



North Carolina Department of Health and Human Services

Beverly Eaves Perdue, Governor

Lanier M. Cansler, Secretary

Division of Mental Health, Developmental Disabilities and Substance Abuse Services

3001 Mail Service Center
Raleigh, North Carolina 27699-3001
Tel 919-733-7011 • Fax 919-508-0951
Leza Wainwright, Director

Division of Medical Assistance


2501 Mail Service Center
Raleigh, North Carolina 27699-2501
Tel 919-855-4100 • Fax 919-733-6608
Craig L. Gray, MD, MBA, JD, Director

March 1, 2010

MEMORANDUM

TO: Legislative Oversight Committee Members
Local CFAC Chairs
NC Council of Community Programs
County Managers
State Facility Directors
LME Board Chairs
Advocacy Organizations
MH/DD/SAS Stakeholder Organizations

Commission for MH/DD/SAS
State CFAC
NC Assoc. of County Commissioners
County Board Chairs
LME Directors
DHHS Division Directors
Provider Organizations
NC Assoc. of County DSS Directors

FROM: Dr. Craig L. Gray
Leza Wainwright 

SUBJECT: Implementation Update #70
Suspension of Mandatory Cost Reporting
CABHA Update
Impact of Merger & Acquisitions on
Enrollment/Accreditation/Endorsement
PSR Service Notes
Day Treatment Endorsement Checksheet
MOA for Child & Adolescent Day Treatment

New CTCM Form for MR/DD Submissions to VO
Policy Changes for Case Management
Extension for Provisionally Licensed Billing
DMA Program Integrity Contract with PCG
Payment Error Rate Measurement in NC
Medicaid Provider Payment Suspension
Census 2010

Suspension of Mandatory Cost Reporting for Rate Adjustments

The Department of Health and Human Services (DHHS) recognizes that the unprecedented Medicaid budget reductions in state fiscal year 2010 have impacted both providers and recipients. In order to remove some of the administrative burden and cost to providers, the Division of Medical Assistance and the DHHS Controller's Office are suspending the requirement for mandatory cost reporting of Medicaid costs for cost reports due after December 31, 2009 for the following provider groups:

- CAP MR/DD Providers
- Substance Abuse (SA) & Personal Care Service (PCS) Adult Care Home Providers
- PCS – Community Based Providers
- Enhanced Mental Health Providers
- Residential Treatment Providers

The Division of Medical Assistance (DMA) is not planning rate adjustments based on cost during this period of suspension. Should it become necessary to determine reasonable costs during the suspension period, DMA will utilize its existing cost report database and cost trending factors.

Any outstanding cost reports from previous cost report periods are due and must be filed. Outstanding issues resulting from a previously filed cost report must also be resolved.

This suspension shall remain in effect until rescinded by the Secretary of DHHS. If you have specific questions please contact the following individuals:

- CAP MR/DD Providers and Residential Treatment Providers – Paul Cole at 919-855-3685 or Mishawn Davis at 919-647-8179.
- SA & PCS - Adult Care Home Providers – Paul Cole at 919-855-3685 or Elizabeth Grady at 919-855-4207.
- PCS - Community Based Providers – Roxanne Krotoszynski at 919-855-4216.
- Enhanced Mental Health Providers – Paul Cole at 919-855-3685 or Christal Kelly at 919-647-8178. The suspension also includes those CAP MR/DD and Mental Health Residential Treatment providers who also provide enhanced mental health services.

For all cost reports due prior to December 31, 2009, the Division of Medical Assistance's policies and rules for timely submission will continue to be in effect.

Providers should continue to record their accounting transactions in accordance with the approved chart of accounts and cost allocation principles to ensure that when the suspension is rescinded, providers will be able to complete and file cost reports within the prescribed timeframe.

We recognize the financial hardships of our provider network and hope that this reduction of administrative cost will assist providers as we work our way through these difficult economic times.

Critical Access Behavioral Health Agency Update

CMS Approval of Critical Access Behavioral Health Agencies in NC Medicaid State Plan

The Centers for Medicare and Medicaid Services (CMS) have approved a State Plan Amendment (SPA) that will allow only Critical Access Behavioral Health Agencies (CABHA) to provide Intensive In-Home Services (IIH), Community Support Team (CST), and Child and Adolescent Day Treatment services effective July 1, 2010.

Updated Letter of Attestation

An updated Letter of Attestation for CABHA certification has been placed on the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS) webpage:

<http://www.ncdhhs.gov/mhddsas/cabha/index.htm>. The letter has been revised to include the following additional information:

- Agency site addresses and endorsing local management entities (LME) for all Medicaid provider numbers.
- Clarification regarding the inclusion of the service continuum in the written explanation of the management and clinical structure of the organization.
- Identify the LME(s) where the continuum of services for the certified CABHA site are located. Services within a continuum are required to be within a 35 mile radius of the site where the core services are provided as referenced in the Centers for Medicare and Medicaid 42 CFR Ch. IV (10-1-09 Edition) § 413.65.
- Identification of the two additional services to be considered as part of the continuum if more than two services are provided by the agency.

Please note that any Letters of Attestation postmarked after the date of this Implementation Update must utilize the updated letter. In addition, due to the overwhelming interest in CABHA it is no longer necessary for providers to submit Letters of Intent; in order to initiate the certification process, providers must submit Letters of Attestation and supporting documentation.

Continuum of Care

Critical Access Behavioral Health Care Agencies are required to operate and describe a continuum of care for a selected age/disability group. This description should include the core services and at least two enhanced services. The description should describe the proposed continuum of care indicating the required competencies and professional qualifications for each level of care (the core plus enhanced services) for the selected population. To be specific each CABHA will describe the following services as a continuum: comprehensive assessment, outpatient treatment, medication management, and two enhanced services for an age/disability group.

The continuum describes treatments as a series of levels of care. The levels are expressed in graduations of intensity within and between levels of care. Levels of care represent intensities of services along the continuum, each of which may be provided in a variety of program types. The continuum should inform the transition of individuals with substance use

and/or mental health problems away from fixed program-driven treatment to assessment-based, clinically driven, person centered treatment. A typical assignment of intensity levels begins with the least intensive professional service available to the individual and might be exemplified as early intervention services followed by outpatient services, then more intensive outpatient services, followed by residential levels of care and culminating with inpatient levels of care. The continuum of care must be flexible enough in its application to allow for stepping up or down in intensities of services based on the consumer's process of recovery.

Treatment should be tailored to the needs of the individual and guided by an individualized person centered plan that is developed in consultation with the consumer. The plan should be written to facilitate measurement of recovery. The length of service at a particular level of care in a continuum should be linked directly to the consumer's response to treatment. The resolution of problems at any level of care determines when the consumer can be treated safely at a different level of care or discharged from treatment.

The levels of care in a continuum are designed to treat the individual's level of clinical severity and to help the individual achieve permanent change in his or her mental functioning and/or alcohol and drug using behavior. Assessment considerations for determining appropriate levels of care should include assessments of risk to health and safety, other chronic health conditions and/or cognitive conditions. The assessment would then be matched with necessary medications and that would be matched to appropriate outpatient strategies or enhanced service levels of care. It is important to note that in assessing co-occurring disorders, a mental health or substance related disorder should be considered secondary only if it shows improvement as a result of stabilization in the other disorder. Effective continuums also include relapse services and continued care levels.

CABHA Medical Director Exception Process

Implementation Update #68 defines other categories of physicians (besides psychiatrists) who could be approved as Medical Directors for CABHAs. These other physicians require specific approval from the Secretary of the Department of Health and Human Services; this update details the exception process that needs to be followed. The other categories include those physicians who are board-certified or board-eligible in:

- general family practice, or
- internal medicine, or
- pediatrics; and
- with two or more years of direct service experience diagnosing, treating, and evaluating the effectiveness of treatment of the population to be served by the CABHA.
- Consideration will also be given to physicians with these credentials who have received additional training or certification related to treating the populations to be served and those who have prior experience as a medical director for a mental health and/or substance abuse provider organization.

Agencies wishing to request an exception under this policy should submit the following with their attestation packet regarding their particular physician:

- Curriculum vitae
- Description of the scope of work and population served in the CABHA
- Other information which may include: additional educational experience in the field; academic work (papers, presentations, publications, etc.)
- Statement of supervisory consultation/ongoing mentoring

If sufficient information is provided to support the exception, the request will be submitted to a committee of DHHS representatives. This committee will then review the information and make a recommendation to the Secretary (or his designee) regarding whether to approve/not approve the exception to the medical director requirement. The decision regarding the exception will be completed as part of the desk review process.

In accordance with N.C.G.S. §150B-23(f), provider's may appeal the decision to the Office of Administrative Hearings within sixty (60) days of the date of notification of the decision. The procedure to file an appeal and the required forms may be obtained from <http://www.ncoah.com/hearings/>.

CABHA Transition for IHH, CST, and Day Treatment

Provider agencies that are interested in achieving CABHA status by July 1, 2010 in order to provide IHH, CST, and/or Day Treatment services must submit a Letter of Attestation to Contact.dmh.lme@dhhs.nc.gov prior to April 1, 2010. The submission of the attestation letter before this date will ensure that the required reviews/certification will be completed within the remaining three months. In addition, this schedule will allow LMEs to assist in the transition of consumers from those agencies who are not certified as CABHA prior to the July 1, 2010 deadline. Providers of these three services that do not submit letters of attestation for CABHA certification by April 1, 2010 must assist the LME in planning and implementing a transition plan for consumers served by the agency.

The April 1 date does not impact providers who are applying for CABHA certification and do not provide IHH, CST, or Day Treatment.

CABHA Certification after July 1, 2010

We have received questions regarding how a new provider could become a Critical Access Behavioral Health Agency (CABHA), especially after July 1, 2010 when endorsement for Community Support Team, Intensive In-Home and Day Treatment will be limited to CABHAs. The steps for becoming a CABHA under those circumstances are outlined below:

1. Create a company that provides a MH/ SA service(s) not subject to CABHA requirements.
2. Become endorsed by the LME, if required, to deliver that service(s).
3. Achieve three year national accreditation for that service(s).
4. Hire, if not already employed or contracted, the physician (half-time or full-time), clinical director, and quality improvement/training director. Individuals must be employed for 60 days prior to submission of an attestation letter for CABHA application.
5. Submit a letter of attestation for CABHA application, indicating if endorsement is being sought for Community Support Team, Day Treatment or Intensive In-Home to create the necessary continuum.
6. Assuming letter of attestation passes the desk review, LMEs will perform endorsement review for other services requested as part of LME verification of the CABHA application.
7. Assuming LME review and endorsement meet requirements, complete CABHA interview process.
8. Enroll the provider as a CABHA if the provider meets all criteria.
9. Apply for endorsement for case management and, if desired, peer support.

CABHA Medicaid Provider Enrollment

Providers who have achieved certification as a Critical Access Behavioral Health Agency will need to complete a Medicaid Provider Enrollment Application to obtain a Medicaid provider billing number.

(<http://www.nctracks.nc.gov/provider/providerEnrollment/>) The new billing number will be used by the CABHA in order to bill for services rendered by both the direct-enrolled individuals and by group service providers certified under the CABHA. Therefore, the CABHA number will be the “billing number” for reimbursement for the services required to be provided by a CABHA. These services include the core services (Comprehensive Clinical Assessment, Medication Management, and Outpatient Therapy services); as well as, Community Support Team, Intensive In-Home and Day Treatment and/or others designated to be provided by the CABHA. After July 1, Community Support Team, Intensive In-Home and Day Treatment will be reimbursed only to the CABHA billing provider number. Upon approval by CMS, Peer Support and Mental Health/Substance Abuse Targeted Case Management may be provided only by the CABHA and reimbursed only through the CABHA billing number. These services will need site specific endorsement and provider numbers that will be the “attending provider number” **on the claim** for reimbursement.

Additional information about Medicaid enrollment of CABHA providers will be provided within the next several weeks.

Policy Guidance on the Notification and Impact of Mergers and Acquisitions on Provider Medicaid Enrollment, National Accreditation, and Endorsement

When there is a reorganization, merger, or change of ownership, the provider has the responsibility to inform DMA, DMH/DD/SAS, the LME, and the provider’s national accrediting body of such change.

Policy for Notification of Change in Ownership/Merger/Acquisition for Provider Organizations and Impact on Medicaid Enrollment Status

Providers are responsible for notifying CSC, N.C. Medicaid’s provider enrollment agent, when information related to their business or practice changes.

Change of ownership/merger/acquisition is constituted by any of the following:

- An exchange of monies or an asset purchase, both of which result in the assignment of a new tax identification number; a stock purchase, which may not result in the assignment of a new tax identification number.
- A change in a shareholder’s/partner’s percentage of interest in ownership.
- A transfer of title and property to another party; or a merger of the provider corporation into another corporation or the consolidation of two or more corporations resulting in the creation of a new corporation.

If there is a change in the organization, CSC must receive notification within 30 days of the change.

1. **Submit an online Provider Enrollment Application for the organization**
<http://www.nctracks.nc.gov/provider/providerEnrollment/>

2. Use company letterhead to provide the following:

Liability Statement - Any change of ownership/merger/acquisition shall not be approved unless and until the new owner/entity agrees in writing to assume all liability, including, but not limited to, cost report settlements, health care assessment settlements, or recoupment actions, that have arisen or that may arise in connection with claims billed by provider. This will allow the new owner to retain the previous owner's Medicaid provider number(s) if desired.

Site Change - Has the organization added or deleted any sites, or have any of the sites moved? List the name of each affected site including the address and telephone number, the services provided at the site, and the effective date of the change.

Services Change - Has the organization added or deleted services since its last endorsement? Has the organization added or deleted services since its last accreditation survey? Please tell us about the service changes and effective dates of the changes.

Merger - Has the organization merged two or more organizations? Please submit the following:

- Names of the organizations merged
- Medicaid provider numbers of the organizations merged
- The effective date of the merger
- Any other detailed information regarding the merger

Acquisition - Has the organization acquired one or more organizations? Please include the following in the letter:

- Names of the organizations acquired
- The effective date of the acquisition
- Any other detailed information regarding the acquisition

Organization Closure - Is the entire organization closing, or an accredited program of the organization closing? Identify the name and address of the organization and the effective date of closure.

Submit the updates within 30 days of the change to:

NC Medicaid Provider Enrollment
CSC
PO Box 300020
Raleigh NC 27622-8020
Or Fax to 1-866-844-1382

AND to:

DMH/DD/SAS
3012 Mail Service Center
Raleigh, NC 27699-3012
Or Fax to 919-508-0968

AND to:

Provider's Endorsing Agency (if applicable)

Policies for Notification of Change in Ownership/Mergers/Acquisitions and Impact on Accreditation Status

Each accrediting body requires that the provider notifies them of any change in management or organizational structure, including reorganization, mergers, acquisitions, and closures. Accreditation is awarded to a specific provider and is typically not transferred from the previous agency to the acquiring or absorbing agency. The determination of whether a new survey is required is made on a case-by-case basis depending on the facts and circumstances of the merger, including, but not limited to

- the information presented to the accrediting body on how the two entities are going to incorporate;
- whether a new 501(c)(3) number is obtained;
- which entity is taking over the management of the new entity;
- the expansion of services to other sites and locations; and
- how close the provider is to the renewal of their accreditation, etc.

An on-site supplemental survey is almost always required when an organization changes its leadership or ownership or engages in a merger, consolidation, joint venture, or acquisition or when the organization wants to add a new program or

service that is not currently accredited, including cases where an accredited provider merges with another provider that is not accredited by the same accrediting body.

In most cases, an organization loses its accreditation when the organization goes out of business or discontinues providing the services for which it was accredited. An organization that loses its accreditation may, in most instances, reapply to re-establish accreditation; however, a provider that has lost its accreditation should no longer represent itself as an accredited agency and should take reasonable steps to notify the public of the same.

Changes in the organizational infrastructure of a provider agency due to mergers or acquisitions may impact the provider's accreditation status. Providers should refer to their accrediting body's policy regarding this matter for more specific details.

Policy for Notification of Change in Ownership/Mergers/ Acquisitions and Impact on Endorsement Status

When two or more corporations merge resulting in the creation of a new corporation (new organization name, new tax ID number) endorsement of the new corporation will be required.

When a provider is endorsed and there is a change of ownership affecting the provider organization, the provider must notify the endorsing agency, DMH/DD/SAS, and DMA of the changes via a letter on company letterhead (as noted above in #2). The following circumstances will require notification:

- A change in a shareholder's/partner's percentage of interest in ownership.
- A transfer of title or property to another agency that is already endorsed.
- A merger of another provider corporation into another corporation that is already endorsed.
- An exchange of monies or an asset purchase, both of which result in the assignment of a new tax identification number, but the service and or site is already endorsed.
- A stock purchase, which may not result in the assignment of a new tax identification number.

When a provider is endorsed to provide services at a specific site and moves to a different site location within the same LME catchment area (providing the same services), the new site does not need to be endorsed. However, if the move is to a new LME catchment area and that site location has not been endorsed, the new site must be endorsed for that service.

Psychosocial Rehabilitation Service Notes

DMA and DMH/DD/SAS are pleased to announce that Psychosocial Rehabilitation (PSR) services may be documented in the service record on a weekly basis, effective March 1, 2010. CMS has granted approval for PSR services to be documented in a full service note, but on a weekly basis instead of per date of service. This means that all the guidance contained in this Implementation Update supersedes the section on page 8-8, as well as on page 10-11, in the *DMH/DD/SAS Records Management and Documentation Manual (RM&DM)* that requires a service note per date of service for PSR.

With this new allowance, PSR providers must be aware that there will be some additional requirements that must be met in order to properly document progress on a less frequent basis. The *RM&DM* already describes how services are to be documented when the frequency requirements are less than per date of service. However, to assist PSR providers in the move from a daily note to a weekly note, "PSR Guidance for Service Notes" is attached to this Implementation Update to delineate the basic requirements needed. Providers are strongly encouraged to use this attachment to ensure that all the proper documentation requirements are met.

Child and Adolescent Day Treatment Endorsement Checklist and Instructions

The endorsement checklist and instructions for the revised Child and Adolescent Day Treatment service definitions are attached and will be posted to the Endorsement Page of the DMH/DD/SAS website at: <http://www.ncdhhs.gov/mhddsas/stateplanimplementation/providerendorse/index.htm>. These items are to be used for any endorsement of Day Treatment that occurs on or following April 1, 2010. The checklist and instructions reflect revisions to the service definition as well as the proposed changes to the Endorsement Policy. As with all service definition changes, currently endorsed providers of this service will be expected to be in compliance with the new service definition on April 1, 2010.

Memorandum of Agreement for Child and Adolescent Day Treatment Services

Medicaid and state mental health funds do not pay for educational services for eligible children. However, we recognize that effective models of practice require intentional interagency coordination to meet both the therapeutic treatment as well as the educational needs of each child or youth receiving day treatment services. Therefore, in accordance with the requirements outlined in the Child and Adolescent Day Treatment Services definition posted with an effective date of April 1, 2010 in the DMA Clinical Coverage Policy 8A (<http://www.ncdhhs.gov/dma/mp/8A.pdf>), a memorandum of agreement (MOA) must be established in order for this service to exist.

The MOA must be established between the provider, local educational agency (LEA), and the LME. The MOA is negotiated, developed, and signed locally. In order for endorsement of this service to be completed, a MOA must be in place. Participation as a party to the MOA is a local option for each entity and is locally determined.

Attached is a document entitled, "Elements to Consider Including in the Memorandum of Agreement for the Implementation of Child and Adolescent Day Treatment Services." This document contains a list of sections and content that may be considered as local MOAs for day treatment services are developed. Items to be considered include:

- Brief description of the day treatment service
- Basic information regarding the MOA
 - Date effective
 - Parties involved
 - Purpose
 - Student criteria as eligible recipient for day treatment services
- Obligations of each party signing the agreement
 - Day treatment provider
 - Local education agency or private school, as appropriate
 - Local management entity
- How modifications will be made
- Maintaining confidentiality
- Conflict resolution
- How the agreement may be terminated
- The term of the agreement
- The signing authorities for each party

Effective implementation of day treatment services must be coordinated with each child's general educational and special educational services in an LEA. Coordination among the provider, the school and the LME must occur with a concerted focus on achieving positive child outcomes through day treatment. When implemented well, the following occur: a reduction in child symptoms, smooth transitions, positive engagement with peers and participation in the 'regular' school day as day treatment goals and outcomes have been achieved or day treatment is no longer clinically appropriate.

New CAP/Targeted Case Management (CTCM) Form for MR/DD Submissions to ValueOptions

A new CAP/Targeted Case Management (CTCM) request for authorization form has been approved and MUST be used in conjunction with the new person centered plan (PCP) for MR/DD plans of care, Continued Need Reviews (CNR) and non-waiver DD Case Management. ValueOptions has posted the new CTCM on their website for immediate use as of March 1, 2010. Due to changes in the PCP, the additional information required on the new CTCM, such as diagnoses and medications, is essential to the review process. The new CTCM form can be accessed at:
http://www.valueoptions.com/providers/Network/North_Carolina_Medicaid.htm

If a CNR was submitted prior to March 1, it does not need to be re-submitted to ValueOptions.

Policy Changes for Case Management Services

This article is being republished to correct the instruction to providers to bill with the new procedure code T1017SC if additional hours (up to six hours/24 units) are needed for completing an assessment, completing a reauthorization or continued need review, or for a crisis/emergency situation. The correct code to bill for these additional hours is **the procedure code currently submitted for case management services with an informational modifier SC appended to the code.**

Beginning **March 1, 2010**, DMA will change the policies as described below for the following programs: CAP/DA, CAP/Choice, CAP/C, CAP/MR-DD, Targeted Case Management for Persons with Developmental Disabilities, and Early Intervention.

- The maximum number of units for case management services will be limited to no more than three hours (12 units) per calendar month for each recipient. See Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) or Medicaid for Children below. Providers should continue to use the current program case management billing codes.
- No more than six additional hours (24 units) may be available if needed for completing an assessment, completing a reauthorization or continued need review, or for a crisis/emergency situation.
 - It is not necessary to bill all of the additional units on the same claim. These additional units can be used cumulatively within a rolling 365 day period.
 - Any billing for assessments and crises case management above this annual limit will not be paid for adults 21 years of age and older. For children under 21 years of age, requests will be reviewed under EPSDT. (See EPSDT below.)

- These six hours (24 units) are in addition to the three hours per calendar month.
- When billing for these additional six hours/24 units, **all programs must use the procedure code currently submitted for case management services and append an informational modifier SC to that detail.** For example:
 - CAP/C and CAP/DA would bill with T1016SC.
 - CAP/MR-DD, Early Intervention would continue to bill with T1017HI and append a second modifier of SC.
 - CAP/Choice would bill with T2041SC.

Early Intervention (EI)

Effective March 1, 2010, any recipient receiving more than three hours (12 units) per calendar month will have his/her hours reduced to the limit of three hour (12 units). This will not affect the entitlement that is applied under the Early Intervention Program for service coordination as listed in the Individualized Family Service Plan.

Providers may request additional units (additional annual and monthly) by following the EPSDT requirements as outlined on <http://www.ncdhhs.gov/dma/epsdt/>. If the request exceeds the policy limits described above, the request will be reviewed under the EPSDT criteria. If the request meets all of the EPSDT criteria and the requested amount is necessary to meet the child's needs, the request will be approved. If the request does not meet all of the EPSDT criteria or the request exceeds what is necessary to meet the child's needs, the request will not be approved at the level requested.

Developmental Disability (DD) Case Management (Waiver and Non-waiver)

The following procedures apply to providers of DD case management (waiver and non-waiver):

- Current authorizations with effective dates prior to March 1, 2010, will continue as authorized until the next annual continued need review (CNR). The three hour/12 unit limit policy will be applied at the next annual review.
- Effective March 1, 2010, prior authorization of case management services for adults on the Supports and Comprehensive waivers will not be required. These adults will be eligible for up to three hours/12 units monthly as well as the additional 24 units for assessment, planning, and crisis management annually. Non-waiver adults will continue to require prior authorization and may be authorized for up to three hours/12 units per month and no more than six additional hours/24 units if needed for completing an assessment, completing a reauthorization or continued need review, or for a crisis/emergency situation. Should a case manager submit a request for a non-waiver recipient that exceeds the policy limits, the case will be reviewed to determine how many hours/units are necessary to meet the recipient's needs (one, two, or three hours per calendar month and/or six or less additional hours if needed for completing an assessment, completing a reauthorization or continued need review, or for a crisis/emergency situation within 365 days).
- Effective March 1, 2010, prior authorization of case management services for children on the Supports and Comprehensive waivers will not be required unless the request exceeds the three hour/12 unit monthly limit or the 24 unit limit for assessment, planning and crisis situations.. Non-waiver children will continue to require prior authorization.
- Waiver and non-waiver children must be evaluated under the EPSDT requirements prior to reducing their current service level at their next annual review and for authorization requests that exceed the three hour/12 unit limit or the 24-unit limits for assessment, planning, and crisis management. See the section below regarding EPSDT.
- State funded case management authorization limits are based on each LME's benefit plan.

The case manager may request the additional six hours/24 units (T1017SC) for these current authorizations even if the current monthly authorization is in excess of the three hour/12 units per month. These requests will be reviewed under the EPSDT criteria.

All Other Programs (CAP/DA, CAP/Choice, CAP/C)

- Case management services for all other affected programs will continue as currently approved until the next CNR, or reauthorization is submitted. At that time, the case management unit limits will be applied as specified in the first paragraph of this article.
- All case management units must be documented on the cost summary. It is **important** to note that the conditions set forth in the CAP waiver concerning the recipient's budget and continued participation in the waiver apply. That is, the cost of the recipient's care, including case management services, must not exceed the waiver cost limits specified in the CAP waiver.
- Children will be evaluated under EPSDT requirements prior to taking any adverse action. See the section below regarding EPSDT.

Documentation for case management billable units is required per respective clinical coverage policies. Lack of supportive documentation for billed units will be referred to Program Integrity for possible recoupment.

EPSDT

While the new limit on case management services has been reduced to no more than three hours (12 units) per calendar month and no more than six additional hours (24 units) if needed for completing an assessment, completing a reauthorization or continued need review, or for a crisis/emergency situation, these limits may not apply to children under 21 years of age. Federal law, 42 U.S.C. §1396d(r)(5), requires the State Medicaid agency to provide to Medicaid recipients under 21 years of age “necessary health care, diagnostic services, treatment, and other measures described in section 1905(a) of the [Social Security] Act to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State [Medicaid] Plan.” For more information about EPSDT and provider documentation requirements for EPSDT requests, please visit <http://www.ncdhhs.gov/dma/epsdt/>.

Recipient Due Process

Children

As indicated above, all requests for recipients under the age of 21 that exceed policy limits will be reviewed against the EPSDT criteria prior to taking adverse action, and the recipient or his/her legal guardian will receive a written notice explaining the decision. The notice will state the decision and effective date of the reduction, explain the reduction is based on Session Law 2009-451, Sections 10.68A.(a)(2)(a) and 10.68A.(a)(10), DMA policy promulgated pursuant to S.L. 2009-451, Section 10.68A.(c), as well as state the EPSDT criteria not met, and an explanation about how to appeal the decision should the recipient or his/her legal guardian so desire.

Adults

If the decision authorizes case management services to the policy limit (three hours per calendar month and/or six additional hours if needed for completing an assessment, completing a reauthorization or continued need review, or for a crisis/emergency situation within 365 days), the recipient or his/her legal guardian will receive a written notice explaining the decision. The notice will state the decision and effective date of the reduction to the policy limit, explain the reduction is based on Session Law 2009-451, Sections 10.68A.(a)(2)(a) and 10.68A.(a)(10) as well as DMA policy promulgated pursuant to S.L. 2009-451, Section 10.68A.(c), and that pursuant to 42 CFR §431.210 and §431.220(b), the recipient is not entitled to appeal this decision.

Should less than three hours (12 units) per calendar month and/or less than six additional hours if needed for completing an assessment, completing a reauthorization or continued need review, or for a crisis/emergency situation within 365 days be authorized, the recipient or his/her legal guardian will receive a written notice explaining the decision, and that he/she is entitled to appeal the decision to authorize less than the policy limit. The notice will state the decision and effective date of the reduction, explain the reduction is based on Session Law 2009-451, Sections 10.68A.(a)(2)(a) and 10.68A.(a)(10), as well as DMA policy promulgated pursuant to S.L. 2009-451, Section 10.68A.(c), and an explanation about how to appeal the decision should the recipient or his/her legal guardian so desire.

Recipient Notice Regarding Reductions in Case Management Services

A notice was sent at the end of January to recipients regarding these changes in case management. See the DMA website (<http://www.ncdhhs.gov/dma/pub/consumerlibrary.htm>) for a copy of the notice.

Extension of Coverage for Provisionally Licensed Providers Billing Outpatient Behavioral Health Services through the Local Management Entity

The deadline for coverage of provisionally licensed providers delivering outpatient behavioral health services as a reimbursable service under Medicaid and state funds and billed through the Local Management Entity (LME) **has been extended to June 30, 2011**. DMA and DMH/DD/SAS will continue to pay for services delivered by the provisionally licensed individuals listed above when billed through LMEs under HCPCS procedure codes H0001, H0004, and H0005 until that date.

As outlined in [Implementation Update # 32](#) (on the [DMH/DD/SAS Enhanced Services Implementation Updates web page](#)), the LME may choose to provide this billing service on behalf of the provisionally licensed professional. If the provisionally licensed professional is employed by an agency, the agency must develop a contract directly with the LME to do this billing for them. If provisionally licensed professionals work independently, they should contact their licensure board prior to developing a contract with the LME to ensure compliance with each profession’s scope of practice. Please note that the LME may charge 35¢ per claim to perform this billing function.

In addition to providing outpatient behavioral health services billed through an LME, there are various other means for provisionally licensed professionals to obtain the clinical experience required by their licensing boards. These include

- providing outpatient services working with a physician using Medicaid's "incident to" policy (see the [March 2009 Medicaid Bulletin](#));
- providing enhanced behavioral health (Community Intervention) services as the qualified professional (QP) in order to receive family- and community-based clinical experience; and
- serving as the licensed professional in the Intensive In-Home service.

DHHS-DMA Program Integrity Contract with Public Consulting Group (PCG)

Medicaid services are provided to recipients in all 100 North Carolina counties. In accordance with CFR 42 Part 455, which sets forth requirements for a State fraud detection and investigation program, the DMA's Program Integrity Section investigates Medicaid providers when clinically suspect behaviors or administrative billing patterns indicate potentially abusive or fraudulent activity.

The review of providers of Community Behavioral Health services has presented unique challenges. These challenges and the related volume of cases have resulted in a backlog that requires immediate attention. Program Integrity is committed to initiating these reviews and safeguarding against unnecessary or inappropriate use of Medicaid services and against excess payments.

In accordance with 10 NCAC 22F.0202, a preliminary investigation shall be conducted on all complaints received or aberrant practices detected, until it is determined that there are sufficient findings to warrant a full investigation; or there is sufficient evidence to warrant referring the case for civil and/or criminal fraud action; or there is insufficient evidence to support the allegation(s) and the case may be closed.

Effective January 28, 2010 Public Consulting Group (PCG), will assist the NC Division of Medical Assistance's Program Integrity, Behavioral Health Review Section in eliminating a backlog of cases and prospectively maintaining a steady state of case reviews, preventing a future backlog of cases from accumulating. For assigned cases, PCG will absorb the full scale of operations, beginning with the receipt of a case file, conducting the clinical review, establishing a statistically valid claim review sample for review, and extrapolating these findings to calculate the recoupment.

PCG will initiate contact with the provider, inform the provider of the post payment review process requirements, and work closely with the provider and DMA. PCG will advise the provider where and how to submit records for the review, and will address provider questions regarding the post payment review process. If the provider is out of compliance, a recoupment letter shall be forwarded to the provider in the amount of the overpayment. The provider will have reconsideration and appeal rights should the agency not agree with the findings of the review. Those instructions will be sent out with the recoupment letter.

If the preliminary investigation supports the conclusion of possible fraud the case shall be referred to the appropriate law enforcement agency for a full investigation.

For more information contact the Behavioral Health Review Section at (919) 647-8000.

Payment Error Rate Measurement in North Carolina

In compliance with the Improper Payments Information Act of 2002, the Centers for Medicare and Medicaid Services implemented a national Payment Error Rate Measurement (PERM) program to measure improper payments in the Medicaid program and the State Children's Health Insurance Program (SCHIP). North Carolina is one of 17 states required to participate in PERM reviews of Medicaid Fee-For-Service and Medicaid Managed Care claims paid in Federal Fiscal Year 2010 (October 1, 2009-September 30, 2010). The SCHIP review for FY2010 is on hold until a final ruling is made to include or exclude the measurement from this PERM cycle.

CMS is using two national contractors to measure improper payments. Livanta is the Statistical Contractor (SC). The review contract (RC) has been awarded to A+ Government Solutions. A+ will request medical records and perform data processing reviews for the FY 2010 PERM cycle. A+ has subcontracted with Health Data Insights to perform the medical reviews, and collect policies necessary for medical review. The review contractor will notify the provider by letter if one of their claims is selected for PERM review. Providers are required to furnish the records requested by the review contractor, within the designated timeframe.

Providers will be notified of medical records request by letter from the review contractor. Providers are urged to respond to these requests promptly with timely submission of the requested documentation. Failure to submit records within the designated time frame will result in an error for the state.

The PERM team within Program Integrity (P.I.) will review all claim errors declared by the RC in an effort to dispute the error and reverse the finding, thereby eliminating the error from the state's final error rate. The P.I. team may contact the

provider for further information. All indefensible errors will be recouped from the provider according to state and federal regulations.

Providers are reminded of the requirement in Section 1902(a)(27) of the Social Security Act and Federal Regulation 42 CFR Part 431.107 to retain any records necessary to disclose the extent of services provided to individuals and, upon request, furnish information regarding any payments claimed by the provider rendering services.

Medicaid Provider Payment Suspension

DMA shall immediately suspend payment to all NC Medicaid providers that currently have outstanding (i.e. thirty days or more past due) balances owed as a result of DMA actions to recoup assessments, overpayments or improper payments until such outstanding balances are either paid in full or the provider enters into an approved payment plan, in accordance with N.C. Session Law 2009-451, Section 10.73A.(a) (b) (c), which states:

SECTION 10.73A.(a) The Department of Health and Human Services may suspend payment to any North Carolina Medicaid provider against whom the Division of Medical Assistance has instituted a recoupment action, termination of the NC Medicaid Administrative Participation Agreement, or referral to the Medicaid Fraud Investigations Unit of the North Carolina Attorney General's Office. The suspension of payment shall be in the amount under review and shall continue during the pendency of any appeal filed at the Department, the Office of Administrative Hearings, or State or federal courts. If the provider appeals the final agency decision and the decision is in favor of the provider, the Department shall reimburse the provider for payments for all valid claims suspended during the period of appeal.

SECTION 10.73A.(b) Entering into a Medicaid Administrative Participation Agreement with the Department does not give rise to any property or liberty right in continued participation as a provider in the North Carolina Medicaid program.

SECTION 10.73A.(c) The Department shall not make any payment to a provider unless and until all outstanding Medicaid recoupments, assessments, or overpayments have been repaid in full to the Department, together with any applicable penalty and interest charges, or unless and until the provider has entered into an approved payment plan.

For additional information on a repayment plan, please contact DMA Budget Management at (919) 855-4140.

Census 2010

The U.S. Census 2010 will begin in a few weeks. It is important that all voices be heard and that every individual is encouraged to participate. As you communicate with consumers, families and staff about Census 2010 you may wish to reference the following facts:

It's easy - The census form only has ten questions and should only take a short time to complete. While some people may be overwhelmed and have questions, assistance is available through Question and Assistance Centers (QAC). The U.S. Census has also published a toolkit, "Supporting the 2010 Census: Toolkit for Reaching People with Disabilities" at the following link: http://2010.census.gov/partners/pdf/toolkit_Disability_Overview.pdf

It's your responsibility and right - The census will help to determine changes in population throughout the country; it plays a part in deciding how billions of dollars per year are spent on important issues such as funding for people with disabilities.

It's safe and confidential - Some people may be reluctant to share personal information on the census form or with census workers. It is important to point out that information on the census form is kept confidential and census workers are sworn for life to keep information confidential. Some people may also be apprehensive about strangers coming to talk to them. Remind everyone that census workers carry identification to protect confidentiality.

Thank you for spreading the word. We all need to participate in the census and to ensure that the voices of all North Carolinians are heard. Please encourage and support everyone's participation in the process. We have also attached a sample fact sheet that you may use in your own written and oral communications to consumers and family members.

Unless noted otherwise, please email any questions related to this Implementation Update to ContactDMH@dhhs.nc.gov.

cc: Secretary Lanier M. Cansler
Allen Feezor
Michael Watson
Dan Stewart
DMH/DD/SAS Executive Leadership Team
DMA Deputy and Assistant Directors
Christina Carter

Sharnese Ransome
Jennifer Hoffmann
Shawn Parker
Melanie Bush
John Dervin
Kari Barsness
Lee Dixo

Attachment: PSR Guidance for Service Notes

Psychosocial Rehabilitation Services: Change in Frequency of Entering Service Notes:

CMS has granted approval for Psychosocial Rehabilitation [PSR] services to be documented in the service record on a weekly basis. Effective, as of March 1, 2010, PSR services will continue to be documented on a full service note, but may be done on a weekly basis instead of per date of service. This means that the guidance contained in this Implementation Update supersedes the section on page 8-8, as well as on page 10-11, in the *DMH/DD/SAS Records Management and Documentation Manual [RM&DM]* that specifically requires a service note per date of service for PSR.

With this new allowance, there must also be clear guidance to assist PSR providers in meeting the requirements for documenting progress on a less frequent basis. Reminder: PSR still requires a full service note, which must meet the requirements outlined in the *RM&DM* on page 8-5. The *RM&DM* already has information that describes how services are to be documented in the record when the frequency requirements are less than per date of service, and certain excerpts have been taken from the *RM&DM* to assist PSR provider agencies in meeting the requirements. **Note: Where the *RM&DM* references monthly or quarter notes, it also applies to weekly notes.**

Clarification: In order to meet the timely documentation requirements, weekly documentation requires PSR provider agencies to enter each full service note within 24 hours of the close of the service period, which in the case of PSR, would typically be designated as the last day of the week, but could be a different closing date, depending on the day of the week that has been designated by the provider agency. In order to meet this requirement, each service note must be entered into the service record within 24 business hours of the designated closing period. The designated close of the service period [e.g., “every Friday”] for PSR must be specified in the provider agency’s policy and procedures manual.

Example: If the PSR provider agency has designated Fridays as being the close of the service period, then the expectation is that the service notes for PSR would be entered in the service record every Friday, but no later than 24 hours [business days] of the close of the service period, which would be the following Monday, if the agency does not operate on weekends, in order for the note to be considered timely; otherwise, the note would have to be treated as a late entry per the RM&DM.

It is also required that the attendance record for each person enrolled in the PSR service be clearly documented in the service record.

Outlined below are additional *RM&DM* requirements that apply to the documentation of PSR:

From page 8-1: **Documenting Service Provision in a Service Note or Grid:** ...For some services where the frequency requirement for documentation of progress spans a range of time, e.g., monthly or quarterly, and/or where one or more service providers within the same team/agency have carried out the same discrete service for an individual on different days, then the Qualified Professional or other designated staff [one of whom directly provided the service during the time frame in which the service was provided] is responsible for gathering all the relevant information from the other staff on the team and writing and signing a composite service note that outlines the individual’s progress during that service period. Such documentation of progress must be based on the individualized goals that were the focus of intervention for the time period being addressed in the service note.

From page 8-2: **Timely Documentation and Late Entries for Service Notes and Grids:** ...Timely documentation is essential to the integrity of the service record and for meeting reimbursement requirements of funding sources. Late entries and missing documentation can cause numerous problems for agencies and should be avoided. Late entries are defined as those which are entered after the required time frame for documentation has expired...

There are a few day/night and twenty-four hour services, where the requirement is that certain categories of service notes, i.e., monthly notes or quarterly notes, are written or dictated on the closing date of a specified

service period, or within twenty-four hours of the close of the service period. In these situations, timely documentation is evidenced by service notes that are written or dictated within these parameters.

From page 8-4: Day/Night Services Requiring Monthly or Quarterly Service Notes: When the frequency requirement for a day/night service is a monthly or quarterly note, the completion of a service note to reflect the services provided within the month or quarter shall be documented at the close of the service period, i.e., on the last day of the service period, or within twenty-four hours of the close of the service period, in order to be considered timely documentation. Any service note or grid written or dictated after twenty-four hours from the close of the service period is considered a late entry and must include the applicable documentation requirements below:

1. Each note shall be labeled as a “late entry” and shall include the date the documentation was made and the date that the documentation should have been entered, i.e., closing date of service period. For example, “Late Entry made on 8/4/08 for service period ending July 31, 2008.”
2. The late entry service note requires a dated signature.

If an electronic health record is used and late entries are tracked/stamped in the system, the procedures for labeling late entries as outlined above are not required.

From page 8-7: **Service Notes When Provided by a Team**: When the same discrete service is provided to an individual by more than one staff member at the same time, as in the case of certain teams, such as ACTT or Day Treatment, etc., one of the members of the team who provided the service may write and sign the service note. The service note must include the other participating staff members involved and describe their role in providing the service. While it may be prudent to have the other participating staff sign the note, there is no state requirement to do so.

Frequency and Other Requirements for Entering Service Notes: The frequency requirements for service notes are largely determined based on the type of service that was provided. However, in all cases, service notes shall be made more frequently than the requirements outlined below when necessary to indicate significant changes in the individual's status, needs, or changes in the PCP. When the frequency requirement for documentation of progress spans a range of time [e.g., monthly or quarterly], and one or more service providers within the same team/agency have carried out the same service to the individual on different days, then the Qualified Professional or other designated staff [one of whom directly provided the service during the time frame in which the service was provided] is responsible for gathering all the relevant information from other providers on the team and writing and signing a composite service note that outlines the individual's progress during that time period. Such documentation of progress must be based on the individualized goals that were the focus of intervention for the time period being addressed in the service note.

From pages 8-8 to 8-9: **Day/Night Services**: A day/night service is defined as a service provided on a regular basis, in a structured environment that is offered to the same individual for a period of three or more hours within a twenty-four hour period [APSM 30-1, Rules for MH/DD/SA Facilities and Services]. The minimum frequency requirements for entering service notes vary among the different services within the day/night category.

...Documentation of day/night services shall be entered in the service record following the required elements noted above in *Contents of a Service Note*. The date(s) of attendance shall also be documented in the service record for day/night services...

...For day/night services...reported/billed in 15-minute increments, the total amount of time spent performing the service per day must be documented in the service record. This information may be indicated with the attendance information or included in the...service note.

If the duration of services is less than the above noted frequency, a service note shall be documented for the period of time that the individual received the service...

Elements to Consider Including in the Memorandum of Agreement (MOA) for the Implementation of Child and Adolescent Day Treatment Services

In keeping with the requirements outlined in the Child and Adolescent Day Treatment Services definition posted with effective date of 4/1/10 in the Division of Medical Assistance (DMA) Clinical Coverage Policy 8A (<http://www.ncdhhs.gov/dma/mp/8A.pdf>), an MOA must be established in order for this service to exist. Please refer to the service definition for all other specific service requirements.

Introduction (from the service definition)

“Day Treatment is a structured treatment service in a licensed facility for children or adolescents and their families that builds on strengths and addresses identified needs. This medically necessary service directly addresses the child’s diagnostic and clinical needs, which are evidenced by the presence of a diagnosable mental, behavioral, and/or emotional disturbance (as defined by the DSM-IV-TR and its successors), with symptoms and effects documented in a comprehensive clinical assessment and the Person Centered Plan.

This service is designed to serve children who, as a result of their mental health and/or substance abuse treatment needs, are unable to benefit from participation in academic or vocational services at a developmentally appropriate level in a traditional school or work setting. ***The provider implements therapeutic interventions that are coordinated with the child’s academic or vocational services available through enrollment in an educational setting. The provider agency shall establish a Memorandum of Agreement (MOA) among the Day Treatment provider, the Local Management Entity, and the Local Education Agency (or private school as applicable).***” (DMA Clinical Coverage Policy 8A <http://www.ncdhhs.gov/dma/mp/8A.pdf>)

Sections and Content Suggested

Section I MOA Basic Information

- effective date of the MOA
- parties participating in the MOA - shall include at a minimum the Provider (day treatment), LEA, and LME
- **purpose of the MOA - efficient and effective provision of day treatment services within the school setting for both general education and special education students.**
- student criteria as an eligible recipient for day treatment services (consider age, strengths, needs, functional and/or diagnostic level of need, insured -Health Choice, Medicaid, private, state funded, pro bono (specify ratio paid), etc)
- frequency of MOA review and renewal (suggest annually)

Section II SCHOOL's responsibilities/obligations (LEA or Private School, as appropriate)

- provide instructional staff for both general and special education and related services
- curriculum materials, support, assessment and staff training for general and special education instruction in the classroom
- use collaborative approach with provider agency for the placement of students in day treatment services
- make referrals through the child and family team process and follow those procedures

- monitor enrollment in the day treatment classroom and to maintain required staffing levels appropriate to the students' educational/instructional needs
- appropriate staff shall attend child and family team meetings to review and monitor transitions into/out of day treatment program
- work collaboratively with provider to implement day treatment services within the state and federal policies/statutes for mental health and substance abuse treatment services and for those for general and special education services and related services
- ensure all school personnel will implement safe and drug free school procedures and policies
- provide joint supervision and oversight through regular meetings among MOA administrators
- exercise authority to ask for removal of any day treatment program staff who do not comply with school policies/procedures after appropriate intervention/mediation
- provide training to all day treatment services personnel on school policies, procedures, student rights, parent handbook, discipline procedures, positive behavior supports, and other areas identified as needed
- require a copy of the personnel criminal background check on each day treatment services staff working in the day treatment services program to be kept on file in the school's personnel office
- develop and maintain updated Individual Education Program (IEP) for all eligible students with a disability. The IEP committee shall be a multi-disciplinary team which shall include the parent(s), guardian(s) or surrogate parent(s) for each student
- review and evaluate the IEP at appropriate intervals, at least annually, and amend as appropriate in coordination with the child and family team
- provide the day treatment services provider and program personnel with a current edition of the NC Procedures Governing Programs and Services for Children with Disabilities
- clarify how burden of administrative costs associated with service and educational components for implementing day treatment will be distributed

Section III PROVIDER obligations

- provide child and adolescent day treatment services as outlined in the Division of Medical Assistance Clinical Coverage Policy 8A
- provide ongoing training on behavioral interventions and school-based practice strategies consistent with treatment for all school personnel providing services in the school
- maintain required staffing ratios as outlined in the Child and Adolescent Day Treatment service definition in Division of Medical Assistance Clinical Coverage Policy 8A
- screen all day treatment personnel/applicants, obtain appropriate background checks and with copies maintained in the provider's and school's personnel office. Provide appropriate supervision and follow school personnel policy regarding recruitment, selection and hiring pursuant to _____ local board of education administrative rules, policies and procedures as outlined in _____.
- participate in each Child and Family Team according to System of Care protocol to develop each child's Person-Centered Plan outlining goals and outcomes within the day treatment services program, obtain authorization for reimbursement of services, monitor and evaluate progress, implement crisis plans as needed and facilitate appropriate transitions into/out of day treatment services
- ensure all day treatment personnel will comply with safe and drug free school procedures and policies, and provide all day treatment/provider personnel with appropriate identification badges to be worn by staff at all times during the operation of the program on school grounds

- prior to implementing services will consult with _____ school administrators to ensure congruence with and no compromise of the _____ local Board Policies, Public State and Federal Education Laws, including IDEA -Individuals with Disabilities Education Act.
- provide notice to the _____ local school in the event the day treatment services are terminated due to loss of funding authorization or clinical reason. Collaboration through the child and family team will occur to determine each student's appropriate transition plan upon discharge and as outlined in each child's PCP.
- provide on-site crisis assessment and stabilization, and coordinate crisis response for students in the day treatment program as outlined in the crisis plan in each child's PCP. Appropriate crisis stabilization will be accessed in coordination with the LME (and mobile crisis team, community hospital...).
- maintain necessary documentation of day treatment services provided to each child in accordance with Division of Medical Assistance Clinical Coverage Policy 8A and the Records Management and Documentation Manual (RMDM)
- maintain relevant data to document student outcomes and develop transition plans with school through child and family team for return to home school
- maintain program effectiveness outcome data for regular review by all MOA participant administrators
- clarify how burden of administrative costs associated with service and educational components for implementing day treatment will be distributed

Section IV LME obligations

- implement provider endorsement requirements for day treatment services and responsibilities prior to provider enrollment
- execute functions of the LME SOC Coordinator functions (identify relevant functions – facilitate access, referral, family partner involvement, child and family team) relevant to children/youth served in these day treatment services
- execute functions of the LME Child and Family Support Team Liaison (if applicable in specific LME) functions (identify relevant functions – serve as liaison with parent, youth and school; and facilitate access, referral, family engagement and involvement, child and family team) relevant to children/youth served in these day treatment services.
- coordinate crisis response and crisis management services with the day treatment provider and the school personnel for each child as outlined in the crisis plan in each child's PCP
- monitor service delivery and provider requirements to ensure compliance with provider requirements and service delivery as outlined in the Child and Adolescent Day Treatment Services definition in the Division of Medical Assistance Clinical Coverage Policy 8A, the Records Management and Documentation Manual (RMDM) and relevant state and federal statutes and policies.

Section V Modifications

- terms by which modifications may be made
- good faith communication, response and action

Section VI Confidentiality

- all parties agree to train and monitor staff to ensure the confidentiality of students enrolled in or discharged from day treatment services as well as other students encountered in the school

setting is protected according to state and federal mental health, substance abuse and education laws and policies.

- all parties agree that necessary releases of information consistent with the Federal Rights to Privacy Act (FERPA) and other relevant state and federal mental health, substance abuse and education laws and policies.
- all parties agree to assure students and their parent(s)/guardian(s) are provided informed consent when obtaining release of information

Section VII Conflict Resolution

- Resolution of concerns regarding employee work or conduct within the day treatment setting shall be dealt with directly with the staff person in open dialogue
- Initial attempt at resolution is unsuccessful, the employee will inform the principal of the host school, the employee supervisor
- ____ the principal of the host school, ____ the provider and ____ LME administrators responsible will investigate and mediate with concerned parties; written accounts of process will be maintained by both parties
- Any concerns expressed and not resolved that pertain to the terms of this MOA will be addressed in a meeting of involved parties resulting in the development of an action plan
- if an issue is not able to be resolved, see termination section
- documentation of the process, meetings and procedures used to resolve the conflict will be provided to _____

Section VIII Termination of Agreement

- Any party may terminate this agreement upon a thirty (30) day notice.

Section IX Term

- in effect the date signed by all MOA parties
- renewed automatically unless modified
- any party to this agreement may terminate participation within 30 days of written notice to all other MOA parties
- Signatures
 - In witness thereof, each party has caused this agreement, to be executed in multiple copies; each shall be deemed and original, as the act of said party.
- **Signatures and Date Signed**
 - LEA - ____ Superintendent, ____ Assist. Superintendent, ____ Principal of Host School
 - Provider - ____ Chief Executive, ____ Medical/Clinical Director
 - LME - ____ Director, ____ Provider Relations Director

**NC DHHS – NC DMH/DD/SAS
Child/Adolescent Day Treatment (MH/SA)
Endorsement Check Sheet Instructions**

Introduction

Prior to site and service endorsement, business verification must take place. In the process of business verification, the business information presented DMA CIS (Community Intervention Services) application is validated. Because Day Treatment is a licensed service, the provider is not required to submit a self study of the core rules (10A NCAC 27G .0201-.0204) verifying that they have met all the requirements therein. However, the documents created in adherence with the core rules should be utilized as evidence of provider compliance where noted in the check sheet and instructions.

The following set of instructions is to serve as general guidelines to facilitate the review of providers for endorsement. Service definition, core rules (as noted above), staff definitions (10A NCAC 27G .104) and other DHHS communications (e.g. *DMH/DD/SAS Records Management and Documentation Manual*, Communication Bulletins, Implementation Updates, Clinical Coverage Policy 8A, and other publications) should be used to support the reviewer's determination of compliance. In addition, the Business Entity Type Reference document assists to clarify the requirements for different business entities such as corporation, partnerships and limited liability corporations and partnerships. On the endorsement check sheet, there are suggested sources of evidence for locating information that may assist the reviewer in determining compliance with the respective requirements. The items identified are not an exhaustive list of sources, nor must each item named be reviewed. The reviewer examines evidence presented only until the element in question is substantiated as being met by the provider.

Provider Requirements

In this section, the provider is reviewed to ascertain that administrative requirements are met in order for services to be provided. The provision of services is addressed later in this endorsement process.

a. This section is reviewed only during the initial review for business status and does not require further scrutiny unless there is a change in the provider's status that would affect this element.

1) Prior to July 1, 2010.

For a provider with endorsements for other services in the reviewing Local Management Entity's (LME's) catchment area, the LME conducting the current endorsement review has already determined business verification requirements are met and no further action is needed. For a provider with services in another LME's catchment area, review Notice of Endorsement Action (NEA) letter from the other LME for evidence that the provider meets business verification requirements.

OR

For a provider that currently has no active endorsements, review documents from the Secretary of State to determine that the provider is an entity legally established to operate a

business in the State of North Carolina and that all business verification requirements are met. Refer to the Business Entity Type reference document.

2) July 1, 2010 and thereafter.

Review documents that evidence that the Department of Health and Human Services has certified a minimum of one of the provider's sites as a Critical Access Behavioral Health Agency.

b.

1) Review documents for evidence that the provider meets DMH/DD/SAS and /or DMA standards as related to administration responsibilities, financial oversight, clinical services and quality improvement. These standards include, but are not limited to, policies and procedures (contents of which are mandated in 10A NCAC 27G .0201 – Governing Body Policies) and the key documents required by law for the formation of the business entity.

2) Providers must demonstrate evidence of facility licensure according to 10A NCAC 27G .1400 or 10A NCAC 27G .3700 for a Day Treatment program that is substance abuse focused, and the provision of this facility based service in a structured program setting appropriate for the developmental level of children/adolescents ages 5-17 years (18 or under for those eligible for Health Choice and 20 or younger for those eligible for Medicaid) served. Review policy and procedure manuals and program descriptions for language demonstrating that developmentally appropriate services are delivered in a structured setting within a licensed facility.

Staffing Requirements

In this section, the reviewer is primarily concerned with the hiring practices of the provider and ensuring that all employees required per the service definition are in place at the time of the clinical interview and are equipped with the evidentiary documentation of education, training and experience for which they were hired. This is important for the clinical integrity of the service. The review of the provision of services is more thoroughly examined in the "Program/Clinical Requirements" section of the endorsement review.

In the desk review, the reviewer is to verify that the provider agency's policies and procedures, as well as other administrative manuals meet the requirements of the service definition. The review of the qualifications of personnel hired will occur later in the endorsement process. Review documentation to verify that provider agency requirements of staff include degrees, licensure and/or certifications that comply with the position as written in the service definition, and are consistent with requirements and responsibilities of their respective job duties. Review job descriptions to determine that the roles and responsibilities identified do not exceed the qualifications of the position. This review ensures that the provider has an understanding of the service definition staffing requirements and has established policies for a program that meet those requirements.

For the clinical interview, review staff employment applications, resumes, licenses, certifications and/or other documentation for evidence that degrees and work experience with the target population the provider will be serving is consistent with the requirements and responsibilities of each position. If **any** staff person hired to meet the staffing requirements of the service definition do not meet the requirements for the position, then the clinical

interview does not take place. The clinical interview process is described in Program Requirements.

For the on site review, the endorsing agency verifies documentation reviewed during the desk review and clinical review. The credentials and qualifications of any additional or ancillary staff hired in the time between the clinical interview and the on site review are examined.

For the 60 day review, include a review of the consumer record and other items necessary to determine that staff are performing clinical interventions commensurate with their credentials and qualifications as well as within the scope of work of their job descriptions. Review staff schedules, attendance rosters, and caseload assignments and interview staff to ascertain consumer to staff ratios. This review should also include a review of supervision plans, notes and documentation of clinical supervision for all staff. Review supervision plans to ensure that they are individualized and appropriate for the level of education, skill and experience of staff. Review supervision notes, schedules and other supporting documentation that demonstrate on-going supervision consistent with the requirements and responsibilities. Personnel records must demonstrate evidence that all required training has been acquired by each staff member delivering day treatment services and completed within the specified time frames.

a., b., c., and d.

The staff hired must include:

- a) A full time Program Director who meets requirements specified in rule for a Qualified Professional (QP) and has a minimum of two years experience in child and adolescent MH and/or SA treatment services. The Program Director must be actively involved in program development, implementation and service delivery;
- b) A minimum ratio of one full time QP to every six enrolled recipients is required to be present at all times. QP must have knowledge, skills and abilities required by population and age served and must be actively involved in service delivery;
- c) Minimum of one additional full time equivalent (FTE) Qualified Professional, Associate Professional (AP) or Paraprofessional (PP) for every 18 enrolled recipients;
- d) Minimum of .5 FTE dedicated Licensed Professional to every 18 enrolled recipients who must be actively involved in service delivery. If a Provisionally Licensed Professional fills this position, the staff must be fully licensed within thirty months from date hired. For substance abuse focused programs, the Licensed Professional must be an Licensed Clinical Addictions Specialist (LCAS);

Licensed Professional: For the desk review, review policy and procedure manuals and program descriptions to ascertain that they specify that an individual hired as a Licensed Professional to provide Child and Adolescent Day Treatment services is required to have the skill, knowledge and experience with the population to be served to provide the various interventions required by the position. Review also to ensure that substance abuse treatment focused programs specify an LCAS as the Licensed Professional. Review the provider agency's policy to ensure that when this position is filled by a provisionally licensed individual, it is clear that the expectation of the provider agency is that the individual will become fully licensed within 30 months.

For the clinical interview, on site and/or 60 day reviews, review employee applications, resumes, certifications, and training for evidence that the individual hired as the Licensed

Professional has the skill, knowledge and experience with the population to be served to provide the various interventions required by the position. When reviewing the supervision and training below, review for evidence that an individual who is provisionally licensed has a plan to obtain full licensure within the required time frame.

Qualified Professional: For the desk review, review policy and procedure manuals and program descriptions to verify that they specify that an individual hired as a Qualified Professional to provide Child and Adolescent Day Treatment services is required to have the skill, knowledge and experience with the population to be served to coordinate initial and ongoing assessment activities, to develop the PCP, to perform ongoing monitoring of PCP implementation and to revise the PCP as needed.

For the clinical interview, on site and/or 60 day reviews, review employee applications, resumes, certifications, and training for evidence that an individual hired as the Qualified Professional has the skill, knowledge and experience with the population to be served to coordinate initial and ongoing assessment activities, to develop the PCP, to perform ongoing monitoring of PCP implementation and to revise the PCP as needed.

Associate Professional: For the desk review, review policy and procedure manuals and program descriptions to confirm that they specify that an individual hired as an Associate Professional to provide Child and Adolescent Day Treatment services is required to have the skill, knowledge and experience with the population to be served to provide the various interventions required by the position.

For the clinical interview, on site and/or 60 day reviews, review employee applications, resumes, certifications, and training for evidence that an individual hired as the Associate Professional has the skill, knowledge and experience with the population to be served to provide the various interventions required by the position.

Paraprofessional: For the desk review, review policy and procedure manuals and program descriptions to verify that they specify Paraprofessionals hired to provide Child and Adolescent Day Treatment services are required to have the skill, knowledge and experience with the population to be served to provide the various interventions required by the position. Paraprofessionals may deliver services under the supervision of an AP, QP, LCAS or CCS according to 10 NCAC 27G .0104.

For the clinical interview, on site and/or 60 day reviews, review employee applications, resumes, certifications, and training for evidence that an individual hired as the Paraprofessional has the skill, knowledge and experience with the population to be served to provide the various interventions required by the position.

Other: Policy, personnel and procedure manuals must contain language that demonstrates that the Child and Adolescent Day Treatment Program Director is on site and is actively involved in the program implementation and delivery of services. In addition, the Director must coordinate the educational and therapeutic services and supports with the family, local education agency (LEA-public/other school) and other providers. Review job descriptions and scope of work for language demonstrating program expectation.

When indicated by the population to be served, staffing qualifications must also reflect the ability to meet consumer needs specific to substance related disorders and/or to those children with needs related to developmental disabilities.

e. Review policy and procedure manuals and program descriptions to verify that they specify that staffing ratios and coverage are adequate for the needs of the program per the service definition requirements.

Staffing at a minimum must be:

- A ratio of one QP to every six recipients to be present at all times.
- Two staff present with children at all times. (Exception: one staff may be present when only one recipient is present);

AND

- A configuration that is adequate to anticipate and meet consumer needs.

f. Review policy and procedure manuals, and personnel manuals to confirm that they contain language that demonstrates the expectations that the Child and Adolescent Day Treatment provider agency ensures the supervision of LP, QP, AP and paraprofessional staff

- based on their level of education, skill and experience;
- consistent with position requirements and responsibilities in 10 NCAC 27G .0203 and 10 NCAC 27G .0204;
- consistent with certification and/or licensure requirements of the appropriate discipline.

For services provided to children/adolescents with substance related disorders, staffing and staff supervision includes Certified Clinical Supervisor (CCS), Licensed Clinical Addictions Specialist (LCAS) and/or Certified Substance Abuse Counselor (CSAC) under Article 5C. Review of job descriptions for language demonstrating supervision expectations.

g. Review employee training, supervision plans, or other documentation demonstrating that training has been scheduled and/or received according to the service definition and that it is consistent with the role of the level of the professional providing Child and Adolescent Day Treatment Services.

Twenty (20) hours must be completed within 30 days of each staff person's hire to provide the service.

- Three (3) hours of service definition components
- Six (6) hours of Person Centered Thinking
- Three (3) hours of crisis response
- Eight (8) hours of Introduction to SOC and Child & Family Team process
- All introductory and follow up training required by the clinical model chosen for service delivery

In addition, the Licensed Professional and any Qualified Professional responsible for the development of the Person Centered Plan must have:

- Three (3) hours of PCP Instructional Elements

Service Type/Setting

The elements in this section pertain to the provider's understanding of the Child and Adolescent Day Treatment Services and the service delivery system.

For the desk review, review documentation to verify that provider demonstrates a schedule of operation that is within the parameters specified by the service definition. This review ensures that the provider has an understanding of the purpose of the service and has established a schedule and a program that meet those requirements.

Items in this section do not apply to the clinical interview.

For the on site review, confirm findings of the desk review and the clinical interview.

For the 60 day review, include a review of consumer records and other items necessary to determine that Day Treatment has been made available to each consumer a minimum of three hours per day during all days of operation. Record review and program schedule should reflect that at least 75% of the treatment services per week are provided in the on-site licensed setting with or on behalf of the consumer. Review the consumers' addresses of residence documented in the service records and on the PCP.

a. Review for language demonstrating that:

- Day Treatment services are provided a minimum of three hours per day during all days of operation,
- the Day Treatment Program operates each day the schools in the local education agency are in operation,
- the Day Treatment Program does not operate solely outside of traditional school hours, and
- during the summer months the program remains in operation a minimum of four days a week.

b. Review documentation that demonstrates that at least 75% of the treatment services per week for an individual recipient shall be provided in the on-site licensed setting. Review program operations schedule and staffing schedule. Make sure that in determining compliance, the provider agency work week is the frame of reference.

c. Review documentation that specifies that Day Treatment services shall be provided in a setting separate from the consumer's residence. Providers must demonstrate evidence that the recipient resides at a location other than the facility licensed according to 10A NCAC 27G .1400 or 10A NCAC 27G .3700.

Program Requirements

The elements in this section are reviewed as they pertain to service delivery. It is important that consumers are served in accordance with the service definition, the clinical model selected by the provider agency and according to individual needs identified in the PCP.

For the desk review, review documentation to verify that the provider demonstrates a clear understanding of best practice and the identification of a clinical model that can be delivered with fidelity within this service.

For the clinical interview utilize the questions attached to the current endorsement policy. Specific expectations for the clinical interview are outlined below.

For the on site review, confirm findings of the desk review and the clinical interview.

For the 60 day review, a review of service records should demonstrate compliance with program requirements as specified in each item below. Review to verify that the provider has an understanding of the service and best practice. Review documentation to determine clinical integrity, coordination with family and local education agencies and other services and supports in delivery of services and documented interventions that indicate fidelity to the clinical model chosen.

a. Program description and policies and procedures and daily plans clearly name the identified best practice clinical model chosen for service delivery. The staff responsibilities, schedule and ratio indicate fidelity to the clinical model chosen as well as to the requirements of the service definition. The training requirements have been identified and completed or scheduled.

After 60 days, review consumer records and other items necessary to determine that Day Treatment has been delivered in a collaborative manner with fidelity to the clinical model chosen for service delivery. Service notes should display evidence of progress and positive outcomes for the recipients of the service outlined in the service definition and in accordance with the expected outcomes of the clinical model chosen.

b. Review for protocol that outlines a process for establishing and maintaining a collaborative relationship with the school system. Review the MOA established with the Local Education Agency (LEA). There should be evidence of ongoing collaborative efforts between the Day Treatment provider and the LEA. There is evidence of a clear delineation between the educational instruction and therapeutic interventions. Review documentation to ensure that all educational activities are the responsibility of the schools, carried out by the schools, and not by the Day Treatment provider.

After 60 days, review for documentation that child and family team (CFT) meetings involve the child and family. Review for evidence that Day Treatment program staff collaborate with the schools prior to admission and throughout service duration. Review service records noting coordination with local education agencies and other services and supports in delivery of services off-site of the licensed setting. Review documentation to confirm that Day Treatment staff are providing interventions related only to the therapeutic needs of the recipients.

c.

1) Review for documentation that outlines a process for establishing and maintaining a collaborative relationship with other service providers and agencies involved in the recipient's life.

After 60 days, review service records for documentation of child and family team (CFT) meetings and evidence that Day Treatment program staff collaborate with other service providers and agencies prior to admission and throughout service duration. Review should include the PCP and service notes the document coordination with other service providers and agencies, including vocational supports when indicated, in delivery of services off-site of the licensed setting.

2) Review for the establishment of protocol relating to the development of the crisis plan. There should be evidence that it is a collaborative effort involving the child, the family, other service providers and the LME. It should clearly indicate how a first responder is identified.

After 60 days, review the service record for the crisis plan and documentation that the planning process was inclusive of all parties with responsibilities in the crisis plan. Review service records for evidence of first responder and 24/7 access to therapeutic interventions (e.g. suicide prevention plan in place and followed in an evening crisis event).

d. Review the provider agency's policies and service records for documentation that outlines a process for establishing and maintaining ongoing family involvement in planning and engagement throughout the provision of Day Treatment services.

After 60 days, review service records for documentation of child and family team (CFT) meetings and evidence that Day Treatment program staff include the family in the making of treatment decisions from the time that admission is planned and throughout service duration. Service records must document direct and indirect interventions with the consumer and family.

e. Clinical Interview. Use the questions included in the current endorsement policy for interviews with the staff to determine the provider agency's clinical competency to deliver services.

Documentation Requirements

a – b. All contacts for Child and Adolescent Day Treatment Services must be documented. A full service note for each date of service, written and signed by at least one of the persons who provided the service is the minimum requirement. Documentation must meet all record and documentation requirements in the *DMH/DD/SA Records Management and Documentation Manual [APSM 45-2]*. Review the provider agency's policy and procedure manuals for language demonstrating the expectation that each full service note per date of service includes all items identified in the service definition.

Review policy and procedure manuals for language that demonstrates that all clinically significant contacts with or on behalf of the recipient must be recorded in the service record. Review policy and procedure manuals for language which addresses completion of required forms, transition and discharge planning.

The 60 day follow-up review should include a review of service records to verify that all components of each full service note are included in the documentation and to verify that contacts are documented. PCPs shall have all the required components and address plans for transition/discharge. Service notes should relate directly to the needs and goals identified in the recipients' PCPs.

Reviewer:
Date Reviewed:

**NC DHHS
DMH/DD/SAS**

Provider: _____
Site: _____

Child and Adolescent (MH/SA) Day Treatment

Day Treatment Elements	Endorsement Review Evidence of Compliance			Findings (Identify review)			60 Day Review Evidence of Compliance
	Desk	Clinical Interview	On Site	MET	NOT MET	NA	
Provider Requirements							
a	1) For endorsements occurring through June 30, 2010, the agency has the required business verification. 2) As of July 1, 2010, the provider agency must be certified as a Critical Access Behavioral Health Agency (CABHA) to provide this service.	1) NEA, Documentation from Secretary of State 2) Documentation of DHHS CABHA certification					
b	1) Services are delivered by practitioners employed by a MH/SA provider organization which meets standards established by the Division of Medical Assistance (DMA) and the Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMHDDSAS) that set forth the administrative, financial, clinical, quality improvement, and information services infrastructure necessary 2) Delivered in a licensed facility under 10A NCAC 27G .1400 or 10A NCAC 27G .3700 when substance abuse focused	1) Policy & Procedure Manuals, Personnel Manual 2) DHSR license					
Staffing Requirements							
a	Full-time dedicated Program Director employed by the provider who 1) meets requirements specified for a QP (10A NCAC 27G .0104) AND 2) has a minimum two years experience with child/adolescent MH/SA treatment AND 3) must be actively involved in program development, implementation, and service delivery	Policy & Procedure Manuals, Personnel Manual, Program Description, Job Description	Personnel Files, Job Application, Resume, Staff Interview				Service records, attendance roster, staff schedule, paid claims information

Reviewer:
Date Reviewed:

NC DHHS
DMH/DD/SAS

Provider: _____
Site: _____

Child and Adolescent (MH/SA) Day Treatment

Day Treatment Elements	Endorsement Review Evidence of Compliance			Findings (Identify review)			60 Day Review Evidence of Compliance
	Desk	Clinical Interview	On Site	MET	NOT MET	NA	
Staffing Requirements Cont.							
b 1) Minimum ratio of 1 full-time QP employed for every 6 enrolled recipients is required to be present. 2) QP must have knowledge, skills, and abilities required by population and age served, who must be actively involved in service delivery	Policy & Procedure Manuals, Personnel Manual, Program Description, Job Description	Personnel Files, Job Application, Resume, Staff Interview	Operating, program and staffs schedules, Attendance records, Personnel files				Service records, attendance roster, staff schedule, paid claims information
c Minimum of 1 additional full-time equivalent (FTE) QP, AP, or PP employed for every 18 enrolled recipients	Policy & Procedure Manuals, Personnel Manual, Program Description, Job Description	Personnel Files, Job Application, Resume, Staff Interview	Operating schedule, Program schedule, Staff schedule, Attendance records				Service records, attendance roster, staff schedule, paid claims information
d Minimum of .5 FTE (20 hours) dedicated Licensed Professional employed for every 18 enrolled recipients and who is actively involved in service delivery. NOTE: A Provisionally Licensed Professional who fills this position must be fully licensed within 30 months from date of hired. NOTE: For Substance abuse focused programs, the LP must be an LCAS.	Policy & Procedure Manuals, Personnel Manual, Program Description, Job Description	Personnel Files, Job Application, Resume, Staff Interview	Operating schedule, Program schedule, Staff schedule, Attendance records				Service records, attendance roster, staff schedule, paid claims information

Reviewer:
Date Reviewed:

NC DHHS
DMH/DD/SAS

Provider: _____
Site: _____

Child and Adolescent (MH/SA) Day Treatment

Day Treatment Elements	Endorsement Review Evidence of Compliance			Findings (Identify review)			60 Day Review Evidence of Compliance
	Desk	Clinical Interview	On Site	MET	NOT MET	NA	
Staffing Requirements Cont.							
e 1) Minimum ratio of 1 QP to every 6 recipients to be present AT ALL TIMES WITH 2) Minimum of 2 staff present with children AT ALL TIMES. <i>NOTE: Exception-when only one child is present, only 1 staff member is required to be present.</i> <i>NOTE: Staffing configuration must be adequate to anticipate and meet the needs of the recipients receiving this service.</i>	Policy & procedure manuals, personnel manual, program description, job description		Program description; personnel manual; job descriptions; personnel files; staff schedule; attendance roster; caseload assignment				Service records, Medicaid RA Forms/Paid Claims
f Supervision is provided 1) according to supervision requirements specified in 10 A NAC27.G.0104 & 10A NCAC 27G .0204 AND 2) is individualized	Policy & procedure manuals, personnel manual, job description		Program description; personnel manual; job descriptions. personnel files; staff interviews				Personnel files, supervision notes, staff interviews
g Within 30 days of employment to provide this service, each staff member must complete a minimum of 20 hours of training specific to the components of the Day Treatment service definition, the clinical model implemented, crisis response, Person Centered Thinking, System of Care (SOC), and Child and Family Team	Policy & procedure manuals, personnel manual, job description, agency training plan		Program description; personnel manual; job descriptions. personnel files; training certificates				Personnel files, supervision notes, staff interviews

Reviewer:
Date Reviewed:

NC DHHS
DMH/DD/SAS

Provider: _____
Site: _____

Child and Adolescent (MH/SA) Day Treatment

Day Treatment Elements	Endorsement Review Evidence of Compliance			Findings (Identify review)			60 Day Review Evidence of Compliance
	Desk	Clinical Interview	On Site	MET	NOT MET	NA	
Service Type / Setting							
a Day Treatment 1) is available year round for a minimum of three hours a day during all days of operation, AND 2) operates each day that the schools in the local education agency are in operation during the school year, AND 3) does not operate solely outside of traditional school hours AND 4) remains in operation a minimum of four days a week during the summer months.	Policy & procedure manuals, program description, operating & program schedules, staff schedule, staff interviews		Policy & procedure manuals, program description, operating & program schedules, staff schedule, staff interviews				Service records, contact log, claim forms, program schedule, staff interviews
b For each individual consumer, no more than 25% of treatment services take place outside the licensed facility. <i>NOTE: This is calculated based upon the provider agency work week. Provider must track for each recipient.</i>	Policy & procedure manuals, program description, program schedules		Program description, staff interviews				Service records, contact log, claim forms, program schedule, staff interviews, tracking log
c Provided in a licensed facility separate from child's residence	Policy & procedure manuals, program description		Observation				Service records

Reviewer:
Date Reviewed:

NC DHHS
DMH/DD/SAS

Provider: _____
Site: _____

Child and Adolescent (MH/SA) Day Treatment

Day Treatment Elements	Endorsement Review Evidence of Compliance			Findings (Identify review)			60 Day Review Evidence of Compliance
	Desk	Clinical Interview	On Site	MET	NOT MET	NA	
Program Requirements							
a Provider must follow a clearly identified best practice clinical model that produces positive outcomes for the population served.	Policy & procedure manuals, program description, program schedules		Program description and operational schedule, staff interviews.				Service records
b 1) Collaborates with schools through an established MOA 2) A clear delineation must be made between the educational instruction and the therapeutic interventions (Day Treatment staff may provide only therapeutic interventions.)	Policy & procedure manuals, program description, contact log		Policy and procedure manuals, program description, MOA				MOA, meeting minutes, service records, PCP, staff interviews
c 1) Collaborates with other service providers 2) Protocols in place for collaboration with the LME and other service providers to identify the first responder	Policy & procedure manuals, program description		Policy and procedure manuals, program description				Meeting minutes, service records, PCP, staff interviews
d Encourages family involvement in planning and treatment	Policy & procedure manuals, program description		Policy and procedure manuals, program description				Meeting minutes, service notes, PCP, staff interviews
e Day Treatment staff will demonstrate their knowledge and understanding of the service as well as demonstrate their clinical expertise and skill level by successfully completing a clinical interview.		Staff interview					

Reviewer:
Date Reviewed:

**NC DHHS
DMH/DD/SAS**

Provider: _____
Site: _____

Child and Adolescent (MH/SA) Day Treatment

Day Treatment Elements	Endorsement Review Evidence of Compliance			Findings (Identify review)			60 Day Review Evidence of Compliance
	Desk	Clinical Interview	On Site	MET	NOT MET	NA	
Documentation Requirements							
a Minimum standard is a full service note per date of service, written and signed by the person(s) who provided the service that includes the following: <ul style="list-style-type: none"> • Child's name • Service record number • Medicaid identification number • Service provided (for example, Day Treatment services) • Date of service • Place of service • Type of contact (face-to-face, telephone call, collateral) • Purpose of the contact • Description of the provider's interventions • Amount of time spent performing the interventions • Description of the effectiveness of the interventions • Signature and credentials of the staff member(s) providing the service 	Policy and procedure manuals, service records manual, program description		Policy and procedure manuals, service records manual, program description				Service records, attendance roster, contact logs
b Documentation of interventions/activities that discussion of Discharge Plan and transition with child, family/caregiver, and Child and Family Team, beginning at the time of admission	Policy and procedure manuals, service records manual, program description		Policy and procedure manuals, service records manual, program description				Service records, attendance roster, contact logs

Reviewer:
Date Reviewed:

**NC DHHS
DMH/DD/SAS
Child and Adolescent (MH/SA) Day Treatment**

Provider: _____
Site: _____

Comments

Reviewer:
Date Reviewed:

**NC DHHS
DMH/DD/SAS
Child and Adolescent (MH/SA) Day Treatment**

Provider: _____
Site: _____

Comments

Reviewer:
Date Reviewed:

**NC DHHS
DMH/DD/SAS
Child and Adolescent (MH/SA) Day Treatment**

Provider: _____
Site: _____

Comments

Reviewer:
Date Reviewed:

**NC DHHS
DMH/DD/SAS
Child and Adolescent (MH/SA) Day Treatment**

Provider: _____
Site: _____

Comments

Important Information for Consumers and Family Members about the 2010 Census

Please use the information below to write to your consumers and family members about the importance of participating in the 2010 census

The U.S. Census 2010 will begin in a few weeks. It is important that all voices be heard and that every individual is given the tools they need to be able to understand and participate in this important process. Here are some reasons why you play a big part in census 2010:

1. It is important - It is both your right and responsibility to take part in the census. The results of the census will affect your community's future as well as your own. The census will help to establish how many people live in the country. This helps decide how many representatives North Carolina will get in the U.S. House of Representatives. The census also plays a part in deciding how billions of dollars per year are spent. Information from the census directly affects the quality of life for people with disabilities and their families through funding for improvements in healthcare, education and social service programs. Correct information on the census is especially important to people with disabilities because many people with disabilities rely on government and social service programs to help them.
2. It is an easy way to make sure you are counted - The census form has 10 questions and should only take a short time to complete. If you have any questions about filling out the form, the census has set up a telephone number that you can call to get answers to your questions. The telephone number to contact is 1-866-872-6868 for English, 1-866-928-2010 for Spanish and TDD for the hearing impaired at 1-866-783-2010. There will also be Questionnaire Assistance Centers (QAC) in your community to help people with completing their census forms. You can contact the Charlotte Regional Census Center for more details about the types of assistance available and for QAC locations near you. You can reach the Charlotte Regional Office at 1-800-331-7360 or at the website at Charlotte.Regional.Office@census.gov.
3. It is safe and confidential - You may be reluctant to share personal information on the census form or with census workers. It is important that you feel comfortable with the process and that any misunderstandings you have about the process are explained to you. By law any information you share on your census form or with a census worker is kept private. In fact, census workers are sworn for life to keep information confidential. Your information cannot be shared with other government agencies or with law enforcement. There are stiff penalties for unlawful disclosure of information shared through the census process. You may also be anxious about strangers coming to talk with you. Census workers will only be going out into the community to try and reach people for whom they have not received a census form. Census workers will carry identification and a census bag which will be easily identifiable. If you have any questions about someone who says they are a census worker you should call the census office and share your concerns. It is very important that you feel comfortable about sharing your information and that you feel your information is being kept safe.

We all need to participate in the census and to ensure that the voices of all North Carolinians are heard. Please be a part of the process and remember, "It's In Our Hands."