

**Smoky Mountain Center LME
Q&A Regarding Enhanced Services Implementation**

Questions	Answers
Access	
1) Will the LME be using the same screening form after March 20 th (page 1 of Client Screening Profile)? Will the provider continue to have access to a review of the screening form?	Beginning March 20 th the LME will use a new STR form designed to make presumptive target population determinations. that will only be available to LME staff.
2) Will the LME always refer new consumers to Community Support and Diagnostic Assessment or will there be times, based on screening information, that an individual will be referred directly to a higher level of service? In these cases, will the alternate service provider be expected to coordinate the Dx Assess. and complete the PCP?	There may be times, based on information obtained during STR that a consumer will need to be referred evaluation for possible treatment to begin before completion of a Diagnostic Assessment and development of a PCP. Alternatively, Diagnostic Assessors who identify a need for treatment to begin quickly should call the LME and review the case with a Care Manager.
3) Will consumers be given the choice of both Community Support provider and Diagnostic Assessment provider or will this be treated as one choice?	Medicaid consumers presumed to be in a Target Population will be offered choice for both services. For State-funded consumers presumed to be in a Target Population and referred for a 90801 or "Basic Assessment," Community Support will not be authorized until results of the Basic Assessment have been reviewed by the LME.
4) Will the LME always refer simultaneously for Community Support and Dx. Assess. or will there be times when the Community Support provider will determine whether a Dx Assess. is needed? In this case, will a PCP be developed?	Community Support providers will not determine the need for Diagnostic Assessment.
5) Would there be situations where referral for a Diagnostic Assessment would not occur for a Medicaid-funded individual presumed to be in a target population?	No. Medicaid consumers presumed to be in a Target Population will be referred for a Diagnostic Assessment.
6) What will the referral process look like to providers? Will the	The LME will contact a designated person at the endorsed

LME expect to schedule directly or refer to a designated person within the provider organization?	agency to schedule the initial appointments. Authorizations will be to agencies, not individuals within agencies.
7) What is the current estimate of Diagnostic Assessment capacity across the counties? How will individuals be referred for a Diagnostic Assessment and how do we, as providers, communicate capacity on an ongoing basis?	We anticipate Diagnostic Assessments being available in all seven counties. The exact capacity is not known at this time.
8) For state-funded individuals, are they typically going to be referred for a 90801 rather than a Dx. Assess? Are there exceptions to this that will be identified at the time of screening? Will the 90801 continue to be documented on our current Client Screening Profile, pages 1-4?	The default assessment for a State-funded individual presumed to be a member of a target population will be a 90801 or “Basic Assessment.” However, such State-funded consumers deemed to present complex service needs may be referred for a Diagnostic Assessment rather than Basic Evaluation. Basic Assessments will be documented in the LME form; we expect that the form will be added to Entity but is not there now.
9) For state-funded, is it true to assume that there will be no direct referral to Community Support since an individual cannot be leveled until after the assessment and some levels do not get community support?	Ordinarily, referral of State-funded consumers to Community Support will be after LME review of the Basic Assessment or Diagnostic Assessment.
The First 30 Days	
10) How will records be opened after March 20 th ? Will the Community Support provider open the record? If so, what will be involved (i.e. what specific information will be included) since the Diagnostic Assessment will not be completed and a working diagnosis has not been established? Will DMA allow Medicaid billing in the absence of a diagnosis?	The Community Support worker may open a record; specific documentation requirements will be determined by the medical record requirements for each agency. A diagnosis or a <i>provisional diagnosis</i> must be given to bill for all services, including those provided during the first 30 days.
11) How is the service order for the first 30 days generated for Community Support? Is it the responsibility of the Community Support provider, the LME of the Diagnostic Assessment provider to obtain the service order? If the Dx. Assess serves as	The Diagnostic Assessment service definition states, “This assessment will include signing the order for the initial PCP.” The LME has received conflicting information regarding Service Order requirements for Community Support delivered

<p>the service order, how does this cover Community Support activities which occurred prior to or simultaneous with the Dx. Assess.?</p>	<p>before the PCP is developed. We will provide clarification when this is resolved. In the interim, providers may wish to write Service Orders to cover the initial 30 days of Community Support.</p>
<p>12) Does it even make sense to establish medical necessity for 30 days of service based on an S-T-R contact?</p>	<p>Referral from the LME is sufficient justification for a Diagnostic Assessment and Community Support necessary to develop a PCP.</p>
<p>13) In the state and/or council documents and/or trainings, there is reference to situations where a Medicaid-funded individual may just want Basic Benefit services. It appears that, as long as this individual has come to the attention of the LME, they are required to receive Community Support for the purpose of coordinating their basic benefit services and monitoring their status. In this case, is there a Dx. Assess? a PCP developed? Does the Community Support provider stay involved on an ongoing basis?</p>	<p>A Medicaid enrollee presumed to be in a target population will be referred by the LME for Diagnostic Assessment and 30 days of Community Support, not basic benefit services. Any Medicaid enrollee may obtain basic benefit services from a direct-enrolled Medicaid provider without referral or authorization from the LME.</p>
<p>14) For state-funded individuals that fall at Level A or B, how would the LME want providers to proceed after the 90801?</p>	<p>This will be determined based on recommendations from the Basic Assessment and review by the LME.</p>
<p>15) Are there situations where Comm. Support would be provided without a Dx. Assess. ever having taken place?</p>	<p>Referral for Diagnostic Assessment or Basic Assessment will always be made concurrently with or prior to a referral for Community Support.</p>
<p>16) Whose responsibility is it to arrange for Dx. Assess, the LME or the Community Support provider?</p>	<p>The LME will refer and offer choice of Diagnostic Assessment (or Basic Assessment) providers to persons beginning service. A Community Support provider working with a Medicaid consumer receiving services before 3/20/06 will offer choice of Diagnostic Assessment provider before development of the first PCP.</p>
<p>17) Will we automatically receive an authorization for 224 units of Community Support for the first 30 days for all Medicaid consumers? Will there be any exceptions to this?</p>	<p>Medicaid consumers may automatically receive up to the number of units of Community Support specified in the current Medicaid Authorization Grid for the first 30 days to develop a PCP.</p>

18) If the Community Support provider is opening the record, how are they coding the initial contact, i.e. an intake assessment code or Community Support code? If a Community Support code, how will we assure that the service order is in place prior to rendering the service so that we can get paid for the service?	Community Support providers will document and code their services as Community Support. No Service Order is required for the first 30 days of Community Support.
19) If you need extensions beyond 30 days to develop the PCP, what is the process for requesting this?	If it is not possible to complete the Diagnostic Assessment and develop a PCP within 30 days, providers may contact the LME to request an extension.
20) During the first 30 days, if there is a need for urgent services, such as residential placement, how does it affect the sequence of activities, including the development of the PCP and the Dx. Assess? How will this process occur?	In this situation, the provider may call the LME to request authorization for another service.
21) How will the Diagnostic Assessment be documented? Is the LME going to develop a template or should providers develop their own?	Diagnostic Assessments will be documented in the LME's Diagnostic Assessment Form that will be available on our website by 3/20/06.
22) Is it correct to assume that there will be 3 documents to be completed by providers during the first 30 days for a Medicaid client:	
a. A document to open the record	Providers complete whatever process is required to open their specific medical record.
b. A diagnostic assessment form	Yes – template to be provided by the LME by 3/20/06.
c. A person-centered plan	Yes – template to be provided by the Division, presumably by 3/20/06
How close are we to having each developed?	See above.
23) In situations where it is not apparent that a specialized SA assessment needs to be done until the Diagnostic Assessment occurs, will the LME pay for the additional specialized assessment?	If specialized assessments not included in the Diagnostic Assessment process are indicated, separate authorization should be requested from the LME. This could apply to a significant substance abuse problem identified in the Diagnostic Assessment but not during screening.
24) If the Community Support provider determines very quickly that	If completion of the PCP is contraindicated before starting

<p>an individual probably needs a higher level of care, are they required to complete the PCP or can they refer the individual on and allow the PCP to be developed by the provider at the appropriate level of care? In this case, would the new provider just continue to coordinate with the Dx. Assess provider to obtain the Dx. Assess. report?</p>	<p>other services, the case should be reviewed with an LME Care Manager who may authorize additional services. That discussion will establish a plan for completion of the PCP.</p>
<p>Person-Centered Planning and Issues of Clinical Home</p>	
<p>25) What will we use if the state has not released the Person-Centered plan by March 20th?</p>	<p>The Division has given assurances that the State PCP will be available by 3/20 06.</p>
<p>26) Will providers have the choice of completing/submitting the PCP in Entity or in another format, such as Provider Link? Will Partnership Model providers be required to submit the PCP in Entity or may they choose another avenue?</p>	<p>Initially, PCPs will be submitted to the LME by fax or hard copy (look for instructions with the PCP form). The LME intends to make the PCP available in Entity for Entity users, and will probably establish a procedure to receive PCPs via ProviderLink.</p>
<p>27) Will the LME provide specific guidelines for completing the PCP in order to assure that we comply with the essential elements?</p>	<p>The State will provide LMEs with a checklist of minimal criteria for approving PCPs. We will make those criteria available to PCP developers.</p>
<p>28) What is the LME's current understanding of the issue of continuity of clinical home? In other words, does the clinical home change as an individual moves into a service at another level of care that has a case management component or does it remain constant, regardless of the service received?</p>	<p>A consumer's clinical home will shift as s/he moves to a new service that has the case management component built into the service.</p>
<p>29) If it is constant, would there be any cases where providers would be expected to work under a PCP developed by another provider? Would there be exceptions for psychiatric services (i.e. the psychiatrist is using the physician plan developed by SMC) or other instances where an individual provider needs the flexibility to determine their own goals and write their own plans? In this case, could it be as simple as appending individual provider goals to the PCP?</p>	<p>NA</p>

<p>30) Regardless of the answer to #28, one instance where a clinical home provider would exist separate from a service would be therapeutic foster care. In this case, who is responsible for developing the PCP, the residential provider or the Community Support provider? If it is the Community Support provider, how does the residential provider facilitate plan modifications? And what recourse would the residential provider have when they have concerns about a plan holding up under audit?</p>	<p>In most instances, a consumer would have a PCP before going into Therapeutic Foster Care. The Community Support worker would be responsible for coordinating all services for the consumer and for updating the PCP as necessary. All service providers should communicate regularly with the Community Support provider about progress in treatment and necessary changes to the plan.</p>
<p>31) At the end of 30 days, the Community Support provider submits the PCP for review and authorization of all formal services in the plan. If the plan actually refers an individual to another service, i.e. SAIOP or MST, how would the authorization process and service order process be coordinated? Who will receive the authorization?</p>	<p>The PCP will serve as the initial authorization request. Each provider is responsible for requesting reauthorization before expiration of their authorizations. Authorizations will be sent to each provider organization.</p>
<p>32) Do PCP's have to be submitted every time there is a modification or just when there is a request for re-authorization?</p>	<p>A PCP will need to be submitted with a reauthorization request when there are changes to the PCP.</p>
<p>Authorizations</p>	
<p>33) Beginning 3/20/06, are there any services that are preauthorized, i.e., the first 30 days of Community Support and Diagnostic Assessment?</p>	<ul style="list-style-type: none"> • Diagnostic Assessment and Basic Assessment (90801, H0031, H0001) do <u>not</u> require authorization for providers endorsed for Diagnostic Assessments • Basic Assessment (90801, H0031 and H0001) with any provider not endorsed for Diagnostic Assessments <u>requires prior authorization</u>. • Community Support always requires authorization by the LME. • The LME will authorize to the provider, without request, 224 units for the first 30 days of Community Support for Medicaid consumers presumed to be in a target population at screening.

	<ul style="list-style-type: none"> • State-funded consumers referred for Basic Assessment (90801, H0031, H0001) will not receive an initial authorization for Community Support. The LME will review the Basic Assessment report with provider recommendations to determine whether any Community Support will be authorized. • State-funded consumers referred for Diagnostic Assessment will also be authorized and referred for 16 units of Community Support at screening.
<p>34) Please indicate all of the documents that the LME will require for submission with the PCP for the authorization of services to occur? What is the process for submission, including who and where to submit to?</p>	<p>The PCP submitted for review will include the Diagnostic Assessment and Crisis Plan. Instructions for PCP submission will be provided after the LME receives and reviews the State PCP form.</p>
<p>35) Will there be a new authorization request form to accompany the PCP or will we use the same one? What will the authorization process look like?</p>	<p>The LME will make that determination & inform providers after we receive the State's PCP form.</p>
<p>36) What is the anticipated turnaround time for authorization requests and how is the LME going to notify us of approval?</p>	<p>Authorization review & decision times (three business days) and notification process (e-mail) will not change.</p>
<p>37) Will the Community Support provider that develops the PCP be responsible for requesting authorizations for all the services in the plan? If other providers are involved, how will they receive authorizations?</p>	<p>The PCP will serve as the initial authorization request for services included in the plan. Each service provider will request reauthorizations as necessary.</p>
<p>38) How will the LME handle situations where a Clinical Home submits for an authorization and then the individual is referred to another service? Will the authorization transfer or will the new provider be required to get another authorization?</p>	<p>The PCP will need to be updated by the Clinical Home to reflect the new service and the provider of each service. The LME will terminate the first authorization and issue a new authorization.</p>
<p>39) What will be the LME's disposition towards authorization of basic benefits for Medicaid recipients after unmanaged visits have been utilized?</p>	<p>At this time, ValueOptions, not the LME, handles requests for extension of basic benefit services.</p>

<p>40) Will the LME authorize plans that include ongoing basic benefit layered with Community Support? What would be the situations where such a PCP would be denied? In other words, is medical necessity the only criteria for authorization of services or is there going to be an effort to encourage transition to the new service philosophy of community support as a clinical intervention?</p>	<p>With the exception of medication management, the LME believes that enhanced services, rather than basic benefit services, will best serve most target population consumers. A variety of services and supports occur within Community Support, including provision of many evidenced-based practices. LME reviewers will look for clinical justification of basic benefit services included in PCPs.</p>
<p>41) In the 2/21/06 memo from the state, there is reference to the latitude that the LME's have to do extended authorization periods: "Following medical necessity criteria, both existing and new Medicaid services may be authorized for up to six months. State funded services may be authorized for up to six months based on funds as available". Does SMC plan to extend any authorization timeframes, and, if so, is this considered by the provider in the request or just done on the LME's end?</p>	<p>Other than extending some authorizations from 90 to 102 days between 3/20/06 and 6/30/06 the LME intends to authorize services within the service definition limitations.</p>
<p>42) If the Diagnostic Assessment takes 30 days, how can a client receive Community Support or other services that might be needed during that period without the diagnosis or service order in place?</p>	<p>The first 30 days of Diagnostic Assessment and Community Support are approved on the basis of presumptive and no service order is required for those services. The Division has indicated, however, that a provisional diagnosis must be made to bill for these services.</p>
<p>43) Once a consumer receives CAP services, who requests authorization, the provider or the case manager?</p>	<p>For CAP, the Case Manager requests authorization.</p>
<p>44) If a consumer is receiving 28 hours per week of Community Support and his/her doctor states that s/he needs more, will the consumer receive this?</p>	<p>For unusual situations, providers may submit Specialist Review requests for service intensities that exceed service definition limits. Care Managers reviewing such requests will look for clear and strong clinical justification for the request and for a plan to step-down services back within service limits.</p>
<p>Transitioning Existing Consumers</p>	

<p>45) Can you outline the process of updating the service plans to incorporate the new service definitions, including the specifics and when we can start doing this? When will new drop-down menus be built which include the new service definitions?</p>	<p>The new services are being added to Entity. For current services that crosswalk to new services, existing service plans can be modified to note the new service name and frequency, and be signed by the provider and consumer/guardian.</p>
<p>46) What about client participation signatures? Does the letter submitted for choice count for the client acknowledgement of plan medication, if no other changes have occurred?</p>	<p>Service plan updates should be made and signed by consumers/guardians.</p>
<p>47) The state identified a transition plan for individuals already receiving services that involved merely updating the plan and continuing to provide services under authorizations already obtained, the LME changed most authorizations to assure that they ended by 3/20/06? In anticipation of the flood of authorizations on 3/20/06, when can we start submitting authorizations for new services for existing consumers and what specific directions should we give our staff?</p>	<p>Authorization requests for new services can be submitted as of 3/16/06. For this transition period only, retrospective authorizations for the period from 3/20/06 through 3/26/06 will be accepted through 3/27/06.</p>
<p>48) For individuals who will receive IIH starting 3/20/06 (who have already been receiving it as a nonbundled service under the grant), how will this service be authorized and ordered during the first 30 days while their PCP is being developed? What documentation will be required by the LME?</p>	<p>Intensive In-Home Service started before 3/20/06 as unbundled services cross-walks to the new IIH Service, requires only a service plan update as described in #45 above, and does not require a PCP until the month of the consumer's next birthday. Documentation requirements are found in the service definition.</p>
<p>49) Are we to understand that we update plans to include Community Support and submit an authorization by 3/20/06 that will extend for 90 days and that there is no expectation for a PCP to be developed until their birth month?</p>	<p>The current services of MH/SA Case Management and Community Based Services crosswalk to Community Support and do not require a PCP until the month of the consumer's next birthday.</p>
<p>50) How can we prepare state funded clients as to whether or not they can continue receiving services after 3/20/06?</p>	<p>State-funded consumers may receive continued authorization for the same services they received before 3/20/06 according to the State-funded Authorization Grid and funding availability until 6/30/06. By 7/1/06 all target population consumers should complete basic services or transition to enhanced services.</p>

General Misc. Questions	
51) What is the LME's sense about the availability of groups – basic benefit, community support or otherwise – after March 20th? Will any group services be pre-authorized as they are currently?	Through June 30 th , group therapy will continue to not require authorization as is currently the case.
52) How will the LME fund service to the TNC individuals in the new world?	No changes are anticipated through June 30 th .
53) Have the notes headers been built for the new service definitions?	Yes, they are built in Entity.
54) How will we determine level of care after March 20?	The Medicaid and State-Funded Level of Care Grids will be posted on our website by March 20.
4) What if my Medicaid client is screened as target population, but does not wish to receive a diagnostic assessment or community support?	Medicaid consumers who fall into a presumed target population are free to independently choose and receive basic benefit services, but the LME will refer such individuals only to enhanced services.
5) As an independent practitioner, can I anticipate continued referrals for basic services after March 20 th ?	The LME expects to refer only basic benefit Medicaid consumers to practitioners not part of endorsed organizations.
6) Because Targeted Case Management has not been approved yet, how can we continue to provide and bill for case management services after 3/20/06?	You can continue to provide case management services and bill them through SMC.
7) Can we get something in writing with guidelines for retro-authorization and how much Community Support services can be provided as we transition from CBS?	<ul style="list-style-type: none"> • Authorization requests for new services can be submitted as of 3/16/06. For this transition period only, retrospective authorizations for the period from 3/20/06 through 3/26/06 will be accepted through 3/27/06. • See the Level of Care grids for authorization guidelines
8) In serving consumers who meet requirements for CAP but who have not been approved yet, is it safe to assume we can provide state funded Developmental Therapy until we can obtain CAP authorization?	Please see separate communication re requesting interim authorizations for Developmental Therapy while MR-2s submitted are pending.

59) What is the cutoff date for submitting MR2 for CAP?	MR2s must be signed by a physician/licensed psychologist on or before 3/19/06 for consideration in this transition from CBS Service.
60) Will a consumer who has been receiving MR/MI services still be able to receive them after March 20?	Yes, unless they are approved for CAP services.
61) After I receive a referred consumer who has been through the screening, triage, and referral process, will I be able to look at Page 1 of the client screening profile in Entity to get specific client information?	Page 1 of the Screening Client Profile will no longer be accessible in Entity after March 20 th .
Billing	
62) Is there a plan to convert the providers to using the HCPCS codes for the new services rather than a SMC code?	New "Attachment A – Rate Schedules" will be mailed to all providers shortly which have the Medicaid and State procedure codes instead of SMC service codes.
63) How should the Dx Assess. Be billed since it may take the provider more than one day to complete?	Diagnostic Assessment is to be reported and billed as one event one time, regardless of the number of days it takes to complete.
64) How will providers bill Medicaid for Community Support during the first 30 days of service when the Dx Assess. and PCP are being completed as there may not be a diagnosis?	A provisional diagnosis must be used in billing these services.