



PBH Waiver Expansion Frequently Asked Questions



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PBH Waiver Expansion Frequently Asked Questions

General Waiver Expansion

1. Please explain the new relationships between PBH and the Alamance-Caswell, Five County, and OPC Local Management Entities.

PBH is partnering with the above Local Management Entities to manage Medicaid-funded behavioral health services under the concurrent 1915 (b)(c) waivers, also called the Cardinal Innovations Health Plan. The partnership with Alamance-Caswell was effective October 1, 2011. Five County's partnership with PBH will begin January 1, 2012, and OPC's partnership is planned for April 1, 2012. On these dates, PBH also will assume management of State-funded behavioral health services for each of these Local Management Entities, which will become local Community Operations Centers affiliated with PBH.

2. How will the Community Operations Centers be structured?

The Community Operations Centers will consist of the following departments: Care Coordination, Network Operations, Community Relations, Consumer Affairs, and Quality Management. Individuals interested in posted positions must apply through the PBH website. Interviews will be conducted by local Community Operations Center staff, in collaboration with PBH staff.

3. How will consumers, families, providers, and community stakeholders be educated?
PBH and the Community Operations Centers are offering meetings specific to waiver expansion for consumers, families, providers, and community stakeholders.

Moving forward, PBH and the Community Operations Centers will provide ongoing education to consumers at periodic community meetings through the Office of Consumer Affairs. This department provides community meetings and trainings, such as "Skills and Pizza" events, which provide information for consumers on a variety of topics.

4. Will training materials be available online?

Training materials will be posted on the PBH website and also will be available through the Community Operations Centers' websites.

5. Will everyone in the counties covered by the Cardinal Innovations Health Plan have access to the Waiver services?

It is important to understand that enrollment in the Cardinal Innovations Health Plan is not based on where an individual physically lives. Instead, it is based on where the individual's Medicaid originates. All individuals who have Medicaid which originates from one of the

counties covered by the Waiver will have access to the services, regardless of where in North Carolina that individual physically lives.

Examples:

An individual who physically lives in Guilford County but whose Medicaid originates from Alamance County will be enrolled in the Waiver.

An individual who physically lives in Alamance County but whose Medicaid originates from Guilford County will not be enrolled in the Waiver.

6. Will there be more services?

The Cardinal Innovations Waiver offers services that are not available in the CAP-MR/DD Waiver. Examples of these services are In-Home Skill Building, Natural Supports Education, Community Guide, and Community Networking.

In addition, managed care tools have allowed PBH to offer services that are not included in the State Medicaid plan. These services, called Medicaid Optional (b)(3) services, are for individuals who have Medicaid and are as follows:

- Respite (Child MH, Child IDD, and Adult IDD);
- Community Guide (Child IDD and Adult IDD);
- Supported Employment (Adult IDD);
- Peer Support (Adult MH and SA);
- Community Transition (Adult IDD);
- Individual Support (Adult MH);
- Psychiatric Consultation (Child and Adult MH); and
- DI Service Array (IDD).

These Medicaid Optional (b)(3) services may be used to support individuals with Medicaid who otherwise would have utilized limited State funding or who may have been waiting for services.

7. How are referrals made to provider agencies?

There will continue to be a toll-free number for the Access call center, which consumers, family members, and providers can call for referral information. Callers are given a minimum of three provider options from a rolling list, so the process is objective. If more options are requested, Access staff will provide contact information for more providers from the rolling list. Callers who already have the name of a provider in mind will receive contact information.

Hospital staff requesting referrals to assist with discharge planning also may call the toll-free number to schedule appointments for follow-up care. Callers will receive three provider choices closest to where the consumer lives who are able to see the consumer within 48 to 72 hours.

8. Once a referral is made, how long before a consumer starts to receive services?
The timeline is contingent upon the consumer's needs. If the consumer requires emergent services, the call center's goal is to schedule an appointment within two hours. If the need is for urgent services, the goal is to schedule an appointment within 48 hours, and if the need is for routine services, the goal is to schedule an appointment within 14 calendar days.
9. Can someone from another county outside of the PBH and expansion catchment areas get services?
PBH and the Community Operations Centers will manage services to consumers with Medicaid **originating** within the PBH counties and the expansion counties, regardless of where in North Carolina the individuals physically live.
10. Are there steps being taken to draw more providers to rural areas?
Capacity studies are being conducted to assess the availability of providers/services in each area where consumers live. Using real data, these studies evaluate the locations of Medicaid consumers, providers, and available services. Provider and/or service expansion efforts will be based on the results of the capacity studies, to ensure that consumers have access to needed care. The Waiver requires that individuals have access to services within 30 minutes/30 miles (45 minutes/45 miles in rural areas, as defined by census data). PBH will ensure that there are sufficient providers to meet this requirement.

Community Collaboration

11. How does PBH promote community collaboration?
PBH actively partners with individuals, families, providers, and community stakeholders through a number of activities and forums: provider trainings; Consumer/Family Advisory Committees (CFAC); Network Council; Global Continuous Quality Improvement Committee; and County Advisory Councils (multi-disciplinary teams of community members representing the local Department of Social Services, Police Department, Courts system, Health Department, etc.).
12. How will PBH obtain information from stakeholder agencies regarding the needs of the expansion counties?
The Community Operations Centers will remain active partners in community stakeholder meetings. PBH staff members also will attend local provider meetings, as needed.
13. How does PBH plan to participate in planning groups in each community?
The Community Operations Centers will participate in community planning groups. Staff members will be learning more about how to use managed care tools to provide services in each community.
14. Will there be System of Care positions for each community?
Yes, there will be a System of Care Coordinator at each Community Operations Center.

15. Will PBH's managed care system reduce the utilization of the hospital emergency department by mental health consumers?

One of the goals of the managed care system is to ensure that consumers have access to needed services in a timely manner. If consumers receive needed services, their risk of crisis is reduced. Outreach is provided to individuals who present at Emergency Departments for behavioral health assessment/treatment, as well as for those who are admitted for psychiatric treatment, to ensure that they are linked to behavioral health homes and appropriate services.

16. Will PBH work to address the local housing needs of mentally ill homeless residents?

There will continue to be a Housing Specialist at each Community Operations Center to address this critical need.

1915(b) Managed Care Waiver (Cardinal Plan)

17. What is being waived?

The federal government allows for the waiving of part of the Social Security Act, permitting more local control over the management of services. The services provided through this Waiver are the State Medicaid Plan services. Medicaid makes monthly payments (capitation) to PBH, which is then responsible for ensuring that consumers receive the services they need. In turn, PBH pays quality providers in a closed network; this Provider Network is based on well-documented community needs.

Through cost savings using managed care tools, additional Medicaid Optional (b)(3) services are available beyond those in the State Medicaid Plan. Individuals with the most severe needs receive the most services and support in the system.

18. Can I choose not to enroll in the Waiver?

The Cardinal Health Plan does require mandatory enrollment to ensure that all needed behavioral health services are available when an individual may need them. Just as with private insurance, some people will access services regularly and others may not.

19. How will the waiver expansion impact enhanced mental health and substance abuse services such as Intensive In-Home Services, Community Support Team, and Assertive Community Treatment Team?

All of the services in the State Medicaid Plan, including those listed above, will continue to be available.

20. How does the Medicaid Waiver assist individuals with developmental disabilities who are not receiving Innovations services?

Medicaid Optional (b)(3) services are available for individuals with Medicaid who are waiting for Cardinal Innovations services (similar to CAP-MR/DD services).

Medicaid Optional (b)(3) services include

- Respite (Child MH, Child IDD, and Adult IDD);
- Community Guide (Child IDD and Adult IDD);
- Supported Employment (Adult IDD);
- Peer Support (Adult MH and SA);
- Community Transition (Adult IDD);
- Individual Support (Adult MH);
- Psychiatric Consultation (Child and Adult MH); and
- DI Service Array (IDD).

There will continue to be limited State-funded services for those individuals without Medicaid.

21. How do individuals without Medicaid access services?

As above, there are limited State-funded services for those individuals without Medicaid. The advantage of a waiver is that Medicaid dollars meet the needs of persons with Medicaid coverage, which leave State dollars available for people who do not have Medicaid.

22. Can new Medicaid Optional (b)(3) services be added to provide additional care/services to those currently on the CAP-MR/DD waiting list?

An additional (b)(3) service called Community Guide recently was added to the PBH benefit package. PBH continues to document unmet needs to justify the addition of Medicaid Optional (b)(3) services or the expansion of services.

1915(c) Home and Community Based Waiver (Cardinal Innovations Waiver)

23. What is being waived?

The following rules in the Social Security Act are waived under the Cardinal Innovations Waiver.

- Comparable Services – The Act requires a state to provide comparable services in amount, duration, and scope to all Medicaid recipients. This requirement is waived to allow services to be offered only to individuals participating in the Cardinal Innovations Waiver.
- Deeming of Income and Resources – The income and resources of the individual is considered in determining Medicaid eligibility, rather than the income of the individual's parent or spouse. Usually, Waiver recipients are eligible for Medicaid regardless of their family/spouse's income or age. There are exceptions; please contact your local Department of Social Services about this issue.
- State-Widedness – Services do not have to be provided in every county of the State. Cardinal Innovations Services are available at this time only in the PBH area, which includes Alamance, Cabarrus, Caswell, Davidson, Rowan, Stanly, and Union counties.
 - Franklin, Granville, Halifax, Vance, and Warren counties will be included in the Cardinal Innovations Waiver effective January 1, 2012.
 - Chatham, Orange, and Person counties will be included in the Cardinal Innovations Waiver effective April 1, 2012.

24. How do current CAP-MR/DD recipients whose Medicaid originates from one of the covered counties become Cardinal Innovations recipients?

CAP-MR/DD recipients will automatically transition to the Cardinal Innovations Waiver on the specified date for waiver implementation. They will continue to receive services, crosswalked with Cardinal Innovations services. Care Coordinators from the Community Operations Centers will assist with the transition.

Individuals receiving services under the CAP-MR/DD Support and Comprehensive Waivers will receive Cardinal Innovations services. Cardinal Innovations services are similar to CAP-MR/DD services, but it is one waiver system instead of two waivers in a tiered system.

The waiting lists from the expansion counties will be transitioned to the Registry of Unmet Needs. As Cardinal Innovations waiver slots become available (typically in April of each year), individuals will be prioritized on a first-come, first-served basis with slots equally distributed across the region on a population basis. Medicaid Optional (b)(3) services may meet the needs of some individuals with Medicaid who are on the Registry of Unmet Needs.

25. Are there any materials that explain the difference between the CAP-MR/DD and Cardinal Innovations Waivers?

PBH has developed a document called "Comparison: Cardinal Innovations and CAP-MR/DD Waivers," which has been distributed at community meetings and will be posted on-line.

26. Will Home Supports be eliminated under Cardinal Innovations?

Home Supports will not be available as a service, but equivalent services will be: In-Home Skill Building, In-Home Intensive Support, and Personal Care. The crosswalk from Home Supports may include more than one of the above services, depending on the consumer's specific goals. Relatives/guardians who live in the same home as the consumer may provide these services, if they are employed by a provider agency and meet the Relative as Direct Support Employee criteria. The provider who employs the relative or guardian will be responsible for ensuring that necessary processes are followed.

27. Do In-Home Skill Building, In-Home Intensive Support, and Personal Care have daily rates like Home Supports?

No – each periodic service is billed in 15 minute units.

28. Can consumers get services out of state?

Cardinal Innovations Waiver services are not available outside of North Carolina, unless approved by PBH's Utilization Review Department under the Cardinal Innovations out of state process. Exception: Individuals living in border counties (along state lines) may utilize services in a neighboring state; services must be provided within 40 miles of the state line.

If a consumer permanently moves out of state, Cardinal Innovations Waiver services cannot follow or be transitioned outside of the state.

29. Will consumers in the Cardinal Innovations Waiver still have deductibles?

The same Medicaid rules regarding deductibles apply. There is a monthly spend down that will have to be met first before the Department of Social Services (DSS) will issue a Medicaid card. Care Coordination staff from the Community Operations Centers will work closely with consumers and their families to assist with deductible issues.

30. Will there be a revised Individual and Family Guide?

Yes, it is available on-line and via mail.

Care Coordination

31. Will Targeted Case Management continue to exist?

Targeted Case Management is not a service offered under Managed Care Organizations (MCOs). The Division of Medical Assistance (DMA) has ended Targeted Case Management as a service for waiver sites statewide.

Care Coordination, an administrative function under MCOs, will be provided as needed. Care Coordinators are responsible for risk management and quality management functions. They identify consumers' special needs, ensure that appropriate assessments are completed, develop plans (or ensure that they are completed), and facilitate access to specialists as needed, etc.

Community Guide, an Innovations service and also a recently approved (b)(3) service, promotes self-determination, increases independence, and enhances the individual's ability to interact with and contribute to his/her local community. Community Guide services emphasize, promote, and coordinate the use of natural (unpaid) supports to address the individual's needs – in addition to paid services. Providers now offering Targeted Case Management for individuals in CAP-MR/DD are invited to join the PBH network to become Community Guide providers.

32. Can consumers continue to work with their Targeted Case Management provider agency?

Targeted Case Management provider agencies will be given the opportunity to join the PBH Provider Network and will be trained to provide Community Guide services. Some Targeted Case Managers may be hired as Care Coordinators with the Community Operations Centers. Consumers who would like to continue to work with these individuals as their Care Coordinators should make their wishes known, so that the Community Operations Centers may accommodate their preferences.

33. What procedures will be used to notify consumers and families of Care Coordinator assignments?

All consumers will receive information in the mail and telephone calls from Care Coordination.

34. How many consumers does a Care Coordinator typically work with at one time?

The average ratio is one Care Coordinator to thirty consumers with intellectual/developmental disabilities. The ratio may be higher for consumers with mental health/substance abuse issues, as Care Coordination for these consumers may be more episodic in nature.

35. Will consumers in Cardinal Innovations still have Person Centered Plans? Who will be responsible for developing them?

Rather than the State's Person Centered Plan, a document called the "Individual Support Plan" is used for Cardinal Innovations. This plan is very similar to the State's Person Centered Plan. Individual Support Plans are developed annually on consumers' birthdates. Care Coordinators are responsible for documenting the team's discussion on the plan document.

The Individual Support Plan contains long range outcomes only. The provider is responsible for developing the short-range goals and associated interventions, strategies, and task analysis. All short-range goals must directly tie back to a long range outcome in the Individual Support Plan. Including only long range outcomes in the Individual Support Plan allows for greater flexibility to revise and/or add short range goals as needed, without the necessity of a team meeting, plan update, Utilization Management approval, etc.

36. Will all individuals transitioning from CAP-MR/DD to Cardinal Innovations be required to have a full Individual Support Plan developed by the implementation date of the waiver?

No – an approved transition plan will allow the current Person Centered Plan to be revised to reflect Cardinal Innovations services and to serve as the Individual Support Plan at the time of waiver transition. Care Coordinators from the Community Operations Centers will meet with individuals/legally responsible persons and their teams to crosswalk services and to make the necessary changes to the Person Centered Plan.

Only individuals whose birthdays fall in the month prior to waiver implementation will have to have a full Individual Support Plan developed and approved by the waiver implementation date.

37. If a consumer's annual Person Centered Plan is already completed, is a transition plan necessary?

Yes – a Care Coordinator will need to assist the team in completing the transition planning process to ensure that there is no lapse in services. Consumers/families are asked to bring copies of their current Person Centered Plans and any revisions to their Transition Meetings.

Provider Network

38. What criteria are used to determine which providers remain in the network after the expansion counties partner with PBH? What is the timeline for determining which providers remain in the network?

To prevent disruption in services, all current providers are invited to join the PBH Provider Network and will have one year to meet PBH's credentialing requirements. Provider meetings will be conducted monthly to assist with these processes.

39. Will PBH issue contracts for both Medicaid- and State-funded providers at the same time?
Yes – any provider that offers both Medicaid- and State-funded services will receive one contract that includes both.

40. What forms must be completed to apply?

PBH Applications are posted at pbhsolutions.org/providers. On the Provider page, a pop-up window will appear. Clicking on the pop-up window will direct providers to the Applications page. Providers should select from the three application types: (1) for Agencies; (2) for Group and Single Licensed Independent Practitioners; and (3) an Additional Service Application, for those providers with existing PBH contracts.

After entering the application site, providers will be directed to enter demographic information. Complete the initial demographic sheet on-line and then scroll down to the link to download or print the application.

Note: Requests for hospital applications should be directed to the PBH corporate office to the attention of Bruce Eads at (704) 939-7749 or Bruce.Eads@pbhsolutions.org.

41. Does a provider with a current PBH contract have to reapply?

Providers with current PBH contracts who are adding services or sites in the expanded catchment areas should complete the Additional Service Application. PBH will add an amendment to the contract to reflect the additional services or sites.

42. What attachments typically are requested with the application packet?

Examples of attachments include facility licenses, policies and procedures, articles of incorporation/amendment, etc.

43. Will providers in the expansion counties view themselves as part of the PBH Network?

Providers will become a part of the PBH Network, but may be partners specific to the local Community Operations Centers.

44. What accountability measures does PBH use to determine which providers remain in the network after one year?

Providers have one year to meet PBH standards through a credentialing process. PBH staff members are working with the Community Operations Centers to determine areas for which correction plans may be needed. Staff members will work with providers to ensure

that correction plans are implemented and supported in efforts to meet criteria within the one-year deadline.

45. With a closed network, how does PBH ensure that community needs are being met?
PBH is conducting capacity studies to determine community needs, using real data. These studies evaluate the locations of consumers, providers, and available services. As service gaps are identified in local capacity studies, PBH recruits providers to provide needed services (first within the network, then outside of the network).
46. Once the capacity studies are completed, will current partners in the Provider Network be closed if there are too many providers in the area?
PBH typically does not end contracts with providers unless there are issues with meeting quality standards or federal regulations. In these circumstances, PBH requests plans of correction before terminating contracts, unless the safety of consumers is at risk. Fair market competition/consumer choice may determine whether or not providers remain in business.
47. Will accredited providers be accepted into PBH's network?
As with other providers, accredited providers have to satisfy PBH's credentialing requirements within one year.
48. How frequently will providers be paid?
PBH pays providers quickly; typically, there is a fourteen-day turnaround for clean claims submitted electronically.
49. Please explain the 30 minute/30 mile rule.
Office-based services must be provided within 30 minutes or 30 miles of consumers. This rule is extended to 45 minutes/45 miles for rural areas (as defined by census data).

Provider Direct/Authorizations

50. When will all Medicaid and State consumers be in PBH's Provider Direct system?
Alamance-Caswell Medicaid and State consumers currently are in PBH's Provider Direct system. Current Medicaid and State consumers for Five County and OPC will be in PBH's Provider Direct system by 1/1/2012 and 4/1/2012, respectively.
51. What is the timeline to enroll clients?
Consumers should be enrolled at the first point of contact if they are new to the Provider Direct system. For services requiring a Treatment Authorization Request (TAR), enrollment is required in order for a provider to complete the request. For consumers receiving unmanaged services, enrollment is required for claims submission.
52. When will providers receive Provider Direct Logins?
Providers will be notified of their logins once (1) their signed contracts are returned to PBH and executed by PBH's CEO, (2) their Trading Partner Agreements (TPA) are completed and

signed, and (3) provider staff members have attended an on-line Provider Direct Overview training.

53. If an authorization expires at the beginning of a transition month, who is responsible for entering requests for reauthorization and when?

In order to ease the transition of services for both consumers and providers, PBH is not requiring an authorization during the first month of each transition (i.e., January for Five County and April for OPC). Exception: Authorizations for CAP-MR/DD or CAP-IDD will end by the transition date for each Local Management Entity. New authorizations will be required for Cardinal Innovations services. The Care Coordination staff members at the Community Operations Centers will manage the transition from CAP-MR/DD and CAP-IDD to Cardinal Innovations (see section on Care Coordination above).

Previously authorized services by will be entered into the PBH system; however, providers should submit any reauthorization requests at least 15 days prior to the end of the current authorization.

Providers are responsible for requesting their own authorizations and submitting required documentation to PBH's Utilization Management Department, unless a new annual plan is being developed by the clinical home and contains services from multiple providers. In these cases, the clinical home submitting the new annual plan should include all requested service on the Treatment Authorization Request (TAR). After the initial authorization, each individual provider is responsible for keeping up with their own authorizations.

54. What is the general length of time for an authorization?

The length of an authorization is based on many factors, including individual need, service guidelines, and medical necessity. Please refer to the most recent authorization guidelines and service definitions.

Authorizations for Cardinal Innovations services do not exceed six months. The Care Coordinator will submit the initial request for authorization when the Individual Support Plan or Update to the Individual Support Plan is submitted; providers are responsible for submitting subsequent requests for continued authorization.

55. Are providers notified of authorizations that are getting ready to end?

It is the provider's responsibly to track and ensure that there is a valid service authorization on file at all times.

56. In the PBH system, will ICF/MR staff be responsible for completing Treatment Authorization Requests (TARs) and enrollment of consumers? In the current LME system, ICF/MR providers do not complete treatment authorizations for ICF/MR services, but bill directly to the State. Please clarify.

ICF/MR staff will not be responsible for completing Treatment Authorization Requests (TARs). They will be responsible for submitting PBH's designated Level of Care form every 180 days to complete their Utilization Review activity.

57. Will providers need new Person Centered Plans and authorizations if they already have current authorizations through Value Options?

Mental Health Providers: PBH will honor current Person Centered Plans and authorizations processed by Value Options through the end of the authorization or for 90 days past the catchment area's transition date, whichever comes first.

Substance Abuse Service Providers: PBH is offering a 30-day soft start after each catchment area's transition date, during which authorizations are not required. However, providers are encouraged to submit authorizations as soon as their contracts with PBH have been fully executed.

58. How do providers send Person Centered Plans to PBH's Utilization Management Department?

E-mail Person Centered Plans to UtilizationM@pbhsolutions.org (for mental health and substance abuse services) or to DD-UM@pbhsolutions.org (for intellectual/other developmental disability services). It is best to password protect the plan; the password can be agency-specific (i.e., one standard password for the provider agency to be used by all staff).

59. How do providers submit the signature page for the authorization?

For mental health and substance abuse services, providers are allowed to type in the names, credentials, and dates of the signatures and to complete the checkboxes. This indicates that the provider has the actual signatures on the original plan in their files, which must be produced upon Utilization Management or Quality Management request or audit.

For Cardinal Innovations, the Care Coordination Department scans the actual signatures and submits the document to DD-UM@pbhsolutions.org. For IPRS, Medicaid Optional (b)(3) services, or Basic Medicaid, the signature may be typed in on the Word document, but the provider must keep copies of the actual signature on file in the event of an audit.

60. Do all crisis plans need to be renewed for all service providers?

Crisis plans are expected to be current and accurate when uploaded.

61. Can providers submit Treatment Authorization Requests (TARs) on the same day a service is provided, or must they be done in advance of seeing the consumer for the service?
Treatment Authorization Requests (TARs) should be submitted 15 days prior to the requested start whenever possible. If this cannot occur, the provider should submit as much in advance as possible. Utilization Management is not able to back-date routine requests. Please see the next question regarding new services.
62. For enhanced services, providers typically see the consumer and complete the initial Person Centered Plan, then submit the initial authorization request asking that it start that same day. Would the 15-day prior submission rule also apply for these initial requests?
For new services that require a plan, the provider can submit the Treatment Authorization Request (TAR) to start the same day, as long as they submit the corresponding plan to PBH's Utilization Management Department on that same date. Utilization Management is not able to back-date services prior to the date a complete request is received.
63. If a provider submits a Treatment Authorization Request (TAR) and corrections are needed, will the request be back-dated to the original submitted date or the date of final completion?
If a Treatment Authorization Request (TAR) is returned to a provider for corrections, Utilization Management will honor the original submission date, which is why it is very important that the provider edit and re-submit the original Treatment Authorization Request (TAR). However, if the Utilization Management decision is to deny the request, no authorization for any of the dates will be given. For this reason, it is important to submit requests 15 days prior to the requested start date to ensure that the provider has a decision prior to delivering the service.
64. Should hospitals submit Treatment Authorization Requests (TARs)?
Hospitals may use the Treatment Authorization Request (TAR), fax in a two-page paper TAR, or call in their authorizations via telephone.
65. How should therapists submit service orders that are not electronic?
For outpatient providers, no plan is required to be submitted to Utilization Management; rather, only a Treatment Authorization Request (TAR) is required. Providers should follow service documentation requirements and maintain all service orders, plans, etc. in their clinical records.
66. Are all five diagnosis required on the Treatment Authorization Request (TAR)?
Any request should contain all known information for Axis I - IV.
67. Does the American Society of Addiction Medicine (ASAM) screening need to be submitted if the mental health diagnosis is the primary diagnosis?
An American Society of Addiction Medicine (ASAM) screening, as well as the Substance Abuse Usage section of the Treatment Authorization Request (TAR), is required for anyone who has a Principal or Primary Substance Use diagnosis. An ASAM is not required if the

consumer has only a mental health diagnosis; however, once providers are trained, a Level of Care Utilization (LOCUS) or Child and Adolescent Level of Care Utilization (CALOCUS) screening will be required for these individuals.

68. Is there a four unit limit on H0004 sessions?

H0004 and other Outpatient codes are unmanaged to a limit. In the Provider Direct system, four units of H0004 are considered the equivalent of one session of service.

69. Are providers able to bill H-codes in 15 minute increments?

This depends on the actual service being billed. PBH uses the same units as identified in the State service definitions, when applicable.

70. Please clarify how providers should define a unit, such as for Intensive In-Home services (mental health), for which providers bill for two-hour per diems.

For Intensive In-Home Services, one unit equals a minimum of two hours. If Intensive In-Home occurs for less than two hours in one day, the provider is not able to bill for this date. Please refer to the authorization guidelines and service definitions for more details. PBH uses the same units as identified in the State service definitions, when applicable.

71. If a provider requests authorization for a service needed two times per month, are there restrictions as to which week the service must be provided?

If a provider requests a service on the Treatment Authorization Request (TAR) as twice per month, the provider has the flexibility to determine when during the month the service is used.

72. If a provider requests 40 per diems in a 60-day period, how would the providers make this request in terms of units?

The best way to do this would be to request 40 units per "lifetime" of the Treatment Authorization Request (TAR) – meaning that the provider wants to use 40 units from the start date on the TAR through the end date.