid requirements in order to provide alternatives to the traditional fee for service system of care. Likewise, through the 1915(c) section of the Social Security Act, States are permitted to submit a request to waive some Medicaid requirements in order to provide alternatives to institutional care.

Both waivers are approved under different Federal Medicaid Regulations and require different reporting and oversight. This type of waiver system is not intended to limit care or choice, but to create an opportunity to work closely with consumers and providers on better coordination and management of services. In the end, this results in better outcomes for consumers and a more efficient use of resources.

The values of Recovery, Self Determination, Person Centered Planning, and Consumer and Family driven services are the basis for this waiver expansion, and are in the North Carolina State Plan.

Opportunities that a 1915(b)(c) waiver system presents:

1. Coordination - The waiver allows for better coordination of a system of care for consumers, families, and providers.
2. Efficient Management of limited public resources- We are able to manage all system resources so that money can be directed to services most appropriate for identified consumer needs.
3. Flexibility in services offered- As additional B(3)codes are made available we will be able to develop a more complete range of services and supports through Medicaid to reduce and redirect reliance on high cost institutional and hospital care.

B. About the NC MH/IDD/SAS Health Plan

1. All Medicaid Clients enrolled in *specified eligibility groups* will automatically be enrolled into this plan for their Mental Illness, Intellectual Developmental Disabilities, and/or Substance Abuse service needs.
2. The services that are available will include current NC State Mental Health Plan

Medicaid services including Inpatient Psychiatric Care and Intermediate Care Facilities for the Mentally Retarded (ICF/MR).

3. MeckLINK Behavioral Healthcare has partnered with the state to create additional services that have been identified as best practices in care, titled B(3) services. These services are not covered in the NC State Medicaid Plan and are not available to consumers with Medicaid that live outside Mecklenburg County.
4. Under Medicaid B(3) authority, funds that are typically used to serve a person with intellectual developmental disabilities in an Intermediate Care Facility for the Mentally Retarded (ICF-MR), through this waiver can be used to "follow the person" to services outside of the ICF-MR facility.
5. The MeckLINK Behavioral Healthcare Provider Network is qualified to provide best practice services.
6. Consumers will be able to choose from any provider in MeckLINK Behavioral Healthcare's network that is credentialed to provide services.
7. Information and education will be provided to consumers to help them choose providers.
8. Access to care is made easier through MeckLINK Behavioral Healthcare's Customer Service Call Center (1-704-336-6404).

C. About the NC Innovations Waiver

The NC Innovations waiver is a 1915 (c) Home and Community Based Waiver. This Waiver is designed to provide an array of community based services and supports to promote choice, control and community membership. These services provide a community-based alternative to institutional care for persons who require an ICF-MR level of care who have a service need, can remain healthy and safe in a community setting, are NC Medicaid eligible and enrolled.

The Goals of the NC Innovations Waiver are:

1. To value and support participants to be fully functioning members of their community
2. To promote Promising Practices that result in real life outcomes for participants
3. To offer service options that will facilitate each participant's ability to live in homes of their choice, have employment or engage in a purposeful day of their choice and achieve their life goals
4. To provide the opportunity for all participants to direct their services to the extent that they choose
5. To provide educational opportunities and support to foster the development of stronger natural support networks enabling participants to be less reliant on formal support systems

NC Innovations promotes participant direction of services. This allows the person to play an essential role in their care and service planning. NC Innovations encourages the participant to direct services to the extent that the individual chooses. The waiver offers both agency directed and self-directed models of service. The self-directed supports are accomplished via two types of self-direction models: Agency with Choice and Employer of Record. Recipients may choose to self-direct some or all services under the self-directed models. Recipients may change models of service delivery and may opt out of self-directed services at any time.

SECTION II
Consumer Eligibility for Medicaid Waivers and State-Funded Services

A. NC Medicaid Waiver Eligibility

1. <u>1915(b) Waiver</u>

a. Persons Eligible for Enrollment in the NC MH/IDD/SAS Health Plan (1915(b) waiver):

To enroll in the PIHP, a person shall be a recipient in the North Carolina Medical Assistance Program (Medicaid) with a Mecklenburg County residence in one of the aid categories listed below:

- Individuals covered under Section 1931 of the Social Security Act (1931 Group, TANF/AFDC)
- Optional Categorically and Medically Needy Families and Children not in Medicaid deductible status (MAF)
- Blind and Disabled Children and Related Populations (SSI)
- Blind and Disabled Adults and Related Populations (SSI, Medicare)
- Aged and Related Populations (SSI, Medicare)
- Medicaid for the Aged (MAA)
- Medicaid for Pregnant Women (MPW)
- Medicaid for Infants and Children (MIC)
- Adult Care Home Residents (SAD, SAA)
- Foster Care Children
- Participants in Community Alternatives Programs (CAP/DA, CAP-MR/DD, CAP/AIDS)
- Medicaid recipients living in ICF's-MR
- Children, beginning the first day of the month following the third birthday (except for CAP-MR/DD)

Eligibility for individuals meeting the criteria listed above is mandatory and automatic. Children are eligible beginning the first day of the month following their third birthday for 1915(b) services, but can be eligible from birth for 1915(c).

b. Persons Ineligible for Enrollment in the NC MH/IDD/SAS Health Plan (1915(b) waiver):

The following categories of people receiving Medicaid are not eligible to enroll in the PIHP operated by MeckLINK Behavioral Healthcare:

- Medicare Qualified Beneficiaries (MQB)
- Non-qualified Aliens or Qualified Aliens during the five year ban
- Medically Needy in deductible status
- Children within the age of 0-36 months, except for CAP-MR/DD participants
- Recipients with Presumptive Eligibility
- Refugee Assistance

2. NC Innovations Waiver (1915 (c) waiver):

a. A person with mental retardation (intellectual developmental disability) and/or a related developmental disability may be considered for NC Innovations funding if all of the following criteria are met:

- The individual is eligible for Medicaid coverage, based on assets and income of the applicant whether he/she is a child or an adult.
- The individual meets the requirements for ICF-MR level of care as determined by the MeckLINK Behavioral Healthcare Utilization Management Department.(Refer to MeckLINK Behavioral Healthcare's NC Innovations Operations Manual for the ICF-MR Criteria.)
- Lives in an ICF-MR facility or is at high risk for placement in an ICF-MR facility. High risk for ICF-MR institutional placement is defined as a reasonable indication that individual may need such services in the near future (one month or less) but for the availability of Home and Community Based Services.
- The individual's health, safety, and well-being can be maintained in the community with waiver support.
- The individual requires NC Innovations waiver services.
- The individual, his/her family, or guardian desires participation in the NC Innovations Waiver program rather than institutional services.
- For the purposes of Medicaid eligibility, the person is a resident of Mecklenburg County.
- The individual will use one waiver service per month for eligibility to be maintained.
- Effective April 1, 2010, new NC Innovations participants must live with private families or in living arrangements with six or fewer persons unrelated to the owner of the facility.
- Qualifies for the NC Innovations Waiver and has been assigned a waiver "slot".

B. Eligibility for State Funded Services:

Consumers that do not have Medicaid may be eligible for state funded services based on their income and level of need. No one that meets eligibility requirements can be denied services based on an inability to pay. The MeckLINK Behavioral Healthcare sliding fee schedule is designed to assess a person's ability to pay. State Funded Services are not an entitlement. MeckLINK Behavioral Healthcare and other LME-MCOs are not required to fund services beyond the resources that are available to them.

There are also some services, including most residential services for adults that are not reimbursed by Medicaid. Therefore consumers who receive Medicaid may also receive state funded services, based on their individual needs and availability of funding.

MeckLINK Behavioral Healthcare maintains a Registry of Unmet Needs to track requests for state funding/non-emergency services that have not been met.

SECTION III
Consumer Enrollment for Medicaid Waiver Services

A. Process

All individuals meeting eligibility requirements for Mecklenburg County Medicaid with MeckLINK Behavioral Healthcare shall be subject to enrollment except those persons listed above under "Persons Ineligible for Enrollment in the NC MH/IDD/SAS Health Plan (1915(b) waiver)."

B. Effective Date

An enrollment period shall always begin on the first day of a calendar month and shall end on the last day of a calendar month, with the exception of the Innovations waiver participants whose enrollment shall be effective on the date of eligibility for participation in the Innovations waiver.

C. Provider Responsibility

It is important for all providers to ensure consumer enrollment data is up-to-date based on the most current MeckLINK Behavioral Healthcare Enrollment Procedures and training. If enrollment data is not complete prior to service provision, authorizations and claims may be affected. This could result in denial of authorizations requested and/or claims submitted for reimbursement.

D. Waiver Disenrollment:

When a Consumer changes county of residence for Medicaid eligibility to a county other than Mecklenburg, the individual will continue to be enrolled in The NC MH/IDD/SAS Health Plan until the disenrollment is processed by the Eligibility Information System at the state. Disenrollment due to a change of residence is effective at midnight on the last day of the month. A Consumer will be automatically disenrolled from the NC MH/IDD/SAS Health Plan if:

1. The individual's Medicaid eligibility moves to a county other than Mecklenburg.
2. The individual is deceased
3. The individual is admitted to a correctional facility for more than thirty (30) days
4. The individual no longer qualifies for Medicaid or is enrolled in an eligibility group not included in the NC MH/IDD/SAS Health Plan or NC Innovations 1915(b)(c) waivers.
5. The individual is admitted to an Institution for Mental Disease (IMD) and is between the ages of 22 and 64. IMDs are hospitals such as the State Facilities because they are more than 16 beds and are not part of a general hospital.

E. Enrollee Education

Upon Medicaid approval, DMA sends the Enrollee a written description of the services and benefits provided by MeckLINK Behavioral Healthcare, a written explanation of how to access those benefits from MeckLINK Behavioral Healthcare, and contact information. Within 14 days after an Enrollee makes a request for services, MeckLINK Behavioral Healthcare shall provide the new Enrollee with written information on the Medicaid managed care program. This information can be viewed at the Consumer Resource Library.

SECTION IV
Services

Service Eligibility
This section contains basic information about available MH/IDD/SA services and how eligibility for services is determined. Services are divided into multiple service categories.

A. State Funded Services:

A consumer may be eligible for State Funded services if the consumer meets Target Population Criteria. This is not applicable to consumers who are only receiving Medicaid services. The Provider, through review of screening, triage and referral information, must determine the specific Target Population for the consumer according to the Division of MH/IDD/SA criteria. Each Target Population is based on diagnostic and other indicators of the consumer's level of need. If the MH/IDD/SAS system does not serve these individuals, there is no other system that will serve them. The MH/IDD/SAS system is the public safety net and its resources will be focused on those individuals most in need.

The most current version of the Target Population Criteria can be found through the IPRS Website link on the NC Division of MH/IDD/SAS homepage at: http://www.ncdhhs.gov/mhddsas/providers/IPRS/index.htm

B. Medicaid Services

Basic Services:
The Basic Benefit package includes those services that will be made available to Medicaid-entitled individuals and, to the extent resources are available, to non-Medicaid individuals. These services are intended to provide brief interventions for individuals with acute needs. The Basic Benefit package is accessed through a simple referral from MeckLINK Behavioral Healthcare to an enrolled MeckLINK Behavioral Healthcare provider or by directly contacting a provider enrolled in the MeckLINK Behavioral Healthcare network. There are no prior authorization requirements for these services. Medicaid and State Funded consumers referred for Basic Benefit Services can access up to eight (8) visits for Adult and sixteen (16) for Children from the Basic Benefit package.

As per Division of Medical Assistance Clinical Coverage Policy 8C 5.4
Medicaid Beneficiaries under the Age of 21 and NCHC Beneficiaries
Services provided to Medicaid beneficiaries under the age of 21 and Health Choice beneficiaries require an individual, verbal or written referral, based on the beneficiary's treatment needs by a Community Care of North Carolina/Carolina Access (CCNC/CA) primary care provider, the LME-MCO or a Medicaid enrolled psychiatrist. Documentation of this verbal or written referral must be in the health record and must include the name and NPI number of the individual or agency making the referral.

Note: Services provided by a physician do not require a referral.

Medicaid Beneficiaries Aged 21 and Over

Services provided to Medicaid beneficiaries age 21 or over may be self-referred or referred by some other source. If the beneficiary is not self-referred, documentation of the referral must be in health record.

Basic Augmented Services:

The Basic Augmented Benefit package includes those services that will be made available to Medicaid-entitled individuals and, to the extent resources are available, to non-Medicaid individuals meeting Target Population Criteria. A consumer requiring this level of benefit is in need of more than the eight (8) unmanaged visits for adult and sixteen (16) unmanaged visits for child Medicaid or State Funded consumers under the Basic Benefit in order to maintain or improve his/her level of functioning. An Authorization for the services available in this level will need to be requested through MeckLINK Behavioral Healthcare UM Department. Authorization is based on the Consumer's need and medical necessity criteria for the service requested.

Enhanced Services:

The Enhanced Benefit package includes those services that will be made available to Medicaid-entitled individuals and, **to the extent resources are available,** to non- Medicaid individuals meeting Target Population Criteria. Enhanced Benefit services are accessed through a person-centered planning (PCP) process. Enhanced Benefit services are intended to provide a range of services and supports, which are more appropriate for individuals seeking to recover from more severe forms of Mental Illness, Intellectual Developmental Disabilities, and/or Substance Abuse with more complex service and support needs as identified in the person-centered planning process. The person-centered plan also includes both a proactive and reactive crisis contingency plan. Enhanced Benefit services include services that are comprehensive, more intensive, and may be delivered for a longer period of time. An individual may receive services to the extent that they are identified as necessary through the person-centered planning process and are not duplicated in the integrated services offered through the Enhanced Benefit (e.g., Assertive Community Treatment). The goal is to ensure that these individuals' services are highly coordinated, reflect best practices, and are connected to the person-centered plan authorized by MeckLINK Behavioral Healthcare.

C. Service Related Information

Service Array

For a listing of services, please refer to the most current version of the service arrays by benefit level and disability. For Mental Illness, Intellectual Developmental Disabilities, and/or Substance Abuse, further detail can be found in the NC Medicaid Clinical Coverage policies 8 A, B, C, D, E, and O located at DMA's website with this link: NC Medicaid and NC Health Choice Clinical Coverage Policies. For the NC Innovations Waiver, further detail can be found in the NC Innovations Technical Manual with this link: NC Innovations Technical Manual.

Service Definitions

The regulations of a 1915 (b) waiver require that all NC Medicaid State Plan services be available under the 1915(b) waiver. When the NC State Medicaid Plan changes the services covered under the NC MH/IDD/SAS Health Plan will also change.

D. Hospital Admissions

DMA is responsible for payment of inpatient hospital services provided to individuals who are in patient prior to the effective date of their enrollment in the Medicaid waiver operated by MeckLINK Behavioral Healthcare and until the Consumer is discharged from the hospital. For individuals hospitalized on or after the effective date of enrollment in the waiver, MeckLINK Behavioral Healthcare will provide authorization for all covered services, including inpatient and related inpatient services, according to Medical Necessity requirements. MeckLINK Behavioral Healthcare shall provide authorization for all inpatient hospital services to consumers who are hospitalized on the effective date of disenrollment (whether voluntary or involuntary) until such consumer is discharged from the hospital.

E. Medicaid Transportation Services

Among the greatest needs identified to assist consumers in accessing care is transportation. Transportation services enable low incomes individuals to access health and community resources that would otherwise be unavailable because of the lack of private or public transportation. It is MeckLINK Behavioral Healthcare's goal to assist consumers in accessing generic public transportation. Providers are requested to assist in meeting this need whenever possible.

The Department of Social Services in Mecklenburg County has an application for Medicaid approved transportation. Transportation is for medical appointments or for traveling to the drug store to get your prescriptions. Riders must call two (2) to four (4) days ahead to arrange for a ride. There is no fee for Medicaid recipients. For those who are not enrolled in Medicaid, transportation depends on available space and may cost from $1.00 to $2.00 each way. For more information on transportation services in the Mecklenburg Region, call your county Department of Social Services at 704-336-3000 or the MeckLINK Behavioral Healthcare Call Center at 704-336-6404.

You may access information on available transportation in other counties by contacting the local DSS. Go to http://www.ncdhhs.gov/dss/local/ to obtain contact information for all NC County DSS agencies.

Publically funded Medicaid transportation services are not available in the evenings and on weekends.

F. Special Needs Populations designed in the NC MH/IDD/SAS Health Plan

Some Medicaid services require that the consumer meet Special Needs Population definitions in order to receive or continue to receive services. Special Needs Populations are population cohorts defined by specific diagnostic, functional, demographic and/or service utilization patterns that are indicators of risk and need for assessment to determine need for further treatment. The goal of the NC MH/IDD/SAS 1915(b)c Waiver is to first identify these individuals and intervene in order to ensure that they receive both appropriate assessment and medically necessary services. Care Coordination is a managed care tool that is designed to proactively intervene and ensure optimal care for Special Needs Populations. The Special Population requirements follow.

1. Intellectual and/or Intellectual Developmental Disabilities

   Individuals who are functionally eligible for, but not enrolled in, the NC Innovations waiver, or who are not living in an ICF-MR facility

   OR

   Individuals with an intellectual developmental disability diagnosis who are currently, or have been within the past 30 days, in a facility operated by the Department of Correction (DOC) or the Department of Juvenile Justice and Delinquency Prevention (DJJDP) for whom MeckLINK Behavioral Healthcare has received notification of discharge.

2. Child Mental Health:

   Children who have a diagnosis within the diagnostic ranges defined below:

293-297.99	298.8-298.9	300-300.99	302-302.6	302.8-302.9
307-307.99	308.3	309.81	311-312.99	313.81
313.89	995.5-995.59		V61.21	

   AND

   Current CALOCUS Level of VI, or who are currently, or have been within the past 30 days, in a facility (including a Youth Development Center and Youth Detention Center) operated by the DJJDP or DOC for whom the LME has received notification of discharge.

3. Adult Mental Health:

   Adults who have a diagnosis within the diagnostic ranges of:

295-295.99	296-296.99	298.9	309.81

   AND

   A Current LOCUS Level of VI

4. Substance Dependent:

   Individuals with a substance dependence diagnosis

   AND

   Current ASAM PPC Level of III.7 or II.2-D or higher

5. Opioid Dependent:

   Individuals with an opioid dependence diagnosis

   AND

   Who have reported to have used drugs by injection within the past 30 days

6. Co-occurring Diagnoses:

   a. Individuals with both a mental illness diagnosis and a substance abuse diagnosis

   AND

   A current LOCUS/CALOCUS of V or higher,

   OR

   Current ASAM PPC Level of III.5 or higher

   b. Individuals with both a mental illness diagnosis and an intellectual developmental disability diagnosis

   AND

   Current LOCUS/CALOCUS of IV or higher

   c. Individuals with both an intellectual or developmental disability diagnosis and a substance abuse diagnosis

   AND

   Current ASAM PPC Level of III.3 or higher

SECTION V
Responsibilities of Contract Parties

A. Provider and/or Contractor Responsibilities

1. Reporting of Investigations
   The provider must notify MeckLINK Behavioral Healthcare if the agency is under investigation by a licensing, accrediting, local, state, or federal agency and will submit findings to MeckLINK upon completion of such investigations. Copies of surveys, reviews, and audits performed by accrediting or regulatory authorities shall be provided to the assigned Provider Relations Specialist upon receipt or completion.

2. Nondiscrimination
   To not employ any policy or practice that has the effect of discriminating against individuals receiving supports, contractors, or colleagues on the basis of race or ethnicity, gender, age, religion, national origin, sexual orientation, or disability.

3. On-Call Coverage
   The Provider agrees to have a functional First Responder system as defined in the Glossary at the end of this manual. For non-clinical home providers, on-call coverage is required 24 hours a day, 7 days a week.

4. Credentialing and Re-credentialing of Professional Staff
   The Provider will ensure that licensed independent practitioners have the necessary credentials and qualifications to provide services to its consumers.

5. No-reject Requirement
   The Provider shall have a "no reject" policy with regard to acceptance of referrals of clients within the capacity and parameters of their competencies, and specializations if the following apply:
   a. The referral meets the provider's admission criteria as established and approved through MeckLINK Behavioral Healthcare's qualifying process; and
   b. The Provider has the open capacity to provide the service(s); and
   c. The referral does not jeopardize the health and safety of staff or clients already in the provider's service.

6. Facility Accessibility
   The Provider's facilities must be accommodating for persons with physical disabilities.

7. Availability and Appointment Access
   The Provider shall meet the following standards for seeing consumers:
   a. Appointments
      - Emergency Care: Consumers shall receive face-to-face emergency care within no more than **two hours** after the request for care is initiated; life threatening emergencies: **immediately**.
      - Urgent Care: Consumers shall receive first face-to-face service (assessment and/or treatment) within **forty-eight (48) hours** of the request for care.

- Routine Care Consumers shall receive first face-to-face service (assessment and/or treatment) within **10 working days (14 calendar days)** of the date of request for care.

b. Office Wait Times
   - Scheduled appointment: Within **one hour**
   - Walk-in: Within **two (2) hours** or schedule for subsequent appointment
   - Emergencies: Receive face-to-face emergency care within no more than **two (2) hours** after the request for care is initiated; life threatening emergencies: **immediately**.

8. Notification of Change of Address

   Formal notification of change of address of either party shall be given to the other. Providers must notify MeckLINK Behavioral Healthcare 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 MeckKLINK as soon as they are known.

9. Licensing of Facilities

   Provider shall not establish, maintain or operate a licensable facility within the meaning of G.S. 122C-3 without first applying for and receiving a license from the Division of Facilities Services. Except for facilities excluded from licensure by G.S. 122C, DFS will deem any facility licensable if its' primary purpose is to provide services for the care, treatment, habilitation or rehabilitation of individuals with mental illness, intellectual developmental disabilities, or substance abuse disorders.

10. Liability Insurance

    Provider shall obtain and continuously maintain:

    a. General Liability Insurance
    b. Automobile Liability Insurance
    c. Worker's Compensation Insurance
    d. Employer's Liability Insurance
    e. Professional Liability Insurance

    …in amounts that equal or exceed the limits established by MeckLINK Behavioral Healthcare. MeckLINK shall review these insurance limits annually and revise them as needed. MeckLINK shall require all Network Providers to obtain coverage that cannot be suspended, voided, canceled or reduced unless the carrier gives 30-days prior written notice to MeckLINK Behavioral Healthcare. MeckLINK Behavioral Healthcare shall require Network Providers to submit certificates of coverage to the Network Development Provider Relations Unit.

11. Documentation Requirements

    a) Providers shall maintain clinical records that meet the requirements in the NC DHHS documents captioned Records Management and Documentation Manual for Providers (APSM 45-2) and Rules for MH/IDD/SAS Facilities and Services (APSM 30-1), and/or in NC DMA's Basic Medicaid Billing Guide.

b) Medical Records shall be maintained at the provider level; therefore enrollees may have more than one record if they receive services from more than one provider. MeckLINK Behavioral Healthcare shall monitor Medical Record documentation to ensure that the standards are met. MeckLINK Behavioral Healthcare shall have the right to inspect provider records without prior notice.

c) Providers must transfer original Medical Records to MeckLINK Behavioral Healthcare in the event that the provider closes its North Carolina business operations, whether the closure is due to retirement, bankruptcy, relocation to another state, or any other reason.

12. Additional Requirements
    a. To provide services for which your Agency is qualified/credentialed/enrolled to provide
    b. To be responsive to the cultural and linguistic needs of the consumers your agency serves
    c. To provide services only at service sites as outlined in your contract
    d. To obtain authorizations as required for contracted services
    e. To adhere to all performance guidelines in your contract and submit required reports
    f. To work to meet the needs of consumers through a evidenced based or best practice approach to treatment and supports
    g. To work in collaboration with other providers, consumers and families
    h. To work in a solution focused and collaborative basis within the network
    i. To work with MeckLINK Behavioral Healthcare staff to mediate problem areas which arise

B. MeckLINK Behavioral Healthcare Responsibilities

1. To actively recruit Network Providers who share our mission and vision
2. To support the development of evidenced based, best practices or emerging best practices
3. To identify gaps in network services/capacity and develop a strategy to develop those services through existing providers or by recruiting new providers for the network
4. To respond to requests for applications for network enrollment according to the needs identified in the Network Capacity Study
5. To update this Provider Operations Manual to reflect changes in requirements
6. To credential and re-credential providers and re-qualify agencies and facilities.
7. To assign a Provider Relations Specialist to each network provider as a resource for technical assistance
8. To conduct provider monitoring in accordance with Waiver requirements
9. To keep network providers informed through provider meetings, disability specific focus or provider groups, and coordinate local training, and the provider relations page on the http://charmeck.org/mecklenburg/county/AreaMentalHealth/Pages/default.aspx website
10. To identify training needs for providers and if possible facilitate or provide the training.
11. To not prohibit or otherwise restrict a health care professional from acting within the lawful scope of practice, from advising or advocating on behalf of an Enrollee who is his or her patient:

a. for the Enrollee's health status, medical care, or treatment options, including any alternative treatment that may be self-administered
b. for any information the Enrollee needs in order to decide among all relevant treatment options
c. for the risks, benefits, and consequences of treatment or non-treatment
d. for the Enrollee's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

SECTION VI
Due Dates for Submission of Regular Reports/Data

Below you will find information about the reports which are due to MeckLINK Behavioral Healthcare on a regular basis. These reports are required as follows:

Report/Form Name	Due Date	Contact
Provider Quarterly Incident Reporting Form	Quarterly; Due Jan. 10th, April 10th, July 10th and Oct. 10th http://www.ncdhhs.gov/mhddsas/statspublications/Forms/index.htm#formslme (see QM 11 Quarterly Provider Incident Report) Send reports to Nancy Cody at Nancy.Cody@mecklenburgcountync.gov	Nancy Cody 704-353-1300
Levels II and III Incident Reporting (sent via IRIS website)	Incident Reporting Information (link) Send within 72 hours.	Carol Goerner 704-336-7109
NC SNAP (IDD consumers only)	As occurs - see the following link for complete info. (http://www.ncdhhs.gov/mhddsas/providers/NCSNAP/index.htm	Paige Walther 704-336-3022
Quarterly Balanced Scorecard Data	January, April, July and October	Gregory West 704-336-6546
NCTOPPS (sent via NC TOPPS website)	Initial: First or second treatment visit with consumer. Updates: 3 months, 6 months, 12 months and semi-annually thereafter. http://www.ncdhhs.gov/mhddsas/providers/NCTOPPS/index.htm	Berkley Moore 704-432-3059

SECTION VII
Division Overview – MeckLINK Behavioral Healthcare

MeckLINK Behavioral Healthcare is organized into various functional divisions. These divisions have been established to perform operational functions that support the overall work of the agency. The divisions with which you will interact are introduced below. Policies, procedures and forms relevant to each division are located in subsequent division-specific sections; however, this link will take you to all public **MeckLINK Behavioral Healthcare Policies and Procedures:**
http://charmeck.org/mecklenburg/county/AreaMentalHealth/ForProviders/Pages/ProviderDocuments.aspx

A. Advocacy, Outreach and Communications **SECTION VIII**

The Administrative Services and Advocacy Division at MeckLINK Behavioral Healthcare, consists of the Advocacy, Outreach, and Communications team. This team is made up of two Consumer Advocates, an Outreach Coordinator, and a Communications Specialist.

B. Provider Operations **SECTION IX**

Provider Operations consists of three teams that handle Provider Monitoring and Network Development. This section of the Provider Manual directs providers to the appropriate procedures and contacts for various concerns they may encounter or with which they need assistance.

C. Financial Services **SECTION X**

The MeckLINK Claims Unit serves to ensure clean claims are submitted by providers and are processed and paid within 30-days of receipt.

D. MeckLINK Customer Services Call Center **SECTION XI**

The MeckLINK Customer Service Call Center serves as the primary portal for access, screening, triage and referral functions for Mecklenburg County residents.

E. Service Management: Utilization Management, Medical Necessity & EPSDT **SECTION XII**

The Utilization Management Program ensures that contracted providers deliver quality individualized services in the most clinically appropriate and cost effective manner to eligible Mecklenburg County enrollees.

F. Care Coordination **SECTION XIII**

Care Coordinators ensure that consumers are referred to and appropriately engaged with providers that can meet their needs, both in terms of MH/IDD/SA services as well as Medical care.

G. Quality Improvement/Quality Management **SECTION XIV**

The Quality Improvement (QI) Program monitors MeckLINK's essential functions through ongoing evaluation of systemic clinical, administrative, and service issues. The focus of these activities includes, but is not limited to: clinical risk and consumer safety; complaints and appeals; consumer, provider, and stakeholder satisfaction; the availability, accessibility, and quality of services within the network; in addition to the performance of the health call center, utilization management, network management, and care coordination divisions. The QI Program ensures the organization's ongoing alignment with the expectations of contractors, accreditation bodies, and stakeholders.

H. Forensic Evaluations Unit **SECTION XV**

MeckLINK Behavioral Healthcare is required to assign forensic evaluators, certified by North Carolina Forensic Services, to screen adult consumers referred by the courts to determine the defendant's capacity to proceed (CTP) to trial. Other court-ordered assessments for adults and juveniles are also the responsibility of this Unit.

SECTION VIII
Advocacy, Outreach and Communications

A. Advocacy

Within the Administrative Services and Advocacy Division at MeckLINK Behavioral Healthcare, is the Advocacy, Outreach, and Communications team. This team is made up of two Consumer Advocates, an Outreach Coordinator, and a Communications Specialist.

The primary functions of a **Consumer Advocate** are:

1. To empower consumers, families, community agencies and advocacy groups with regard to consumer rights and responsibilities.
2. Respond to consumer, family member, provider and community complaints related to Mental Illness, Intellectual Developmental Disabilities, and/or Substance Abuse services.
3. Investigate and address complaints to ensure the safety and well-being of consumers, to ensure service quality, and to facilitate the protection of human rights for consumers of Mental Illness, Intellectual Developmental Disabilities, and/or Substance Abuse services.
4. Maintain data and compile reports in compliance with Balanced Scorecard measures, quality improvement initiatives, and state performance requirements.
5. Actively participate in QI projects including consumer satisfaction, as assigned.
6. Serve as the MeckLINK staff liaison for MeckLINK's Human Rights Committee.

B. Outreach

The primary functions of the **Outreach Coordinator** are:

1. Develop rapport and trust with targeted populations through grassroots outreach efforts.
2. Identify and determine barriers for access to treatment for consumers, specifically non-English speaking.
3. Serve as liaison between targeted population and MeckLINK.
4. Provide education and information to targeted populations regarding treatment access and the availability of services.
5. Initiate efforts and seek out opportunities to increase cultural competence among providers and the community at large.
6. Develop strategies to increase capacity within the provider network to serve limited English speaking individuals.
7. Analyze service trends and assess needs of the non-English speaking communities and recommend improvement initiatives.
8. Work closely with the Consumer Advocates to empower consumers, families, community agencies and advocacy groups with regard to consumer rights and responsibilities.

C. Communications

The primary functions of the **Communications Specialist** are:

1. Development and oversight of the annual communications plan, including any multi-platform advertising campaigns.
2. Produce, distribute and maintain supply levels of social marketing campaign materials to support department initiatives and events.
3. Coordinate management and content updates for the MeckLINK Behavioral Healthcare website.

4. Strengthen relationships between MeckLINK, partner agencies, and the community
5. Facilitate focus groups and lead creative teams.
6. Raise awareness by providing outreach and informational support to providers and consumers on Mental Illness, Intellectual Developmental Disabilities, and/or Substance Abuse services including the Medicaid Waiver and IPRS components.
7. Plan events to recognize and empower consumers, community partners, and agencies.
8. Design engagement activities to share information, data, and resources.

D. Consumer Choice Forms

1. Documentation of Choice Memo
2. Documentation of Consumer Choice Form
3. Consumer Request to Change Provider Procedure
4. Consumer Request to Change Provider Form
5. Provider Information Request Transfer Form

SECTION IX
Provider Operations

The Provider Operations Division consists of two functional areas: Provider Relations and Network Development and Provider Monitoring and Accountability. The Provider Operations Division supports the local community of providers through staff involvement on the Mecklenburg Provider Council's Executive Board and participation in its subcommittees, task teams and work groups. The activities of the division focus on ensuring that network providers are serving consumers in ways that demonstrate a commitment to best clinical and business practices, that ensure consumers are treated in a healthy and safe environment, and that consumers are included in the decisions regarding their treatment and support. Staff in both functional areas provides technical assistance and targeted training when needed to ensure providers understand and are aware of all network requirements.

Provider Relations and Network Development is responsible for the development of the provider network to meet the treatment and support needs of consumers and to ensure consumer access and choice. This functional area manages the overall activities of network capacity, provider enrollment, provider credentialing, contract development, community needs assessment and data analysis and the Request for Proposal (RFP) process.

Provider Monitoring and Accountability is responsible for the system of review, monitoring and investigation activities to ensure that providers are in compliance with all aspects of contract requirements and that providers meet all competencies and qualifications specific to service delivery and consumer outcomes. This functional area conducts on-going reviews in accordance with the Provider Performance Profile Gold Star process, manages and tracks the results of routine and targeted provider reviews, monitoring and investigations, and establishes plans of corrections where appropriate.

A. Problem Resolution/Disputes and Appeals

If problems arise between the Provider and MeckLINK Behavioral Healthcare 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 for Disputes Policy and Procedure:

1. PO-01 Administrative Contract Appeals Policy
2. Procedures for Local Reconsideration (Manuals/Guides)

B. Technical Assistance/Training Collaboration

MeckLINK Behavioral Healthcare coordinates provider training and technical assistance it deems necessary regarding administrative and clinical procedures and requirements, as well as clinical practices.

Technical Assistance/Training Collaboration, Cont'd

The Provider must attend all relevant Orientation Sessions as determined by MeckLINK Behavioral Healthcare at no cost to the provider. The Provider shall attend all mandatory trainings as related to business practices at no charge to the Provider as space permits. MeckLINK reserves the right to charge the usual and customary fee for additional staff attendance or scheduling additional trainings to meet Provider demand. MeckLINK shall also mandate provider attendance at selected Clinical Sessions of which the provider bears the cost, whether MeckLINK sponsored or offered by outside parties. The Provider shall also bear the cost of all trainings related to licensure or accreditation activities. The Provider must be able to demonstrate to MeckLINK its application of training information received in the delivery of services and in compliance with the provisions of their contract.

Trainings may include awareness and sensitivity to the needs of persons who may be disadvantaged by low income, intellectual disability, and illiteracy or who may be non-English speaking. Trainings may also include topics such as sensitivity to different cultures and beliefs, the use of bilingual interpreters, the use of Relay Video Conference Captioning, Relay NC, TTY machines, and other communication devices for the disabled, overcoming barriers to accessing medical care, understanding the role of substandard housing, poor diet, and lack of telephone or transportation for health care needs.

C. MeckLINK Behavioral Healthcare Contacts: Contracts, Monitoring and/or Insurance Requirements

Provider Relations and Network Development:

Provider Network, Manager	Charles Hill	704-336-2550

Provider Monitoring and Accountability:

Provider Monitoring, Manager	Kimberly Alexander	704-336-2739
Provider Monitoring, Manager	Angie Jackson	704-336-6954

Financial Services:

Finance, Manager	Jelese Jones	704-353-1768
Claims, Manager	Faye Sanders	704-353-1769

Other MeckLINK Behavioral Healthcare Contacts:

Advocacy, Outreach, and Communications, Manager	Nancy Cody	704-353-1300
Privacy Officer	Gregory West	704-336-6546
Quality Improvement, Manager	Linda Margerum	704-353-0389
Clinical Risk, Manager	Carol Goerner	704-336-7109

MeckLINK Behavioral Healthcare Leadership Team:
http://charmeck.org/mecklenburg/county/AreaMentalHealth/AboutUs/Pages/management.aspx

D. MeckLINK Monitoring Policies and Procedures

1. PO-03 Local Monitoring Policy
2. PO-06 Requesting Plan of Correction
3. Elements of a Functional 1st Responder System (Manual)

E. **NC DMH/IDD/SAS Gold Star Provider Monitoring Information and Tools**
(Please note: some of the monitoring tools are being consolidated and renamed, this manual will be updated upon finalization of those tools)

1. **MeckLINK PowerPoint Presentation**
   a. Gold Star LME-MCO Training

2. **Gold Star Monitoring Process Flow Chart**
   a. DHHS Gold Star Monitoring Process Flow Chart

3. **Policies and Procedures Review Tools**
   a. DHHS Additional Service Policy and Procedure Review Tool
   b. DHHS Application Policy and Procedure Review Tool

4. **Initial Review Tools**
   a. DHHS Initial Rights Notification Review Tool
   b. DHHS Initial Funds Management Review Tool
   c. DHHS Initial Medications Management Review Tool
   d. DHHS Initial On-Site Health and Safety Review Tool
   e. DHHS Initial Personnel Review Tool
   f. DHHS Initial Record Review Tool

5. **Routine Review Tools**
   a. DHHS Routine Rights Notification Review Tool
   b. DHHS Routine Compliance Safety Review Tool
   c. DHHS Routine Consumer Record Review Tool
   d. DHHS Routine Funds Management Review Tool
   e. DHHS Routine Medications Review Tool
   f. DHHS Routine Personnel Review Tool

6. **Licensed Independent Practitioner Review Tools**
   a. DHHS LIP Site Quality Review Tool
   b. DHHS LIP Review Tool

7. **Non-Contract Provider Monitoring Tool**
   a. Non-Contract Provider Monitoring Tool

8. **Unlicensed Alternative Family Living Program Review Tools**
   a. DHHS Unlicensed Alternative Family Living Program Health and Safety Review Tool

9. **Domain Review Tool**
    a. DHHS Domain Review Tool

10. **Provider Performance Profile Review Tools**
    a. DHHS Provider Performance Profile Grid
    b. DHHS Provider Performance Profile Review Tools (note the referenced tool has tabs at the bottom of the file page, once opened)
        - Preferred Provider Review Tool
        - Exceptional Provider Review Tool
        - Gold Star Provider Review Tool

11. **Billing Audit/Payback Tools**
    a. DHHS Provider Billing Audit Tool
    b. DHHS LIP Billing Audit Tool
    c. DHHS Payback Form
    d. DHHS Provider Self-Audit Payback Form

F. General Policies of Interest to Providers

1. PO-02 Dissemination of Information to Providers Policy
2. PO-04 Assessment of Adequacy of Provider Community
3. PO-05 Request for Proposal Policy
4. LME-01 LME State and Local Disaster Plan
5. LME-05 Delegation Policy
6. LME -16 Communication Practices Policy Revised
7. LME-29 Acceptance of Monetary Donations
8. LME -30 Acceptance of Donated Goods
9. HCC-09 Provider Compliance with STR Requirements
10. AMH-22 Limited English Proficiency Policy
11. UM-02 Adolescent Transition to Adult Status
12. FS-05 Payment of Services to Family Members
13. County Board Policy on Sexuality Counseling for Children

G. Local Resources

MeckLINK Behavioral Healthcare provides this list of local resources and contact information for the convenience of our consumers, stakeholders and any other user of this site. The listing is not intended to be all inclusive and may vary periodically. Additionally, these resources are in no way approved, recommended, evaluated or suggested to be preferred by MeckLINK Behavioral Healthcare. Click here for Local Resources

SECTION X
Finance Information

A. Eligibility for Reimbursement by MeckLINK Behavioral Healthcare

Consumers who have their services paid for in whole or in part by MeckLINK Behavioral Healthcare must be enrolled in the MeckLINK Behavioral Healthcare system. Medicaid and State Funds should be payment of last resort. Providers are responsible for verifying consumer coverage at the time of referral, admission and at each appointment or treatment session.

B. Provider Responsibility (State Funded Services)

Providers are required to assess the consumer's ability to pay for services using the MeckLINK Sliding Fee scale. This scale is based on Federal Poverty Guidelines, family income, and the number of dependents. Individuals who are at 100% ability to pay based on the sliding fee scale or who have insurance coverage that pays 100% of their services, must not be enrolled into the MeckLINK Behavioral Healthcare system for state funding. However, the person may still receive and pay for services from a provider within and independent of MeckLINK Behavioral Healthcare. Providers should not submit these claims to MeckLINK Behavioral Healthcare for payment.

C. First and Third Party Payers (State/Medicare Funds)

Providers are required to bill for first and third party payers prior to sending claims to MeckLINK Behavioral Healthcare. All payment and denial responses should be included on the claim even if there is a zero (0) payment amount from the other payer.

D. Provider Responsibility (Medicaid)

Consumers with a Medicaid card from Mecklenburg County are fully enrolled in the MeckLINK Behavioral Healthcare system and are eligible to receive Basic Benefit Services, Basic Augmented, or Enhanced Services which have been authorized by MeckLINK Behavioral Healthcare.

NOTE: Provider contracts specify the funding source available for Provider billing. Providers should know if they have been contracted for Medicaid, State Services, or both. If you have questions, please contact your assigned Provider Relations Specialist.

E. 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.

F. Electronic Connectivity Requirements

1. Providers should complete the required online training prior to obtaining access or a login for the Alpha MCS system
2. Providers should inform MeckLINK Behavioral Healthcare when staff is no longer with the agency in order to change Login access.

G. Payment Schedules

1. State Medicaid Funded Providers Only

    a. MeckLINK Behavioral Healthcare 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, however will be processed within 30 days of receipt. MeckLINK Behavioral Healthcare will follow the Division of Medical Assistance Check Write Schedule.

    b. Prompt Pay

    - Within 18 calendar days of receiving a claim, the Alpha system will approve payment, deny payment or pend a claim submitted in the system. Payment will occur within 30 calendar days of approving the claim.
    - The Provider shall bill State services to MeckLINK Behavioral claims 60 days from the date of service. Any bill received after this will be denied.
    - The Provider will bill Medicaid services to MeckLINK Behavioral Healthcare within 90-days of date of service.

H. Billing for Residential Services (State Funded 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.

I. Payment Information

An Electronic Funds Transfer (EFT) Agreement will be provided to each new provider. Payment is by check or EFT. MeckLINK Behavioral Healthcare encourages providers to complete an authorization agreement for EFT. Once the provider's bank information is entered into the Advantage financial system, the provider will no longer receive paper checks for payment. During the check-writing cycle, Advantage will identify providers who have requested EFT and create a file of the payment amounts rather than writing a check.

Checks to contract providers and vendors will be mailed. MeckLINK Behavioral Healthcare 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 MeckLINK Behavioral Healthcare Financial Services with sufficient time within the Check Write Schedule to process the payment.

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. Providers will receive an email notification of the payment amount, date sent and items being paid.

J. 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. Providers can download claim files in Alpha and should download their Remittance Advice (RA) and/or their 835 weekly. Researching denials and resubmitting claims in a timely manner is strongly encouraged.

K. To access the MeckLINK Behavioral Healthcare Claims – CLICK HERE

SECTION XI
MeckLINK Customer Service Call Center

The Customer Service Call Center provides 24 hour/7 day week coverage for incoming calls.
Local: 704-336-6404
Toll Free: 1-877- 700-3001

The MeckLINK Customer Service Call Center serves as the primary portal for access, screening, triage and referral functions for MeckLINK Behavioral Healthcare. All department functions are performed in compliance with all federal and state regulations including NC DHHS/ DMA and MCO Contract., 42 C.F.R. 438, the Centers for Medicare and Medicaid Services, the NC Department of Health and Human Services and the NC 1915 (b)(c) Waiver and URAC accreditation standards. The operations within the Customer Services Department are pivotal to the assurance of clinically and fiscally sound managed care practices within MeckLINK Behavioral Healthcare.

The Customer Service Call Center is staffed by a multi-disciplinary team of clinical and non-clinical team members led by three licensed clinical supervisors, managed by the Senior Manager of Customer Service. The MeckLINK Behavioral Healthcare Medical Director and Clinical Director provide input and direction for all Customer Service Call Center clinical activities and ensure the consistent application of medical necessity criteria.

A. Purpose

The Customer Service Call Center for MeckLINK Behavioral Healthcare is designed to receive a high volume of calls and to address a range of customer service requirements including:

1. Providing enrollees and their family members (including those with limited English proficiency) information on where and how to access behavioral health services
2. Performing screening, triage, and referral 24 hours a day 7 days a week including linking and referring enrollees to needed services
3. Connecting enrollees, family members, and stakeholders to crisis services when clinically appropriate
4. Logging all customer service related grievances, complaints and requests for appeals by enrollees, providers and other individuals

B. Program Structure

All calls are answered live by a call center representative who determines the nature of the call and then transfers the call to the most appropriate team member. If the call is emergent or of a clinical nature the call is immediately transferred to a licensed professional. For routine calls if a licensed professional is not available within a reasonable hold time and the caller agrees, a message is taken by a non-clinical team member and the call is returned within 30 minutes by the next available licensed clinician.

For afterhours support, MeckLINK Behavioral Healthcare will provide after hour enrollment, linkage and scheduling (when available by provider), information, referral, hospital placement,

emergency authorization, telephonic assessments and crisis intervention. To ensure continuity of care, a Customer Service Call Center team member follows up on all consumers identified by the after-hours call center contractor during normal business hours to insure an appropriate disposition.

The Customer Service Call Center has TTY capabilities to accommodate individuals with hearing impairments. However as an alternative callers may request Relay services rather than using TTY. Additionally, interpreter services are available for all languages 24/7 with no cost to the caller. During normal business hours, one Spanish speaking Customer Service Call Center team member is available to provide interpretation for Spanish-speaking callers.

C. Customer Service Call Center Primary Functions

1. Enrollment and Eligibility

   The Customer Service Call Center is tasked with ensuring that all consumer demographic, membership and insurance data is correct and up to date in the electronic record system. Providers who have been designated as MeckLINK Behavioral Healthcare Portals can enroll consumers by completing the enrollment module in Alpha MCS or faxing the Standardized STR Form to 704-432-3453 within 5 days of initial screening.

2. Screening, Triage and Referral

   All incoming callers are triaged for clinical severity by NC Licensed Mental Health Professionals using a standard protocol that includes the uniform screening tool mandated by DHHS, the NC Standardized STR Registration Form and the clinical decision support tools for the determination of emergent, urgent or routine need for services. The following Access to Care Standards are mandated by the Division of Mental Health Intellectual Developmental Disabilities and/or Substance Abuse Services (DMH/IDD/SAS) and adopted by MeckLINK Behavioral Healthcare.

   a. Emergent Response: consumers with life threatening/non-life threatening emergency needs will be seen immediately or no later than 2 hours. 911 services will be called if indicated.
   b. Urgent Response: consumers with urgent needs will be seen within 48 hours of the request of care.
   c. Routine Response: consumers with routine needs will have their first face-to-face medically appropriate service within 14 calendar days of the date of the request for care.

3. Use and Review of Standardized Functional Assessments

   For individuals with primary mental health disorders, the Customer Service Call Center will complete the initial LOCUS or CALOCUS. For individuals with primary substance abuse disorders, Customer Service Call Center will complete the ASAM. Licensed Clinical Team members will review functional assessment levels previously assigned by network providers to ensure that the service requested meets medical necessity and is consistent with the level of care recommendation.

   For non-emergency intellectual developmental disability customers are warm transferred to the Intellectual Developmental Disabilities intake line for further screening and referrals.

Callers are provided education about services available to individuals with intellectual developmental disabilities including entrance criteria for Innovations.
Standardized functional assessments to be utilized by MeckLINK Behavioral Healthcare include:

a. Mental Health: Adult-Level of Care Utilization System (LOCUS); Child- Child Adolescent Level of Care Utilization System (CALOCUS)
b. Substance Abuse: American Society for Addiction Medicine (ASAM) Placement Criteria-ASAM levels are required
c. Developmental Disabilities: NC-Supports Needs Assessment Profile (NC-SNAP)

4. Referral to Care Coordination
   The Customer Service Call Center will act as a portal of entry for referral to Care Coordination for new consumers enrolling with MeckLINK Behavioral Healthcare and for existing consumers being managed by UM who meet special health care needs as outlined in the care coordination plan. Referrals will be managed through a high risk team staffing process involving the Customer Call Center Case Coordinator, UM, identified care coordination staff and MeckLINK Senior Clinical Staff. If a consumer does not meet special health care eligibility, the Customer Call Center case coordinator will assist the enrollee in identifying appropriate services offered through the MeckLINK Behavioral Healthcare Network or other community stakeholder provider.

5. Pre-Certification for Inpatient Hospitalization and Initial Assessments
   The Customer Service Call Center Care Managers review and authorize all initial inpatient hospitalization requests for Individuals who receive either Medicaid or IPRS Funding 24 hours/7 days a week for voluntary and involuntary commitments. If a consumer cannot be admitted to a local community hospital due to acuity, The Customer Service Call Center will assist the Community Hospital in identifying an appropriate state facility. Care Managers also pre-certify all initial assessments.

6. Call Follow-Up and Disposition
   Appointments are scheduled at the end of each call through warm transfer to the provider. To the extent reasonably possible, callers are provided with a choice of at least two network providers. For all callers seeking service linkage, A Customer Service Call Center team member ensures safe disposition through follow up calls to the referred service provider to verify the consumer's arrival.

7. MeckLINK Customer Service Call Center Forms
   a. Standardized Consumer STR Interview and Registration Form
   b. MeckLINK Consumer Admission and Discharge Form

8. MeckLINK Customer Service Call Center Policies
   a. HCC 06 Screening, Triage and Referral Policy
   b. HCC 09 Provider Compliance with STR Procedures
   c. HCC 11 Developmental Disability Eligibility Reviews

SECTION XII
Service Management: Utilization Management, Medical Necessity and EPSDT

MeckLINK Behavioral Healthcare serves as an umbrella organization to arrange, authorize, and coordinate Mental Illness, Intellectual Developmental Disabilities, and/or Substance Abuse services within the network of credentialed providers and in accordance with all Federal, State, and County funding sources, benefits or requirements.

A. Service Management

The Service Management Division is staffed by a multi-disciplinary team of licensed Care Managers housed in the Customer Call Center and the Utilization Management Division. Care Managers in the UM Division are divided into two teams that review and authorize Mental Illness, Intellectual Developmental Disabilities, and/or Substance Abuse services. The two teams are led by a MH/SA UM Manager and an IDD UM Manager with operational management by the Senior Manager of Utilization Management.

B. Utilization Management

The ultimate purpose Utilization Management is to ensure that credentialed providers deliver quality individualized services in the most clinically appropriate and cost effective manner to eligible Mecklenburg County enrollees.

The purpose of UM is to assure that enrollees in Mecklenburg County receive clinically appropriate services and supports which are sufficient in scope, frequency, and duration to achieve effective outcomes.

Potential Medicaid and State-funded enrollees (IPRS) are defined as Mecklenburg County residents (children, adolescents and adults) who may be or are living with a Mental Illness, Intellectual Developmental Disabilities, and/or Substance Abuse problem or co-occurring disorders. Individuals who have private commercial insurance or who participate in another managed care organization require a denial of services from that organization to be considered for eligibility for services with MeckLINK Behavioral Healthcare.

Administrative oversight for all Service Management functions is provided by the Division Director for Service Management. The MeckLINK Behavioral Healthcare Medical Director and Clinical Director provide input and direction for all Utilization Management clinical activities and ensure the consistent application of medical necessity criteria.

C. Determination of Medical Necessity

MeckLINK Behavioral Healthcare is committed to providing clinically appropriate services. Enrollee's may enter service at any level and be moved to more or less-restrictive settings or levels of care as their changing clinical needs dictate. At any level of care, services are expected to be person centered, family focused, community based, culturally competent and take into consideration the individual's stage of readiness to change/readiness to participate in treatment. The UM staff utilize standardized, evidence based criteria in making a medical necessity determination for covered ICD 9 diagnoses.

Medically necessary treatments are:

1. Clinically appropriate for the prevention or treatment or support of the individual's diagnosis.
2. Consistent with national or evidence-based standards, Department of Health and Human Services defined standards, or verified by independent clinical experts at the time the procedures, products and the services are provided
3. Provided in the most cost effective, least restrictive environment that is consistent with good clinical standards of care
4. Not provided solely for the convenience of the member, member's family, custodian or provider
5. Not for experimental, investigational, unproven or solely cosmetic purposes
6. Furnished by, or under the supervision of, practitioners licensed under state law in the specialty for which they are providing service and in accordance with North Carolina and federal laws, rules and regulations.
7. Sufficient in amount, duration and scope to reasonably achieve their purpose
8. Reasonably related to the diagnosis for which they are prescribed regarding type, intensity and duration of service and treatment setting

Medically necessary treatments are designed to:

1. Be provided in accordance with a Person-Centered Plan or Treatment Plan
2. Conform to any Advance Medical Directives the individual has prepared
3. Respond to the unique needs of linguistic and cultural minorities and be furnished in a culturally relevant manner
4. Prevent the need for involuntary treatment or institutionalization

UM staff utilizes one or more of the following in making a medical necessity determination:

1. Clinical Coverage Policies/Service Definitions: Medical necessity criteria sets are mandated by the North Carolina Division of Medical Assistance
2. NC Division of Medical Assistance Clinical Coverage Policies 8a-8e
3. NC DHHS, Division of Mental Health, Intellectual Developmental Disabilities, and/or Substance Abuse Service Definitions, ASPM 1026 1-2003
4. B3 Medicaid Services (Respite, Peer Support and Community Guide)
5. Alternative State Service Definitions (Community Activity and Employment Transition and Hospital Discharge and Transition Services)
6. Use and Review of Standardized Functional Assessments-In order to standardize the information received from enrollees and providers related to medical necessity and appropriate level of care.

D. Early Periodic Screening Diagnosis and Treatment (EPSDT)

EPSDT services include any medical or remedial care that is medically necessary to correct or ameliorate a defect, physical or mental illness, or condition [health problem]. This means that EPSDT covers most of the treatments a recipient under 21 years of age needs to stay as healthy as possible. North Carolina Medicaid must provide and arrange for (directly or through referral to appropriate agencies, organizations, or individuals) corrective treatment as is determined by child health screening services. **"Ameliorate"** means to improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems. Even if the service will not cure the recipient's condition, it must be covered if the service is medically necessary to improve or maintain the recipient's overall health.

EPSDT Criteria: Service can only be covered under EPSDT if all criteria specified below are met;

1. EPSDT services must be coverable services within the scope of those listed in the federal law at 42 U.S.C. § 1396 d(a) [1905(a) of the Social Security Act]. For example, "rehabilitative services" are a covered EPSDT service, even if the particular rehabilitative service requested is not listed in DMA clinical policies or service definitions.
2. The service must be medically necessary to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] diagnosed by the recipient's physician, therapist, or other licensed practitioner. The requested service must be determined to be medical in nature.
3. The service must be safe.
4. The service must be effective.
5. The service must be generally recognized as an accepted method of medical practice or treatment.
6. The service must not be experimental or investigational.

Additionally, services can only be covered if they are provided by a North Carolina Medicaid Provider credentialed for the specific service type. Services can also be covered if an out-of-state provider is willing to be credentialed and an in-state provider is not available.

E. Authorization Process Resources

1. Regional Referral Form for Admission to State Psychiatric Hospital or ADATC

F. MeckLINK Benefit Plans

1. IPRS Benefit Plans

G. Utilization Management Policies

1. UM-01 Administrative Denial Policy
2. UM-02 Adolescent Transition to Adult Status
3. UM-04 Availability and Communication With UM Staff
4. UM-05 Non-Certification Determinations Policy
5. UM-06 Distribution of Medical Necessity Criteria
6. UM-07 Clinical Appeals for Non-Medicaid Services Policy
7. UM-08 Medical Necessity Exceptions
8. UM-11 Standard Timeframes Policy

9. UM-15 Intensive Care Management Policy
10. UM-16 Lack of Clinical Information Policy
11. UM-17 Retrospective and Administrative Reviews Policy
12. UM-24 Protocol for Review of Medical Care Coordination
13. UM-36 Management of the MeckLINK Behavioral Healthcare Benefit Plans
14. UM-37 Non Certification of Medicaid Service Requests
15. LME-17 Out of State Placement Policy
16. LME-34 At Risk Adult Flex Funds Policy
17. HCC-05 Clinical Decision Support Tools for MeckLINK Call Center
18. HCC-06 Screening Triage and Referral Policy
19. HCC-09 Provider Compliance with STR Requirements
20. HCC-11 Developmental Disabilities Eligibility Reviews
21. FS-04 Consumer Eligibility Policy
22. FS-11 Recoupment of CAP MR/DD Supplies
23. FS-15 Contractor Access to Provider Connect

H. Utilization Management Forms

1. Authorization Form (PDF) (Word)
2. Criterion 5
3. Discharge Event
4. Discharge Plan- Child
5. Inpatient Certificate of Need- Children Under 21
6. Non-Medicaid Appeal Request for Extension
7. Notification of Out of Community Placement
8. Out of State Placement Forms
9. PCP Form (Complete)
10. PCP Manual
11. PRTF Certificate of Need
12. Target Pop Update

SECTION XIII
Care Coordination

The primary functions of the Care Coordination Division include the following: (a) education of consumers and families about available services and supports, (b) linkage to needed evaluations, (c) development and updating of service plans (i.e., treatment planning case management), and (d) monitoring implementation of services and supports according to the plan, including both behavioral health and medical services. Duties include coordination with other MeckLINK Behavioral Healthcare Divisions and units as well as hospitals, providers, community agencies, and professionals.

The Care Coordination Division is separate from other MeckLINK Behavioral Healthcare Divisions and will not be involved in any service authorization, service management, or utilization review activities.

A. Care Coordination Functions

Per the North Carolina Innovations Technical Manual, Care Coordination "originated in the health care system where it was focused on management of chronic diseases. Care Coordinators manage consumer care across the continuum of care, throughout various care settings, and work in conjunction with the person, providers, and others to improve outcomes for the individual and make the best use of health care dollars." As such, MeckLINK Behavioral Healthcare's Care Coordination Division is not practice based (provider based) and, instead, is a managed care administrative function that relies on aggregate service utilization and demographic/diagnostic data profiles to identify Special Needs Populations. The goal is to identify at risk individuals, and proactively intervene in order to improve the status of the individual and change the pattern of resource utilization. The Care Coordinator focuses on the individual, ensuring that special needs are assessed and identified, and monitors to ensure that needed treatment is received. The Care Coordinator role serves as both a Risk Management and Quality Management monitoring function that ensures the health and safety of vulnerable individuals. Moreover, care coordinators "…have the capacity to intervene directly in access to care, continuity of care, and the assessment and treatment planning…" for identified individuals (NC Innovations Manual).

In an effort to fulfill these goals, the Care Coordination Division employs a cadre of highly trained professionals committed to promoting the most optimal outcomes for consumers. Services provided will include treatment planning case management, quality monitoring of services, discharge planning, oversight for special needs populations, and collaboration with the Mecklenburg County Community Care of North Carolina network (i.e., Community Care Partners of Greater Mecklenburg or CCPGM) to address the physical and behavioral health needs of consumers. The Division will support and encourage positive treatment outcomes through identification of individuals who may need care coordination oversight.

Targeted populations will include the following:

1. Adults with Severe and Persistent Mental Illness
2. Children with Severe Emotional Disturbance
3. Individuals with Intellectual Developmental Disabilities who are functionally eligible for ICFR-MR services, but not enrolled in ICF-MR or the Innovations Waiver
4. Women enrolled in Work First (TANF) with SA dependency diagnosis
5. Individuals with co-occurring diagnosis
6. Individuals who are IV drug or opiate users
7. Consumers slated for discharge from 24-hour care facilities
8. Consumers with two (2) or more admissions to state-operated facilities, acute inpatient or residential level of treatment within thirty (30) days
9. High risk medically compromised consumers, particularly those with co-existing major medical issues, such as diabetes or COPD that effect behavioral health treatment including individuals identified by the Community Care Partners of Greater Mecklenburg
10. Additional admission criteria will be added at the discretion of the Clinical Team to address specific needs within the community

B. Care Coordination Policies

- CARE-01 CARE Service Levels
- CARE-02 CARE Eligibility for and Referral for Care Coordination
- CARE-04 MeckLINK Behavioral Healthcare Care Coordination Roles and Responsibilities
- CARE-06 Assessment of Needs and Development of PCP
- CARE-07 CCPGM Collaboration Four Quadrant Model
- CARE-08 Care Coordination Liaisons
- CARE-09 Children Adolescent Care Coordination
- CARE-11 Termination of Care Coordination Services
- CARE-13 Participant Crises
- CARE-14 Clinical Coverage Bulletins
- CARE-15 CARE Coordination Use of Evidence Based Practices

SECTION XIV
Quality Improvement and Performance Management

A. Provider Monitoring

1. The Provider and its practitioners shall cooperate with MeckLINK Behavioral Healthcare Quality Improvement activities, such as:
    a. Credentialing
    b. Quality Improvement Projects
    c. Satisfaction Surveys
    d. NC TOPPS
    e. Incident reporting and clinical risk management
    f. Quality of Care reviews
    g. Consumer access to care assessments
    h. Implementation of best practices
    i. Medical record audits
    j. Reporting and resolution of grievances and appeals

2. Providers and their practitioners shall allow MeckLINK access to treatment records.

3. Providers shall maintain the confidentiality of MeckLINK consumer information and records.

4. Providers will follow MeckLINK Behavioral Health care and NC DHHS policies.
    a. Confidentiality Policies
        - IM-03 Confidentiality and Protection of Consumer Information
        - IM-10 Request for Data
        - IM-25 Special Protection of PHI
        - IM-28 Security or Privacy Breach of PHI
        - IM-29 Provider Responsibility for Safeguarding Records
        - IM-31 Adoption Records
    b. State Monitoring Rules (link)
    c. Monitoring Policies
        - PO-01 Administrative Contract Appeals
        - PO-03 Local Monitoring Policy
        - PO-06 Requesting Plan of Correction
        - HCC-08 Telephone Performance Monitoring
    d. Compliance Policies
        - CO-01 False Claims Act Compliance Policy
        - CO-02 Reporting and Investigating Compliance Concerns
        - CO-07 Person Centered Planning Policy
        - CO-08 Crisis Services Policy
        - HCC-09 Provider Compliance with Screening, Triage, and Referral Requirements

e. Credentialing Policies
   - CR-01 Confidentiality of Credentialing and Re-credentialing
   - CR-02 Provider Standards and Credentialing of Agency Providers
   - CR-04 Credentialing LIPs
   - CR-05 Quality of Care Review and Appeals
   - CR-06 Ongoing Monitoring of Sanctions Complaints Against LIPs
   - CR-08 Re-credentialing Licensed Independent Practitioners
   - CR-09 Results of Primary Source Verification
   - CR-10 Review of Performance Data
   - CR-11 Site Visits for LIPs
   - CR-15 Quality of Care Review, Notification of Authorities and Appeal (physicians)

f. Client Record Policies
   - HCC-04 Collection and Coordination of Consumer Data
   - CO-05 Exchange of Information for Continuity of Care Policy
   - IM- 08 Records Retention and Disposition Policy
   - IM-25 Special Protection of Protected Health Information

B. Client Rights Reporting

1. 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. Consumers may contact the MeckLINK Consumer Representative for assistance or to file a complaint.

2. Client Rights Policies
   a. CA-01 Complaint Management Policy
   b. CA-02 Consumer Choice Policy
   c. CA-03 Human Rights Policy
   d. CA-07 Referral of Complaints
3. Client Rights Handbook
   a. Rights Handbook
   b. Rights Handbook (Spanish)
4. Client Rights Forms
   a. Health Information Privacy Complaint

C. Incident Reporting

1. All incidents pertaining to MeckLINK clients shall be reported to the MeckLINK and NC DHHS as required. Incidents should be reported using the North Carolina Incident Response Improvement System (IRIS)
2. IRIS Technical Manual (Link)
3. IRIS FAQ'S (Link)

4. Incident Reporting Information
5. Consumer Safety Policies
    a. CO-06 Incident Management
    b. Provider Quarterly Incident Reporting Form
    c. http://www.ncdhhs.gov/mhddsas/LMEGovernment/IRIS/index.htm
    d. State QM 11 Quarterly Provider Incident Report

6. Levels II and III Incident Reporting Form

   The paper incident form is included only for use if NC IRIS is down and providers need to use it for timely submission. Providers will be required to submit again through IRIS when it becomes available again.

D. Person-Centered Planning

1. Person Centered Information
    a. CO-07 Person Centered Planning Policy
    b. Person Centered Plan (PCP)
    c. PCP Update/Revision Supplemental Page
    d. PCP Update/Revision Supplemental Signature Page
    e. PCP Instructional Manual

E. Clinical Outcome Measures

1. NC-TOPPS
    a. NC-TOPPS Operations Manual
    b. NC-TOPPS Quick Start Guide
    c. NC-TOPPS 2.0 FAQs
    d. NC-TOPPS 2.0 Guidelines

SECTION XV
Forensic Evaluations Unit

Pursuant to General Statute § 15A-1002 and accompanying documents, MeckLINK Behavioral Healthcare is required to assign forensic evaluators, certified by the North Carolina Forensic Services, to screen adult consumers referred by the courts. The purpose of the screening is to determine the defendant's Capacity To Proceed (CTP) to trial. As a result, the Care Coordination Division assumes responsibility for assigning court-ordered referrals to certified evaluators and oversees the process to ensure the evaluations are completed in a timely manner, and per protocol as outlined by the state. Other court-ordered assessments for adults include comprehensive clinical assessments, multidisciplinary evaluations and diagnostic assessments to address issues related to familial and/or guardianship issues.

Additionally, pursuant to N.C.G.S 7B-2502, MeckLINK Behavioral Healthcare is required to screen, assess, and evaluate adults and juveniles that are referred from juvenile or family court. Specifically, MeckLINK Behavioral Healthcare assigns referrals to trained contracted forensic evaluators to conduct a variety of forensic and court-ordered assessments and evaluations.

A. Populations targeted include the following:

1. Adults and juveniles undergoing Capacity to Proceed (CTP) evaluations
2. Adults undergoing Comprehensive Clinical Assessments
3. Juveniles undergoing:
    a. Comprehensive clinical assessment(s) to aid in dispositional hearings. Additional evaluations recommended from the CCA could include: Substance abuse assessment, Psychological Evaluation, Neuropsychological Screening, Neuropsychological Testing, or a Psychiatric evaluation.
    b. Child Sex Abuse Evaluation
    c. Evaluation for mental status at time of the alleged offense
    d. Evaluation of competency to waive Miranda rights
    e. Risk Assessment for Future Violence
    f. Sex offender and Risk of Recidivism
    g. Evaluation for transfer to adult court
4. Adults undergoing parenting capacity, custody, and other assessments to address issues related to familial and/or guardianship issues.
5. Parent or Caregiver Competency to Proceed in Civil Matters
6. Parenting Capacity evaluations in Civil Matters.

B. Key Responsibilities include the following:

1. Assigning court-ordered evaluations to credentialed forensic evaluators
2. Ensuring that evaluations are completed and submitted in a timely manner
3. Delivering records as necessary to agencies and evaluators for assignment
4. Maintaining the evaluation tracking database
5. Submitting billing to the Finance Division and preparing budget reports
6. Distributing copies of completed or approved reports to all parties specified in the court order
7. Collaborating with court officials, contracted evaluators, and other professionals
8. Provide technical assistance

9. Generating and disseminating monthly and quarterly reports according to established protocols
10. Remaining current on applicable North Carolina law and Memoranda of Understanding pertaining to court-ordered assessments

C. Timeframes for report completion:

Comprehensive Clinical Assessment **Substance Abuse Assessment**	**7-10 days** **7-10 days**
Mental Health Evaluation Subtypes: **Psychological and Emotional Functioning, Neurological Screening, Neurological Testing, Child Sexual Abuse** **Psychiatric Evaluation**	 **60 days** **30 days**
Parenting Capacity Evaluation **(based on up to 2 caregivers and 5 children)**	**90-150 days**
Custody Evaluation (based on up to 2 caregivers and 5 children)	**60-120 days**
Criminal Delinquency Evaluation Subtypes: **Adult Capacity to Proceed** **Juvenile Capacity to Proceed** **Transfer to Adult Court, Mental Status at Time of Alleged Offense, Competency to Waive Miranda Rights, Risk Assessment for Future Violence, Sexual Offender and Risk of Recidivism**	 **10-14 days** **90 days** **60 days**
Multidisciplinary	**60 days**
Other Evaluation Subtypes: **Family Systems** **Guardianship, Parent/Caregiver Competency to Proceed in Civil Matters**	 **60-120 days** **60 days**

D. Manuals/Guides

1. Evaluator Guide Table of Contents
2. Guidelines for Reimbursement
3. Instructions for Completing SRF and RFR
4. Notice of Confidentiality to Consumer
5. Request for Reimbursement
6. Service Reporting Form

E. Forms

1. Release of Information Form
2. Release of Information Form - Spanish

SECTION XVI
Links to Rules, Regulations, and Resources

The chart below serves as direction to providers for accessing pertinent rules, regulations, standards, and other information referenced in Article I, item 4 of the Procurement Contract for the Provision of Services. These rules, regulations, standards, and other information can change based on legislative action; change in federal and state policies; and state procedures.

There is a mutual responsibility for providers and MeckLINK Behavioral Healthcare to routinely check these items for updates on requirements. If a provider is uncertain how a State or Federal change will be implemented, or if MeckLINK Behavioral Healthcare has concerns about how a change will be implemented, then MeckLINK Behavioral Healthcare 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 MeckLINK Behavioral Healthcare for information.

If a provider has problems obtaining or understanding the information referenced in this section, please contact your MeckLINK Provider Relations Specialist.

REQUIREMENT	SUGGESTED CONTACTS	WEB SITE, IF AVAILABLE
APSM 30-1 (Rules for MH/IDD/SA- Core rules for services and also includes State-covered services definitions) **APSM 45-1** (Confidentiality) **APSM 45-2** (Records Management and Documentation 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/IDD/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.ncdhhs.gov/mhddsas/statspublications/Manuals/index.htm
NC Innovations Waiver **(Technical Guide version 1.0 – June 2012)** (1915(c) Home and Community Based Services Waiver)	NC Division of Medical Assistance NC Innovations Waiver 2501 Mail Service Center Raleigh, NC 27699-2501	http://www.ncdhhs.gov/dma/lme/Innovations.html http://www.ncdhhs.gov/dma/lme/Final_NC_Innovations_Manual_06252012.pdf
DMA - Waiver-related Questions		DMA.waiver@dhhs.nc.gov
Medicaid-related Documents **Medicaid Covered Service Definitions** **Medicaid Services Guidelines** **Medicaid Communiqués**	NC Division of Medical Assistance (enter name of Section) 2501 Mail Service Center Raleigh, NC 27699-2501	http://www.ncdhhs.gov/dma/medicaid/index.htm
Substance Abuse Services Cluster Requirements	DMH MH/IDD/SAS 3007 Mail Service Center, Raleigh, NC 27699-3007	http://charmeck.org/mecklenburg/county/AreaMentalHealth/ForProviders/Pages/ProviderDocuments.aspx Then scroll down to “Additional Policies”

REQUIREMENT	SUGGESTED CONTACTS	WEB SITE, IF AVAILABLE
Health Care Personnel Registry	2709 Mail Service Center, Raleigh, NC 27699 (919) 855-3968	http://ncdhhs.gov/dhsr/hcpr/index.html and www.ncnar.org
Monitoring of Providers Gold Star Process **SB 163/Session Law 2002-164- Monitoring of Providers** **House Bill 576** **Provider Performance Report (PPR)**		http://www.ncdhhs.gov/mhddsas/providers/providermonitoring/index.htm http://www.ncleg.net/Sessions/2001/Bills/Senate/PDF/S163v6.pdf http://www.ncleg.net/Sessions/2009/Bills/House/PDF/H576v5.pdf http://charmeck.org/mecklenburg/county/AreaMentalHealth/ForProviders/Pages/ProviderRatings.aspx
DHHS Disaster Preparedness, Response and Recovery Plan		http://www.ncdhhs.gov/mhddsas/services/disasterpreparedness/index.htm
Performance Agreement between DMH and Area programs		http://www.ncdhhs.gov/mhddsas/LMEGovernment/perfcontracts/index.htm
Contract between the Area Authority and the NC Division of MH/IDD/SAS – Results and information regarding Performance Measures		http://www.ncdhhs.gov/mhddsas/statspublications/Reports/DivisionInitiativeReports/pc-reports/index.html
National Provider Information Number		https://nppes.cms.hhs.gov/NPPES/StaticForward.do?forward=static.npistart
North Carolina Council of Community MH/IDD/SAS Programs		www.nc-council.org
Civil Rights Act of 1964	Library-Federal Laws	www.eeoc.gov http://www.eeoc.gov/policy/vii.html
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

REQUIREMENT	SUGGESTED CONTACTS	WEB SITE, IF AVAILABLE
General Statutes **122-C Mental Health, Substance Abuse, Developmental Disabilities Act of 1985** **Applicable sections include but are not limited to:** • **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-102 State Plan for Mental Health, Developmental Disabilities, and Substance Abuse Services; System Performance Measures** • **122C-115.4 Functions of Local Management Entities** • **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.** • **122C-170 Local Consumer and Family Advisory Committees**		http://www.ncga.state.nc.us/EnactedLegislation/Statutes/HTML/ByChapter/Chapter_122C.html
Drug Free Workplace Act of 1988 as revised	Library-Federal Laws	http://www.dol.gov/elaws/drugfree.htm

REQUIREMENT	SUGGESTED CONTACTS	WEB SITE, IF AVAILABLE
Section 503 and 504 of the Rehabilitation Act of 1973	Library-Federal Laws	http://www.dol.gov/dol/compliance/compliance-majorlaw.htm#eeo
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
• **Sub chapter I Protection and Advocacy Systems** • **Sub chapter 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 Intellectual 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
SAMHSA's National Mental Health Information Center **National Mental Health Consumers' Self-Help Clearinghouse** **SAMHSA's National Registry of Evidence-Based Programs and Practices** **NC Practice Improvement Collaborative** **NC Peer Support Specialist Program**		http://mentalhealth.samhsa.gov/ http://www.mhselfhelp.org/ http://nrepp.samhsa.gov/ http://www.ncpic.net/ http://pss-sowo.unc.edu/index.php?q=pss

Links to Cultural Competency Resources

Annie E. Casey Foundation www.aecf.org

Association of Gay and Lesbian Psychiatrist www.aglp.org

Association for Lesbian, Gay, Bisexual& Transgender Issues in Counseling www.algbtic.org/
Diversity Inc. www.diversityinc.com

Indian Country (The nation's leading American Indian news source) www.indiancountry.org

Latino Behavioral Health Institute www.lbhi.org

Medline Plus has health information in over 40 different languages www.medlineplus.gov

National Asian American Pacific Islander Mental Health Association www.naapimha.org

National Congress of American Indians www.ncai.org/

National Latino Behavioral Health Association www.nlbha.org

National NAMI www.nami.org - Has NAMI en Español, as well as the NAMI Multicultural Center Resources

National Organization of People of Color Against Suicide www.nopcas.org/

Native Web (resources for indigenous cultures around the world) www.nativeweb.org

NCLR–National Council of La RAZA (the largest Latino civil rights and advocacy organization in the US) www.nclr.org

Pan American Health Organization www.paho.org

Association of Black Psychiatrists http://www.abpsi.org/

The Black Mental Health Alliance www.blackmentalhealth.com

The Office of Ethnic Minority Affairs of the American Psychological Association http://www.apa.org/pi/oema/index.aspx

World Federation for Mental Health (making mental health a global priority) www.wfmh.com/

World Health Organization- this website can be accessed in Arabic, Chinese, English, French, Russian, and Spanish www.who.int/en/

SECTION XVII
Glossary of Terms

1915 (b)/(c) Medicaid Waiver: "refers to two sections of the Social Security Act that allow states to apply for waivers from federal Medicaid policy. The (b) Waiver allows Medicaid beneficiaries to enroll in managed care plans and allows Medicaid to limit the provider network based upon the needs of the recipients. The (c) Waiver provides home and community-based care to Medicaid beneficiaries who would otherwise be institutionalized."

Ability-to-Pay Determination: The amount a consumer is obligated to pay for services. The ability to pay is calculated based on the consumer's income, and number of dependents. The Federal Government Poverty Guidelines are used to determine the consumer's payment amount.

Abuse: Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes beneficiary practices that result in unnecessary cost to the Medicaid program. (Guidelines for Addressing Fraud and Abuse in Medicaid Managed Care, October 2000)

Access: An array of treatments, services and supports are 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. (Not to be confused with the Access Program.)

Accreditation: Certification by an external entity that an organization has met a set of standards.

ACT - Assertive Community Treatment

Action: An action is defined as an event by which MeckLINK responds to findings from a provider audit, review, investigation or report by outside investigative authorities. An action includes, but is not limited to: paybacks, plan of correction as a result of an audit and sanctions. The denial or limited authorization of a requested service, including the type or level of service; the reduction, suspension, or termination of a previously authorized service; the denial, in whole or in part, of payment for a service; the failure to provide services in a timely manner, as defined by the State; the failure of MeckLINK to act within the timeframes provided in 42 C.F.R. 438.408(b).

Adjudicate: A determination to pay or reject a claim.

Administrative Review: A review of documentation to determine whether MeckLINK Behavioral Healthcare procedures were followed, and if any additional information provided warrants a change in a previous determination.

Administrative Services: Means the services other than the direct provision of MH/IDD/SAS (including case management) to eligible or enrolled persons, necessary to manage the MH/IDD/SA system, including but not limited to: provider relations and credentialing, 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.

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.

Advanced Directive: A communication given by a competent adult which gives directions or appoints another individual to make decisions concerning a patient's care, custody or medical treatment in the event that the patient is unable to participate in medical treatment decisions.

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.
ANSI - American National Standards Institute

AOC- Administrative Office of the Courts

Appeal: 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/IDD/SA appeals panel established under NC. G.S.371.

Appellant: An individual filing an appeal.

ASAM - American Society of Addiction Medicine: 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.

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 practices. 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 Benefit Plan: The Basic Benefit package includes those services that will be made available to Medicaid-entitled individuals and, to the extent resources are available, to non-Medicaid individuals according to local business plans. These services are intended to provide brief interventions for individuals with acute needs. The Basic Benefit package is accessed through a simple referral from MeckLINK Behavioral Healthcare, through its screening, triage and referral system. Once the referral is made, there are no prior authorization requirements for these services. Referred individuals can access up to eight (8) visits for Adults ages eighteen (18) and up and twelve (12) visits for Children and Adolescents below age eighteen 18) for Non-Medicaid (State Funded) Consumers and twenty-four (24) Visits for Medicaid Consumers under the Basic Benefit package from any provider enrolled in the LME's provider network. Psychiatric services do not count against the allotted visits under the Basic Benefit.

Basic Services: Mental Illness, Intellectual Developmental Disability and/or Substance Abuse Services that is available to North Carolina residents who need them whether or not they meet criteria for target or priority populations.

Best Practices: Interventions, treatments, services or actions that have been shown by substantial research or professional consensus to generate the best outcomes or results. The terms, Evidenced-based or Research-based may also be used.

Billing Audit: An audit conducted by MeckLINK Behavioral Healthcare to assess the presence of appropriate documentation to support claims submitted for payment by MeckLINK Behavioral Healthcare

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.

Business Associate: A person or organization that performs a function or activity on behalf of a HIPAA defined covered entity, but is not part of the covered entity's work force. A business associate can also be a covered entity in its own right. See the HIPAA definition as it appears in 45 CFR 160.103.

CABHA - Critical Access Behavioral Healthcare Agency: A provider who delivers a comprehensive array of mental health and substance abuse services. This does not include intellectual developmental disability services. The role of a CABHA is to ensure that critical services are delivered by a clinically competent organization with appropriate medical oversight and the ability to deliver a robust array of services. CABHAs ensure consumer care is based upon a comprehensive clinical assessment and appropriate array of services for the population served. A CABHA is required to offer the following Core Services: Comprehensive Clinical Assessment, Medication Management and Outpatient Therapy.

CALOCUS – Child and Adolescent Level of Care Utilization System: A standardized measure of level of care needs for children and adolescents.

Care Management: A multidisciplinary, disease centered approach to managing medical care using outcome measures to identify best practices. The purpose of care management is to identify level of risk, stratify services according to risk, and prioritize recipients for services. The approach utilizes collaboration of services, systematic measurement and reporting and resource management.

CARF: Commission on Accreditation of Rehabilitation Facilities

Catchment Area: The geographic part of the State served by a specific MCO. The geographic area can be a specific county or defined grouping of counties that are available for contract award. The MCO is responsible to provide covered services to eligible residents of their area.

CDW – Client Data Warehouse: The DHHS's source of information to monitor program, clinical and demographic information on the clients served. The data is also used to respond to Departmental, Legislative and Federal reporting requirements.

CFAC - Consumer and Family Advisory Committee: A group of persons receiving services or families of persons receiving services who participate in meaningful decision making relative to local community programs. The group shall meet at least monthly in a public forum to review data, practices, policies and plans of MeckLINK and make recommendations to the Board from the consumer/family perspective.

CFR: Code of Federal Regulations

Child: 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.

Claim: An itemized statement of services, performed by a provider network member or facility, which is submitted for payment.

Claims Management: The process of receiving, reviewing, adjudicating, investigating, paying, and otherwise processing service claims submitted by network and facility providers.

Clean Claim: A clean claim is a claim that successfully passes all adjudication edits and can be processed without obtaining additional information from the provider of the services or from a third party. It does not include a claim under review for medical necessity, or a claim that is from a provider that is under investigation by a governmental agency for fraud or abuse.

Client: An individual who is admitted to or receiving public services. "Client" includes the client's personal representative or designee. The terms Consumer, Recipient, Participant, Enrollee, Individual and Patient are often used interchangeably.

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. These guidelines or Treatment Protocols are summaries of best practice research and consensus. They include professional standards for providing care based on diagnostically related groups.

CMS - Centers for Medicaid and Medicare Services: The federal agency responsible for overseeing the Medicaid and Medicare programs. Formerly, it was known as the Health Care Financing Administration, (HCFA).

COA - Council on Accreditation

Co-Morbid Condition – Co-Occurring Disorders: 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. Dual Diagnosis is also a commonly used term.

Complaint: A report of dissatisfaction with some aspect of the public MH/IDD/SA system.

Concurrent Review: A review conducted by an MCO during a course of treatment to determine whether services meet medical necessity and quality standards and whether services should continue as prescribed or should be terminated, changed or altered.

Conflict of Interest: A situation where self-interest could negatively impact the best interests of the person being served by the provider or the MCO.

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. The terms Consumer, Recipient, Participant, Enrollee, Individual and Patient are often used interchangeably.

Consumer & Family Handbook: A document developed and disseminated by the Provider according to the parameters established to inform potential, eligible and enrolled persons of their rights, responsibilities and treatment coverage.

Contract Year: Generally, defined as a period from July 1 of a calendar year through and including June 30 of the following year.

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.

Contractor: An organization or entity agreeing by signature to provide the goods and services in conformance with the stated contract requirements: NC statute, rules, federal law, and regulations.

Co-Payment: The portion of the cost of services which the enrolled person pays directly to the contractor or the subcontracted provider at the time covered services are rendered.

Corporate Compliance: The systematic local governance plan for detection of fraud and abuse as defined in the Balanced Budget Act.

Covered Services: The services identified in Attachment K which MeckLINK Behavioral Healthcare agrees to provide or arranges to provide to all enrollees.

Credentialing: The process an MCO completes to determine a providers' access for membership to the network approving their ability to provide services to consumers. This term can also refer to a peer competency-based credential such as a license for professionals.

Crisis Intervention: Unscheduled, assessment for the purpose of resolving an urgent or emergent situation requiring immediate attention. The goal is 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. Also see *Emergency Services*.

Crisis Plan: NC requires a crisis plan for consumers to promote recovery and to lessen the trauma of emergency events. A Crisis Plan is an individualized written plan developed in conjunction with consumer and treatment team. The Plan contains information to assist in deescalating a crisis as well as clear directives to the individual crisis workers or others involved. Crisis plans are developed for consumers at-risk for inpatient treatment, incarceration, or out-of-home placement.

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.

Cultural Competency: The attainment 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. This understanding of social, linguistic, ethnic, and behavioral characteristics of a community or population, gives the ability to translate systematically that knowledge into practice during the delivery of behavioral health services. Such understanding may be reflected, for example, in the ability to: identify and value differences; acknowledge the interactive dynamics of cultural differences; continuously expand cultural knowledge and resources with regard to populations served; collaborate with the community regarding service provisions and delivery; and commit to cross-cultural training of staff and develop policies to provide relevant, effective programs for the diversity of people served.

Days: Except as otherwise noted, refers to calendar days. "Working day" or "business day" means day on which DMA is officially open to conduct its affairs.

Default: The breach of conditions agreed and/or failure to perform based upon defined terms and conditions the scope of work specified.

De-institutionalization: The 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.

Denial of Services: A determination made by MeckLINK Behavioral Healthcare (in response to a Provider's request for authorization to provide in-plan services of a specific duration and scope) which: Disapproves the request completely; or Approves provision of the requested service(s), but for a lesser scope or duration than requested by the provider; (an approval of a requested services which includes a requirement for a concurrent review by MeckLINK Behavioral Healthcare during the authorized period does not constitute a denial); or Disapproves provision of the requested service(s), but approves provision of an alternative service(s).

DHHS – Department of Health and Human Services: North Carolina agency that oversees State government human services programs and activities.

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.

Disenrollment: Action taken by DMA to remove an Enrollee's name from the monthly Enrollment following DMA's determination that the Enrollee is no longer eligible for enrollment in MeckLINK Behavioral Healthcare.

Diversion: Choosing lower cost and/or less restrictive services and/or supports. An example is 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.

DJJDP - **Department Of Juvenile Justice and Delinquency Prevention**

DMA - Division of Medical Assistance

DMH/IDD/SAS – Division of Mental Health, Intellectual Developmental Disabilities and Substance Abuse Services: 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.

Domains: Major areas of concern to the NC public MH/IDD/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.

DSM IV– Diagnostic and Statistical Manual: A book, published by the American Psychiatric Association that identifies and describes MH/IDD/SA disorders, and lists specific codes for each.

DSS- Department of Social Services

Dual Diagnosis: 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.) that require specialized approaches. Co-morbid Condition and Co-occurring Disorders are also commonly used terms.

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.

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.

Emergency Medical Condition: A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy Serious impairment to bodily functions Serious dysfunction of any bodily organ or part

Emergency Services: With respect to a member, covered inpatient and outpatient services that: Are furnished by a provider that is qualified to furnish such services; and Are needed to evaluate or stabilize an emergency medical condition as defined above.

Emergent Need (Mental Health): A life threatening condition in which a person is suicidal, homicidal, actively psychotic, displaying disorganized thinking or reporting hallucinations and delusions that may result in harm to self or harm to others, and/or displaying vegetative signs and is unable to care for self.

Emergent Need (Substance Abuse): A life threatening condition in which the person is by virtue of their use of alcohol or other drugs, suicidal, homicidal, actively psychotic, displaying disorganized thinking or reporting hallucinations and delusions which may result in self-harm or harm to others, and/or is unable to adequately care for self without supervision due to the effects of chronic substance abuse or dependence.

Enhanced Benefit Plan: Includes those services, which will be made available to Medicaid- entitled individuals and non-Medicaid individuals meeting priority population criteria. Enhanced Benefit services are accessed through a person-centered–planning process. Enhanced Benefit services are intended to provide a range of services and supports, which are more appropriate for individuals seeking to recover from severe forms of mental illness and substance abuse and with more complex service and support needs as identified in the person centered planning process.

Enrollees: A Medicaid recipient that is currently enrolled with MeckLINK Behavioral Healthcare. The terms Consumer, Recipient, Participant, Enrollee, Individual and Patient are often used interchangeably.

Enrollment Period: The time span during which a recipient is enrolled with a MeckLINK Behavioral Healthcare.

Enrollment: Action taken by the DMA to add a Medicaid recipient's name to the monthly Enrollment Report following the receipt and approval by DMA of Medicaid Eligibility for a person living in the defined catchment area.

Early and Periodic Screening, Diagnostic and Treatment Services - EPSDT: 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/IDD/SA component of the EPSDT diagnostic and treatment services for Title XIX members under age 21 years are covered by this contract.

Expanded Services: Services included in Covered Services, which are in addition to the minimum coverage required by DMA and which MeckLINK Behavioral Healthcare agrees to provide throughout the term of this Contract in accordance with the standards and requirements set forth in this Contract.

Facility: As defined in 122-C subsection 14, "Facility" means any person at one location whose primary purpose is to provide services for the care, treatment, habilitation, or rehabilitation of the mentally ill, the developmentally disabled, or substance abusers, and includes:

An *"area facility"*, which is a facility that is operated by or under contract with the area authority or county program. For the purposes of this sub paragraph, a contract is a contract, memorandum of understanding, or other written agreement whereby the facility agrees to provide services to one or more clients of the area authority or county program. Area facilities may also be licensable facilities in accordance with Article 2 of this Chapter. A State facility is not an area facility.

A "*licensable facility*", which is a facility, that provides services for one or more minors or for two or more adults. When the services offered are provided to individuals who are mentally ill or intellectual developmentally disabled, these services shall be day services offered to the same individual for a period of three hours or more during a 24-hour period, or residential services provided for 24 consecutive hours or more. When the services offered are provided to individuals who are substance abusers, these services shall include all outpatient services, day services offered to the same individual for a period of three hours or more during a 24-hour period, or residential services provided for 24 consecutive hours or more. Facilities for individuals who are substance abusers include chemical dependency facilities.

A "*private facility*", which is a facility that is either a licensable facility or a special unit of a general hospital or a part of either in which the specific service provided is not covered under the terms of a contract with an area authority. The psychiatric service of the University of North Carolina Hospitals at Chapel Hill.

A "*residential facility"*, which is a 24-hour facility that is not a hospital, including a group home.

A "*state facility*", which is a facility that is operated by the Secretary.

A "*24-hour facility*", which is a facility that provides a structured living environment and services for a period of 24 consecutive hours or more and includes hospitals that are facilities under this Chapter.

A "*Veterans Administration facility*" or part there of that provides services for the care, treatment, habilitation, or rehabilitation of the Mental Ill, Intellectual Developmental Disabled, and/or Substance Abusers.

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 payment methodology for health care that associates a unit of service with a specific reimbursement amount. 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

Fidelity: Adheres to the guidelines as specified in the evidenced based best practice.

Financial Audit: Audit generally performed by a CPA in accordance with Generally Accepted Accounting Principles to obtain reasonable assurance about whether the general purpose financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosers in the financial statements. Audits also include assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall general purpose financial statement presentation.

First Responder: A functional First Responder system includes the following:

- A 911 prompt for medical crisis on their voicemail system.
- A prompt that provides a phone or pager number for assistance with “urgent" or "crisis" needs that cannot wait until the next business day (this number should connect to a person and not another telephone number or voicemail).
- If crisis number contacts a pager, the message explains briefly what the caller will hear and how to respond.
- If the caller does not reach a live person, the voicemail message gives the caller a wait time of no more than 15 minutes to expect a return call. If the caller does not reach a live person, the call is returned within 15 minutes.

Fiscal Agent: An agency that processes and audits provider claims for payment and performs certain other related functions as an agent of DMA and DMH.

Fiscal Audit: Audit performed by the Financial Department of the LME which includes a review of the Contractor’s evaluation of client’s income, client’s determined ability to pay, third party insurance verification, first and third party billing, receipts and denials. A review of COB information will also be conducted to verify support of claimed amounts submitted to MeckLINK.

Forensic: This term is a synonym for LEGAL.

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

Fraud: An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law. (Guidelines for Addressing Fraud and Abuse in Medicaid Managed Care, October 2000)

Functional Outcomes: The extent to which individuals receiving services and supports reach their goals. These outcomes generate from Domains 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

GAF- Global Assessment of Functioning

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 and Appeal Procedure: The written procedures pursuant to which Enrollees may express dissatisfaction with the provision of services by MeckLINK Behavioral Healthcare and the methods for resolution of Enrollee grievances and appeals by MeckLINK Behavioral Healthcare.

Grievance: An expression of dissatisfaction by or on behalf of an Enrollee about any matter other than an action, as "action" is defined in this section. The term is also used to refer to the overall system that includes grievances and appeals handled at the MeckLINK Behavioral Healthcare level and access to the State fair hearing process. (Possible subjects for grievances include, but are not limited to; the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the Enrollee's rights).

Good Standing: Means the provider has a history of compliance with DMA Clinical Policy specific to service delivery and does not have an open Plan Of Correction (POC) with the LME. A POC must be timely submitted, approved, and implemented before the POC action can be closed. A POC is fully implemented when the POC is being followed and all out of compliance findings have been minimized or eliminated as determined by the LME in a maximum of two follow-up reviews. The POC action is closed when the provider receives the official notification from the LME stating the action is closed.

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.

Healthcare Coordination: Working with a participants' Primary Care Physician to coordinate behavioral healthcare services.

HEDIS- Health Plan Employer Data and Information Set: is a set of standardized performance measures designed to reliably compare the performance of managed health care plans.

Hearing: A formal proceeding, before an Office of Administrative Hearing Law Judge, in which parties affected by an action, or an intended action of DMA are allowed to present testimony, documentary evidence and argument as to why such action should or should not be taken.

HIPAA- Health Insurance Portability and Accountability Act: 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.

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.

IBNR- Incurred But Not Reported: 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.

IDD- Intellectual and Developmental Disabilities

IDEA- Individuals with Disabilities Education Act: A federal law (PL 99-457) which requires special services for children with special needs from birth to age twenty-one (21) years.

Incident: An unusual occurrence as defined in APSM 30-1. Incidents are reported as Level I, II, or III as defined in APSM 30-1.

Innovations Waiver: The Section 1915(c) Home and Community Based Services Waiver that operates in the geographic area covered by this Contract. The Innovations Waiver replaces the Community Alternatives Program for Persons with Mental Retardation and Developmental Disabilities (CAP-MR/DD) in these counties.

In-Plan Services: Services which are included in the behavioral health capitation rate and are the payment responsibility of MeckLINK Behavioral Healthcare.

IMD- Institute for Mental Disease: IMDs are hospitals such as the State Facilities because they are more than 16 beds and are not part of a general hospital.

Intellectual 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.

IPRS – Integrated Payment and Reporting System: 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/IDD/SAS and Medicaid claims.

IRIS - Incident Response Improvement System: An electronic system of The Department of Health and Human Services (DHHS), 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/or substance abuse services (MH/IDD/SAS). Providers of publicly funded services licensed under NC General Statutes 122C (Category A providers), except hospitals, and providers of publicly funded non-licensed periodic or community-based MH/IDD/SA services (Category B providers), are required to report these incidents.

JCAHO – Joint Commission on Accreditation of Healthcare Organizations: An 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.

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

LME - Local Management Entity: A local political subdivision of the state of North Carolina as established under General Statute 122C with the purpose of ensuring the provision of services to individuals with mental health, developmental disabilities, and substance abuse needs. The LME is an administrative agency that plans, develops, implements and monitors services within a specified geographic area, and must develop of a full range of services and/or supports for both insured and uninsured individuals. Each LME operating as an MCO receives from Medicaid a capitation rate based on historical service utilization patterns. The functions of an MCO include development of a provider network comprised of the most qualified providers, management of the network, authorization of services, coordination of care for individuals with the highest needs, and reimbursement of approved services.

LOC – Level of Care: 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.
Local Business Plan: In the reformed MH/IDD/SA system, a comprehensive plan required of local management entities for mental health, developmental disabilities and substance abuse services in a certain geographical area.

LOCUS - Level of Care Utilization System: A standardized tool for measuring the level of care needs for adult consumers.

LOS - Length of Stay: The amount of time that a person remains in a service program, including hospitals, expressed in days.

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.

Material Change: A material change in any written instrument is one which changes its legal meaning and effect.

MCO– Managed Care Organization: A Local Management Entity using 1915 (b) and 1915 (c) Medicaid Waivers to serve those who are eligible for Medicaid. An umbrella term for health plans that provide health care in return for a predetermined monthly fee; coordinating care through a defined network of providers, physicians and hospitals.

Medicaid for Infants and Children (MIC): A program for medical assistance for children under the age of nineteen (19) whose countable income falls under a specific percentage of the Federal Poverty Limit and who are not already eligible for Medicaid in another category.

Medicaid for Pregnant Women (MPW): A program for medical assistance for pregnant women whose income falls under a specified percentage of the Federal Poverty Limit and who are not already eligible in another category.

Medicaid Identification (MID) Card: The Medical Assistance Eligibility Certification card issued annually by DMA to Medicaid Recipients. The card is gray color and is mailed to the recipient at the time of approval for Medicaid. Thereafter a card is mailed every 12 months from the last issuance date if the customer remains eligible.

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 Assistance (Medicaid) Program: DMA’s program to provide medical assistance to eligible citizens of the State of North Carolina, established pursuant to Chapter 58, Articles 67 and 68 of the North Carolina General Statutes and Title XIX of the Social Security Act, 42 U.S.C. 1396 et. seq.

Medical Director: A Board Certified Psychiatrist responsible for establishing and overseeing medical policy throughout the system, under the terms of this contract.

Medical Record: A single complete record, maintained by the Provider of services, which documents all of the treatment plans and behavioral health services received by the Consumer.

Medically Necessary Treatment: Medically necessary treatment means those procedures, products and services that are provided to Medicaid recipients (excluding Qualified Medicare Beneficiaries) that are: Necessary and appropriate for the prevention, diagnosis, palliative, curative, or restorative treatment of a mental health or substance abuse condition consistent with Medicaid policies and National or evidence based standards, North Carolina Department of Health and Human Services defined standards, or verified by independent clinical experts at the time the procedures, products and the services are provided in the most cost effective, least restrictive environment that is consistent with clinical standards of care not provided solely for the convenience of the recipient, recipient's family, custodian or 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 Title 42 of the Code of Federal Regulations, the Medicaid State Plan, the North Carolina Administrative Code, Medicaid medical 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 within the scope of the above guidelines, medically necessary treatment shall be designed to: be provided in accordance with a person centered service plan which is based upon a comprehensive assessment, and developed in partnership with the individual (or in the case of a child, the child and the child's family or legal guardian) and the community team conform with any advanced medical directive the individual has prepared respond to the unique needs of linguistic and cultural minorities and furnished in a culturally relevant manner prevent the need for involuntary treatment or institutionalization

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

MH- Mental Health

MIS- Management Information System

MMIS - Medicaid Management Information System: The mechanized claims processing and information retrieval system used by state Medicaid agencies and required by federal law.

Monitoring: MeckLINK Behavioral Healthcare's Provider Operations staff shall monitor the provision of public services to include Category A,B, C and D providers as applicable in its catchment area per 10A NCAC 27 G .0600 through a variety of monitoring activities.
The frequency and extent of monitoring will vary depending on the following factors:

- Provider incident reporting as required in 10A NCAC 27 G.0603, .0604 and .0606 and responses to incidents when assistance is requested by with Clinical Risk Manager.
- Provider complaints and responses to complaints when assistance is requested by the Consumer Representative or when reported to the Regulatory Compliance Analyst directly by community entities in accordance with 10A NCAC 27G .0606.
- Routine monitoring schedule that occurs according to provider performance via use of the Division of Medical Assistance (DMA) standardized Gold Star Rating and Monitoring system. The Gold Star system rates providers in Routine, Preferred, Exceptional and Gold Star categories.

MST- Multi-Systemic Therapy

Natural and Community Supports: Places, systems and people who are part of our community lives that when accessed, can become support systems that optimize functioning.

NC Innovations Waiver: A 1915(c) Home and Community Based Wavier for Developmental Disabilities. This is a waiver of institutional care; Funds that could be used to serve a person in an ICF-MR facility can be used to serve people in the community.

NC MH/IDD/SAS Health Plan: A 1915(B) Medicaid Managed Care Waiver for Mental Health and Substance Abuse allowing for a waiver of freedom of choice of providers so that the LME can determine the size and scope of the provider network. This also allows for use of Medicaid funds for alternative services.

NCQA- National Committee for Quality Assurance: An independent, 501(c)(3) non-profit organization whose mission is to improve patient care quality and health plan performance in partnership with system management plans, purchasers, consumers, and the public sector. NCQA uses the accreditation process (a rigorous on-site review of key clinical and administrative processes); through the Health Plan Employer Data and Information Set (HEIDAS®). The HEIDAS is a tool used to measure performance in key areas; and through a comprehensive member satisfaction survey.

NC-SNAP – North Carolina Support Needs Assessment Profile: An assessment instrument used to determine the care or supports needed by a person with developmental disabilities

NC-Topps – North Carolina Treatment Outcomes and Program Performance System: The program by which NC DMH/IDD/SAS measures outcomes and performance.

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.

Network Provider: A provider that has been enrolled, credentialed, and accredited with an MCO and has a written agreement to provide behavioral health services to consumers.

No Reject: Provider must have a "no reject" policy. Providers must agree to accept referrals for all enrollees meeting criteria for services they provide. Provider capacity to meet individual referral needs will be negotiated between the LME and the provider.

NPDB – National Practitioner Data Bank: 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.

Operations Manual: A document attached to a contract for the purpose of explaining how to work with the local system, the requirements for service delivery, authorization, claims submission, etc.

Out-of Area Provider: A contracted Agency or Licensed Independent Practitioner, who provides services to a Consumer outside the MeckLINK catchment area as per Policy and Procedure.

Out-of-Network Provider: Any person or entity providing services that does not have a written provider agreement with MeckLINK Behavioral Healthcare and is therefore not included or identified as being in MeckLINK Behavioral Healthcare's Provider Network.

Out-of-Plan Services: Services which MeckLINK Behavioral Healthcare is not required to provide. These services are covered by NC Medicaid and are reimbursed on a fee-for-service basis.

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

PCP- Person Centered Plan or Primary Care Physician

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: 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.

PIHP- Prepaid Inpatient Health Plan: Ex: MeckLINK Behavioral Healthcare; An entity that provides medical services to Enrollees under contract with the State agency, and on the basis of prepaid capitation payments, or other payment arrangements that do not use State plan payment rates; provides arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services for its Enrollees; and does not have a comprehensive risk contract.

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.

Potential Enrollee: A Medicaid recipient who is subject to mandatory enrollment.

PP- Primary Provider

PPC - Patient Placement Criteria: 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.

Pre Authorization – also called Prior Authorization: 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.

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.

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.

Promising Practices: Interventions, treatments, services or actions that have not been fully shown by substantial research or professional consensus enough to generate the term Best Practice.

Prompt Services: Services provided when needed. For target or priority populations, routine appointments within 14 calendar days, initial hospital discharge visits within 3 days, urgent visits within 2 days, emergent visits immediately and no later than 24 hours.

PHI- Protected Health Information: Any written, spoken or read Information transmitted by a covered entity that can be identified as belonging to an individual. Also includes information when it takes any other form.

Provider Network: The agencies, professional groups, or individual professionals under contract to MeckLINK Behavioral Healthcare that meet MeckLINK Behavioral Healthcare standards and that provide authorized Covered Services to eligible and enrolled persons.

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.

Provider: In this contract, a person or an agency that provides MH/IDD/SA services, treatment, and supports under a subcontract to MeckLINK Behavioral Healthcare.

PSR- Psychosocial Rehabilitation

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: A process which involves periodic monitoring of compliance with standards.

QHP- Qualified Health Plan

QI - Quality Improvement: 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.

QIC- Quality Improvement Committee

QIP- Quality Improvement Plan

QM- Quality Management: The framework for assessing and improving services and supports, operations, and financial performance. Processes include Quality Assurance and Quality Improvement.

QPN-Qualified Provider Network: The group of subcontractors contracted by MeckLINK Behavioral Healthcare to provide supports and services to persons for whom MeckLINK Behavioral Healthcare authorizes care.

Quality Management Committee: A cross system group of stakeholders including MeckLINK Behavioral Healthcare providers, consumers, and family members that reviews data and trends to make recommendations for continuous improvement in the system of care and supports.

Re-authorization: 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.

Recipient: An Enrollee who is receiving services. The terms Consumer, Recipient, Participant, Enrollee, Individual and Patient are often used interchangeably.

Reconsideration Review: An informal hearing before a DMA Hearing Officer and Medical Policy Director wherein an Enrollee, affected by an action or an intended action by MeckLINK Behavioral Healthcare, shall be allowed to present and discuss information as to why such action should or should not be taken, and described more specifically in NCAC T10: 22H (for s) and NCAC T10: 22J (for MeckLINK Behavioral Healthcare). The decision of the Hearing Officer is subject to appeal through the Office of Administrative Hearings (OAH).

Recovering Staff: A person with or without an educational degree, employed as a counselor in recovery working in the substance abuse treatment field.

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.

Re-Credentialing: The review process to determine if a provider continues to meet the criteria for inclusion as a MeckLINK Behavioral Healthcare network provider.

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.

Responsible Clinician: An assigned professional deemed competent and credentialed to serve as a fixed point of accountability for the consumer's PCP, monitoring and outreach.

Retrospective Authorization: authorization to provide services after the services have been delivered.

Revenues: Money earned through reimbursements paid for covered services or from other local sources, Grants, etc.

Risk Contract: A contract under which MeckLINK Behavioral Healthcare: 1) assumes risk for the cost of the services covered under the contract; and 2) incurs loss if the cost of furnishing the services exceeds the payments under the contract. This contract is a risk contract because MeckLINK Behavioral Healthcare assumes the risk that the cost of providing Covered Services to Enrollees may exceed the capitation rate paid by DMA.

Routine Need- Mental Health: A condition in which the person describes signs and symptoms which are resulting in impairment and functioning of life tasks; impact the person's ability to participate in daily living; and/or have markedly decreased the person's quality of life.

Routine Need – Substance Abuse: A condition in which the person describes signs and symptoms consequent to substance use resulting in a level of impairment which can likely be diagnosed as a substance use disorder according to the current version of the Diagnostic and Statistical Manual.

SA- 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.

SAMHSA – The Substance Abuse and Mental Health Administration of the Federal Government: 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.

SAPT- Substance Abuse Prevention and Treatment

SAPTBG– Substance Abuse Prevention and Treatment Block Grant: A federal program to provide funds to States to enable them to provide substance abuse services.

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.

SED – Seriously Emotionally Disturbed: 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. Age seventeen (17) or under Mental, behavioral, or emotional disturbance severe enough to substantially interfere with or limit the minor's role or function in family, school, or community activities Global Assessment Scale (GAS) score less than sixty (60)

Self-Determination: The right to and process of making decisions about one's own life.

Sentinel Event: 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. Other terms used are Critical Incident, Unusual Incident, etc.

Service Location: Any location at which a consumer may obtain any covered service from a Network provider.

Service Management Record: A record of Enrollee demographics, authorizations, referrals, actions and services billed by Network Providers.

Service Management: An administrative function that includes Utilization Management and Care Coordination 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.

Site: The location where a service occurs, records are kept or supervision occurs.

SMI- Seriously Mentally Ill: Refers to adults with a mental illness or disorder that is described in the Diagnostic and Statistical Manual of Mental Disorders, 4th Edition (DSM IV), 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.

SPMI – Severely and Persistently Mentally Ill: 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.

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/IDD/SA services provided across the State.

State Plan (Medicaid): The written agreements between the State of NC and CMS which describe how the NC DMH/IDD/SAS programs meet all CMS requirements for participation in the Medicaid program and the Children's Health Insurance Program.

State Plan: Annual (each fiscal year) updated comprehensive DMH/IDD/SAS systems reform plan derived from the systems reform statute and titled "Blueprint for Change".

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 (DHHS).

State or Local Consumer Advocate: The individual carrying out the duties of the State or Local Consumer Advocacy Program Office.

State: The state of North Carolina

Subcontract: An agreement which is entered into by MeckLINK Behavioral Healthcare for the performance of its administrative functions and for the provision of covered services to Enrollees and for the following administrative functions: Information Technology/System; Claims Processing; Customer Service; Provider Enrollment; Credentialing and Monitoring; Professional Consultation and Peer Review.

Subcontractor: Any person or entity which has entered into a subcontract with MeckLINK Behavioral Healthcare.

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.

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 Populations 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.

Third-Party Billing: Services billed to an insurance company, Medicare or another agency.

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: 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.

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.

UR - Utilization Review: 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.

URAC: A non-profit organization that promotes continuous improvement in the quality and efficiency of health care management through processes of accreditation, education and measurement.

Urgent Need (Mental Health): A condition in which a person is not actively suicidal or homicidal; denies having a plan, means or intent for suicide or homicide but expresses feelings of hopelessness, helplessness or rage; has potential to become actively suicidal or homicidal without immediate intervention; displays a condition which could rapidly deteriorate without immediate intervention; and/or without diversion and intervention will progress to the need for emergent services and care.

Urgent Need (Substance Abuse): A condition in which the person is not imminently at risk of harm to self or others or unable to adequately care for self, but by virtue of their substance use is in need of prompt assistance to avoid further deterioration in the person's condition which could require emergency assistance.

Utilization: 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.

WFFA- Work First Family Assistance