Sandhills Center Catchment Area

Counties include Anson, Guilford, Harnett, Hoke, Lee, Montgomery, Moore, Randolph and Richmond Counties.
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A Message from Victoria Whitt, CEO of Sandhills Center

Dear Service Provider:

Welcome to the Sandhills Center Provider Network. We appreciate your interest in serving our members and look forward to working with you to assure that individuals with mental health, intellectual/developmental disabilities and substance abuse needs in our catchment area receive quality services.

The General Assembly and the Secretary of the Department of Health and Human Services (DHHS) have implemented a plan that moved North Carolina into a statewide system to provide management of publicly funded MH/I/DD/SA services under the 1915 (b) (c) waiver. Sandhills Center began operation under the waiver system on December 1, 2012 and has managed publicly funded services for our area since that time.

Our challenge in this environment is to do the very best we can with the resources that are available to us. Our achievements will be made possible through a strong working relationship with our Provider Network. You represent Sandhills Center to the people we serve as you join us in helping people with disabilities and special needs improve the quality of their lives.

This manual provides information that supports efficient and effective management of the system, and ensures the delivery of quality MH/I/DD/SA services. As a provider of services for Sandhills Center, it is important that you become familiar with, and adhere to the policies and procedures described in this manual. It includes information pertinent to the contract that you entered into with Sandhills Center. It is a binding part of the contract between Sandhills Center and providers of Medicaid funded services. We hope you find this manual informative and hope that it will assist as you operate in our provider network.

Thank you for joining our Provider Network. We look forward to a positive relationship as we work to provide the best quality of care for the people we serve.

Sincerely,

Victoria Whitt, Chief Executive Officer
A. Welcome to Sandhills Center MH, I/DD & SAS

As a provider for Sandhills Center, a Local Management Entity/Managed Care Organization, (LME/MCO), you become a part of a network dedicated to providing quality care for members residing in Anson, Guilford, Harnett, Hoke, Lee, Montgomery, Moore, Randolph and Richmond counties. By joining our provider network, you assist us in fulfilling our mission to develop, manage and assure that persons in need have access to quality mental health, developmental disabilities and substance abuse services.

As a contracted provider, you are responsible for adhering to all policies and procedures outlined in this manual. Compliance is necessary to fulfill your contractual obligations in providing services. This manual begins with who we are, our vision and values, and describes our policies, procedures and the services we cover.

We thank you for your participation in our network and look forward to a long and rewarding relationship as we work together to provide care and treatment to the people we serve.

B. Who We Are

Sandhills Center is a Local Management Entity (LME)/Managed Care Organization (MCO) responsible for publicly funded behavioral health (mental health and substance use) and intellectual/developmental disability services and supports for people living in or whose Medicaid eligibility was established in the counties we serve.

Sandhills Center serves a nine-county geographic area consisting of Anson, Guilford, Harnett, Hoke, Lee, Montgomery, Moore, Randolph and Richmond counties, with a total population of approximately one million people of varying ethnic and socioeconomic groups. The nine counties (referred to as “catchment area”) cover a diverse geographic area of 4,876 square miles, and diverse demographic areas from urban to extremely rural areas. Sandhills Center has deemed status as a local government equivalent and currently has a total budget of approximately $350 million. Sandhills Center is governed by an independent Board of Directors.

C. Mission Statement

The mission of Sandhills Center, a Local Management Entity/Managed Care Organization, is to develop, manage and assure that persons in need have access to quality mental health, intellectual/developmental disabilities and substance abuse services.

D. Vision

Sandhills Center, a Local Management Entity/Managed Care Organization, will partner with members, family members, service providers, policy makers, and other community stakeholders in creating, managing, and supporting behavioral health services that meet the needs of our community.
E. Working Principles

Sandhills Center, a Local Management Entity/Managed Care Organization, strives to promote:

1. Access to a continuum of services to meet the behavioral health needs of the citizens of Anson, Guilford, Harnett, Hoke, Lee, Montgomery, Moore, Randolph, and Richmond counties of North Carolina;
2. Active partnerships among members, families, providers, and the community;
3. High quality mental health, intellectual/developmental disabilities, and substance abuse services;
4. Cost-effective delivery of services in the least restrictive environment, appropriate to the needs of members;
5. A provider network that is culturally competent and respectful in meeting members’ needs;
6. A collaborative approach to problem solving and resource development.

F. About the Medicaid Waiver

The NC MC/DD/SAS Health Plan is a Pre-Paid Inpatient Health Plan (PIHP) funded by Medicaid. All Medicaid MH/DD/SAS services are authorized by and provided through the Sandhills Center Provider Network in accordance with the risk-based contract between the NC Division of Health Benefits and Sandhills Center. As a pre-paid inpatient health plan, Sandhills Center is at financial risk for a discrete set of MH/DD/SA services, including both NC Medicaid State Plan services and services included in the NC Innovations Waiver.

The NC MH/DD/SAS Health Plan is a combination of two types of waivers authorized by the Federal Social Security Act, the Federal legislation creating and governing the Medicaid program. They are identified by the specific sections of Social Security Act, which authorizes them.

A Section 1915 (b) Waiver, commonly referred to as a “Freedom of Choice Waiver”, allows states to waive the provisions of the Medicaid program that require “any willing and qualified provider” statewide requirements (meaning Medicaid has to operate the same way in every part of the state), and certain fiscal requirements regarding rate setting and payment methodologies.

A Section 1915 (c) Waiver, generally known as a “Home and Community Based Waiver” allows the state to offer home and community based services not normally covered by the State’s Medicaid program if they can be proven to be no more expensive than an institutional level of care covered by Medicaid.

The two waivers are approved under different Federal Medicaid regulations and require different reporting and oversight. This type of waiver system is not intended to limit care, but to create an opportunity to work closely with members and providers on better coordination and management of services, resulting in better outcomes for members and more efficient use of resources.

1. About the NC MH/DD/SAS Health Plan

This waiver applies to members with Medicaid from any of the counties in our catchment area. All Medicaid members in specified eligibility groups will be eligible and automatically enrolled into this plan for their mental health, intellectual/developmental disability, and substance abuse service needs.

Available services include all current NC Medicaid State Plan services for Mental Health, Intellectual/Developmental Disabilities and Substance Abuse services, including Inpatient Hospitalization, Outpatient Therapy, Enhanced Services, Residential Services, Crisis Services,
Psychiatric Residential Treatment Facilities (PRTF) and Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF-IID) and Division of State Operated Healthcare Facilities (DSO HF).

Members are able to choose from any provider in the Sandhills Center Network contracted with Sandhills Center to provide the service(s) they need.

2. About the NC Innovations Waiver

The Innovations Waiver is a 1915 (c) Home and Community Based Waiver. Under this waiver, individuals who would otherwise meet the criteria for services in an ICF-IID setting may receive services in their home and community, as long as the aggregate cost of those services does not exceed the cost of the ICF-IID care.

This waiver incorporates the essential elements of Self Direction, Person Centered Planning, Individual Budgets, Participant Protections and Quality Assurance. The waiver supports the development of a stronger continuum of services enabling individuals to move to more integrated settings. People served and their families have the information and opportunity to make informed decisions about their health care and services, and exercise more control over the decisions they make regarding services and supports.

   a. Agencies with Choice

The NC Innovations Waiver has a Provider Directed and Individual / Family Directed track. In the Provider Directed track, the services are delivered in a traditional manner with staff in the employment of an agency. In the Individual and Family Directed track, participants and their families may participate in the Agency with Choice model or the Employer of Record model. Further information is available at NC MH/DD/SAS Health Plan and the NC Innovations Waiver at: https://www.ncdhhs.gov/providers/provider-info/mental-health/idd-systems-of-services
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A. Governance

Sandhills Center is a political subdivision of the state under G.S. 122C. It is a public authority and is governed by a 21-member board. The Sandhills Center Board is a governance board and focuses on establishing and monitoring goals as well as development of public policy. The CEO reports to the Board and all other Sandhills staff report to the CEO. The Corporate Compliance Officer has the authority to report directly to the Board, if necessary.

B. Administrative Services

Administrative services are responsible for the overall management of Sandhills Center, including both short and long term planning. Planning includes the management of resources, including direction of the network toward best practices, alignment of incentives with goals of the LME/MCO, planning how to invest new dollars and how to reinvest savings, which occur as service utilization changes. Maintaining strong working relationships with stakeholders, local and state partners including local public agencies, provider agencies, public officials, elected officials, advocacy organizations as well as state and regional staff is a critical component.

Sandhills Center is organized into various departments established to perform the operational functions that support the overall work of the agency. The following provides a description of the major departments and how they support the Sandhills Center Provider Network.

C. Community Relations, Communications & Training

The Community Relations Department of Sandhills Center has three main components:
  1. Training
  2. Community Development
  3. Communications

Staff in this unit design and deliver provider orientation, provider forums, provider training, and training for Sandhills Center staff, with input from providers and consumers, and committees such as the Consumer and Family Advisory Committee (CFAC), Clinical Leadership and Quality Management.

Community development activities include participation in initiatives related to behavioral health care and/or integrated care activities and work with advocacy organizations such as NAMI and The Arc. Staff also provides consultation to other professionals in areas such as access to care or crisis services, and delivers training to consumers, families, school districts, health systems, providers and the community at large. Sandhills Center has a certified Mental Health First Aid instructor on staff.

Staff in this unit produce educational materials and quarterly and annual reports, and maintain the organization’s website. The Community Relations, Communications and Training Director serves as Sandhills Center’s public information officer.

Members of the Community Relations Department are liaison to the Consumer and Family Advisory Committee (CFAC) and the Client Rights Committee. Staff also works closely with Crisis Interventions Team (CIT) training throughout the Sandhills Center catchment area.
D. Network Operations

The Network Operations Department consists of the Network Development Section, Network Management Section, & Network Monitoring Section. The Department is responsible for the development, management & monitoring of the provider and practitioner network that meets the service needs of members in the catchment area, and for ensuring the provision of quality services. Sandhills Center enters into relationships with service providers and practitioners through the establishment of contracts for the delivery of MH/DD/SA services. Each contract outlines the specifics for the provider type, including disabilities to be served and related provisions. For the purpose of clarification, the term “provider” that is used throughout this manual means agency, facility, and hospitals. “Practitioner” means fully licensed independent professional, and licensed professional associate.

The Network Operations Department makes available to provider network members access to all pertinent rules and regulations necessary for provider performance under the terms of the contract and monitors for compliance.

Routine communication with providers occurs to share information and resources, provide technical assistance and respond to questions as needed.

Information is maintained on network providers for the purposes of assisting members with choosing a provider, analyzing and monitoring service array, capacity and accessibility, providing general and specific service provider information to other departments of the LME/MCO, and for assisting providers in collaboration and access to other service providers.

The Network Operations Department also implements a system of review, and monitoring. The Sandhills Center Provider/Practitioner Performance Reviews are a part of the monitoring and review activities completed by the Network Monitoring Section. The review process is based on targeted quality initiatives for provider/practitioner performance.

Your Responsibilities as a Sandhills Center Contracted Provider are:

1. Provide services for which you/your agency is credentialed by Sandhills Center to provide;
2. Be responsive to the cultural and linguistic needs of the members you serve;
3. Provide services only at the sites identified in your contract;
4. Adhere to all performance guidelines in your contract and work to deliver best practices;
5. Work in collaboration with other providers, members and families; and
6. Work in a solution-focused and collaborative basis within the network.
7. Keep updated on current information through the communication offered.
8. Review the Sandhills Center website for updates on a regular basis. Sandhills Center Clinical Practice Guidelines can be found in the Provider Section https://www.sandhillscenter.org/clinical-practice-guidelines-evidence-based-practices
9. Perform required outcome instruments such as NCTOPPS and NCSNAP in a timely manner.
10. Pursuant to Section XI, Letter - I Clinical and Business Records, maintain and keep member records in accordance with State retention and documentation guidelines and appropriate licensing board as applicable.
11. Ensure provider/practitioner compliance with treatment record standards and confidentiality practices, and follow-up on any out of compliance standards, or grievances regarding these areas.
12. Regularly review the State and Federal websites for the most up-to-date information on a regular basis:
https://www.ncdhhs.gov/divisions/mhddsas
https://medicaid.ncdhhs.gov/
https://www.cms.gov/

Sandhills Center’s Primary Network Responsibilities are:

1. Actively recruit providers with a mission and vision consistent with Sandhills Center;
2. Support the development of best practices or emerging best practices;
3. Monitor capacity of the network and develop strategies to develop services through existing providers, when possible;
4. Recruit providers through a Request for Proposal (RFP) process, based on needs of community and provider capacity.
5. Keep network providers informed through forums, and email distribution for relevant provider and community updates and bulletins;
6. Respond to provider questions both telephonically, by email or by fax;
7. Identify training needs, develop an annual training plan, and facilitate training that meets the needs of providers; and
8. Credential and re-credential providers.
9. Monitoring of providers to ensure compliance, efficiency and accountability
10. Conduct on-site monitoring of providers to ensure appropriate implementation of services, member’s health and safety, member satisfaction, positive outcomes for members, and compliance with provisions of the provider’s contract. Refer any alleged fraud and abuse identified to Program Integrity.
11. Ensure provider/practitioner compliance with treatment record standards and confidentiality practices, and follow-up on any out of compliances or grievances regarding these areas.
12. Ensure follow up on any out of compliance, grievance, or quality of care concerns regarding these areas, and that the rights of members have been protected.
13. Ensure publication and availability of the review and monitoring standards for Sandhills Center LME-MCO.

Provider Reviews

Network Provider Monitoring conducts biannual post-payment, grievance, and quality of care reviews of provider/practitioners to ensure appropriate implementation of services, member health and safety, member satisfaction, positive treatment outcomes, compliance with provisions of Medicaid and State standards, and provisions of the provider contract. A Program Integrity referral will be made if alleged fraud or abuse is identified.

Network Provider Monitoring compiles results of monitoring reviews, grievances, incidents, quality of care concerns, and Quality Management reports, and submits the “blinded” Requests for Adverse Actions grid to the Credentialing Committee for feedback to the Network Operations Committee. Once Feedback is obtained, and action approved for Network Operations Committee consideration; Network Operations Committee will review all documentation for determination of possible actions or sanctions, if appropriate.
E. Customer Services

The Customer Services department is comprised of four sections:

- Customer service representatives who provide general information to callers
- Call Center Licensed Clinicians provide clinical screening triage and referral
- Member eligibility and enrollment specialists who provide information regarding member eligibility and enrollment status, and register new members into the system as needed
- Grievances and incident support specialists who track, evaluate, and investigate grievances and incidents

1. Customer Services

Sandhills Center Customer Services department includes access to the service and information system provided by a 24/7/365 toll-free 800 number (1-800-256-2452). This toll-free number and the services of the Customer Services department are available to all members of the Sandhills Center service area, regardless of payer source. This includes information on service providers, community resources, making grievances, and crisis services. The department has customer service representatives available to answer questions and link callers to the proper department or resources.

2. Health Call Center

Sandhills Center is responsible for timely response to the needs of members’, quick linkage to qualified providers through the 1-800 number, and a secure electronic enrollment system. Sandhills Center maintains a telecommunications clinical screening triage and referral system with access to licensed clinicians 24 hours per day, 7 days per week. The clinicians provide information and screening, as well as arrange appointments for the caller, if needed.

3. Member Eligibility and Enrollment

Sandhills Center maintains enrollment information that includes member demographic data, and payer and benefit plan information. The electronic member record keeps an up-to-date log concerning each member.

A member’s eligibility for enrollment is dependent on their status regarding the following:

1) Residency – For state-funded services, the member must be a resident of a county in the Sandhills Center catchment area (Anson, Guilford, Harnett, Hoke, Lee, Montgomery, Moore, Randolph or Richmond counties).
2) For members who hold a current Medicaid card for a county within Sandhills Center catchment area, these members are eligible for medically-necessary services based on their Medicaid benefit level.

Enrollment: Please refer to Member Enrollment on the Sandhills Managed Care Software System by utilizing specific login information. If you do not have login information, please contact providersupport@sandhillscenter.org and request the login information specific to your provider.

When a provider wishes to enroll a member into Sandhills Center, the following steps should be followed:

a. The provider should utilize Patient Search to verify whether the member has a previously-assigned record number and is already enrolled in the Sandhills Center Managed Care Software System.
b. If the member is enrolled, go to the Client Update tab, complete all necessary fields including Clinical Information, and submit the update electronically (with all fields completed) to Sandhills Center for review. If all fields are not completed, or if additional information is required, the Client Update will be returned to the provider. Once the additional information is completed on the form, the provider must resubmit the form.

c. If the member is not enrolled, the provider needs to go to Enrollment and complete all the fields on the form, including the Clinical Information, and submit it to Sandhills Center for review and approval. All fields must be completed. If additional information is required, the Enrollment will be returned to the provider electronically. Once the additional information is completed on the form, the provider must resubmit the form.

d. When all information is received, the provider will be able to complete the Service Authorization Request (SAR) and/or submit claims. If the provider has any questions, they are encouraged to contact Member Enrollment & Eligibility staff at 1-800-256-2452.

4. Grievances and Incident Reports

The grievance and incident reports section of the Customer Service department’s primary function is to review, mediate, and/or investigate grievances received regarding the quality of services provided by any agency, ensure appropriate corrections are completed if needed, and review critical incidents that occur within the network. All allegations of abuse, neglect, and/or exploitation are referred to the appropriate Department of Social Services.

A grievance is when a member or provider is not satisfied with any part of services by a provider or Sandhills Center staff. Reasons for could include:
- The quality of care or services received or access to any service.
- A disagreement about a service received or with Sandhills Center.
- The failure of a provider or Sandhills Center to respect a person's rights, privacy or confidentiality.
- An employee of a provider or Sandhills Center being rude or abusive, neglectful, or exploitative in any way.

How to make a grievance
- By talking to any Sandhills Center staff
- By phone: 1-800-256-2452
- Online: Complete a grievance form on the Sandhills Center web site
- By writing: Sandhills Center Customer Service PO Box 9 West End, NC 27376
- In person: Sandhills Center 185 Grant St., West End NC 27376.
- For hearing impaired: TTY number: 1-866-518-6778

F. MH/SA/I/DD Care Management/Utilization Management

The purpose of the Care Management/Utilization Management (CM/UM) Department is to ensure members receive the right services, at the right level of care, for the right intensity, frequency and duration with the right provider to accomplish the best clinical outcomes for each individual member. The department is under the direct oversight of the Chief Medical Officer/Chief Clinical Officer and the Clinical Director with secondary oversight and support from the CM/UM Committee and subcommittees and the Quality Management Committee. Providers, through participation in the Clinical Advisory
Committee, serve to support and advise CM/UM functions. CM/UM functions are implemented using an established CM/UM Program Description and policies and procedures based upon regulatory requirements. The CM/UM Department is nationally accredited.

1. Utilization Reviews

The primary function of the CM/UM Department is to conduct utilization reviews of individual requests for service authorization. Under this process, providers submit Service Authorization Requests (SARs) through the Sandhills Center managed care software system portal. Masters-level clinically licensed CM/UM Care Managers review the requests for required documentation and medical necessity. Sandhills Center uses State-developed medical necessity criteria found in clinical coverage policies (Medicaid) and state service definitions (State-funded). In addition, care managers utilize nationally established evidence-based practice standards and community treatment standards when making medical necessity determinations. Sandhills Center uses a delegated vendor, Prest & Associates (Prest), to review any authorization request that cannot be approved upon initial review by the care manager. All Prest reviews are conducted by a physician or licensed psychologist.

All clinical coverage policies (Medicaid) can be found on the NC Division of Health Benefits website. All state services definitions (State-funded) can be found on the NC Division of Mental Health, Developmental Disabilities, and Substance Abuse Services website. Evidence-based practice guidelines can be found on the Sandhills Center website.

CM/UM decision making is based solely on the appropriateness of care, the availability of the requested service, and the member’s Medicaid eligibility. CM/UM reviewers do not receive incentives, monetary or otherwise, for issuing denials or for decisions that result in underutilization.

2. Review Timeframes

Sandhills Center adheres to all regulatory requirements for review timeframes:

- Urgent services will be reviewed within **72 hours** of an initial request and within 24 hours of a concurrent (i.e. reauthorization) request if the request is submitted prior to the authorization start date or 72 hours if the concurrent request is not submitted prior to the authorization start date.
- Non-urgent services will be reviewed within **14 days** of receipt of the request.
  - If a delay in services could seriously jeopardize the member’s life or health or ability to regain maximum function, the request will be reviewed using the urgent timeframes. Please contact the CM/UM Department to flag any such requests.
- Retrospective requests will be reviewed within **30 days**.
  - A retrospective request requires that a member become eligible for new Medicaid benefits retroactive to a past date. Note: A backdated request is not considered a retroactive request. Sandhills Center does not accept backdated requests unless there are extenuating circumstances (ex: natural disaster, technology failure, etc.). If there is a need to backdate a request, please reach out to the CM/UM Department as soon as possible to arrange accommodations. All providers are urged to submit reauthorization requests **14 days in advance** for non-urgent services.
3. Authorization Decisions

- **Approved:** If the authorization request is approved, you may begin billing services once services have been rendered per the criteria of the treatment modality.

- **Denied:** Prior to an authorization being denied, you will have an opportunity to participate in a peer review with a reviewer from Prest. Because Prest reviewers are physicians or licensed psychologists, Sandhills Center recommends that your highest level clinical staff participate in the peer review with Prest. If the request is denied, the member has the right to appeal the decision. The provider cannot bill any provided services unless the decision is overturned during an appeal.

- **Administrative Denial:** If you fail to provide required documentation during the review process, the request will be administratively denied. The member may appeal the decision or a new request may be submitted with the required material. *Note: If your request is administratively denied and you submit a new request with the required documents, Sandhills Center will not backdate the authorization to the date of the original request. Any authorization that is generated will begin on the day the request is submitted if the requested start date is not a future date.*

- **Unable to Process (UTP):** Under certain circumstances (ex: errors on the SAR), a request may be unable to process. The care manager will UTP the request and a new request may be submitted.

4. Your Responsibility as a Provider

1. Ensure member eligibility and request services using the correct funding source (Medicaid or State-funded)
2. Submit authorization requests timely; 14 days prior to the requested start date is recommended (non-urgent requests only)
   a. Submitting authorization requests timely will ensure that members have access to the services needed without delay.
3. Provide additional clinical information as requested within the required time frames
4. Participate in peer reviews
5. Work collaboratively with Sandhills Center care managers
6. Notify members of service approvals within 72 hours of receiving the notification through the Sandhills Center managed care software system
   a. Sandhills Center does not notify members when services are approved. Sandhills Center will notify members of any denial or partial denial.

5. Our Responsibility as an LME/MCO

1. Ensure all authorization requests contain the required elements
2. Review SARs and render a decision within required time frames
3. Communicate with providers when additional information is necessary to approve a request or if problems arise
4. Utilize the appropriate medical necessity criteria/decision support tools and practice good clinical judgment when making authorization decisions
5. Facilitate peer reviews
6. Work collaboratively with providers to ensure members receive the right services, at the right level of care, for the right intensity, frequency and duration with the right provider to accomplish the best clinical outcomes
6. How to Contact CM/UM

CM/UM staff are available from 8:30 am-5:00 pm during all business days. On-call licensed CM/UM Care Managers are available during weekends, holidays, and other closures to ensure expedited requests are reviewed within the required 72-hour timeframe. You may contact care managers individually either by phone or email. You may also contact any CM/UM staff at 1-800-241-1073.

7. Other CM/UM Functions

In addition to the primary function of utilization review, the CM/UM Department engages in supportive activities that ensure members receive the right services, at the right level of care, for the right intensity, frequency and duration with the right provider to accomplish the best clinical outcomes.

- **Care Management:** This is a whole person look at the overall service array of a member to ensure appropriate care is being offered to achieve member goals.
- **Utilization Tracking:** This is an overall look at use of services and includes analysis of utilization by service, population, provider, etc. This information is utilized to identify high-risk members and make care coordination referrals, to identify areas of over- and under-utilization, and to monitor high-cost services.
- **Quality Improvement Activities:** These are activities that help the CM/UM Department make internal and provider-driven improvements to meet best practice and regulatory standards and to ensure best outcomes for members. Quality Improvement Projects (QIPs) and Quality of Care Concerns (QOCs) are two mechanisms used to achieve improvement goals.

G. Care Coordination

1. I/DD Care Coordination

The Sandhills Center I/DD Care Coordination Department provides care coordination services to members with intellectual and/or developmental disabilities that are enrolled in the NC Innovations Waiver, enrolled in the B3-DI Service Array and to individuals in identified special needs populations. I/DD Care Coordination activities are focused on the member and ensure that each individual receives the services they need.

I/DD Care Coordinators manage care across the continuum of care, throughout various care settings, and work in conjunction with the member, providers, and others to improve outcomes for the individual and make the best use of resources. This is both a risk management and quality management function and has a significant impact on both the management of resources and the quality of care for the member.

The I/DD Care Coordinator provides the following activities:

1. Education about all available MH/DD/SA services and supports, as well as education about all types of Medicaid and state funded services.
2. Complete or arrange for needed assessments to identify support needs and to facilitate person centered planning processes. Needed assessments will include psychological, behavioral, educational, and physical evaluations.
3. Development of the Individual Support Plan (ISP) in collaboration with the member, family, and all other service and support providers.
4. Coordinate services to ensure members have access to the care that they need.
5. Monitoring of the ISP to ensure that services and supports is received and ensure the health and safety of the member.
6. Coordination of Medicaid eligibility and benefits.

Supports Intensity Scale

The Supports Intensity Scale (SIS) is an assessment tool that measures practical support requirements of a person with intellectual and developmental disabilities (I/DD). Unlike traditional assessments, the SIS focuses on what daily supports individuals need to live as independently as possible within their communities. The SIS is conducted by professionals with intellectual and developmental disabilities experience. The SIS assessment is completed for members needing supports in the NC Innovations Waiver program. The SIS is then updated every two to three years, or as significant changes occur for the member.

The SIS directly assesses the type, frequency, and amount of support and assistance that a person needs to accomplish important every day community living activities. SIS uses a small group interview to engage the person and other respondents to consider supports needed to meet individual needs and promote personal growth. The SIS is intended to be used in conjunction with person-centered planning processes and can be used in combination with other assessment tools, such as psychological assessments, and risk assessments to assist individuals receiving services.

The SIS has been reviewed independently and found to be a well-designed instrument. It provides a comprehensive and standardized process to gather the same information in the same way for each person, no matter the time, place, or level of support needed.

Additional information regarding the SIS can be found at the following websites:

North Carolina Division of MH/DD/SAS: https://medicaid.ncdhhs.gov/nc-innovations-supports-intensity-scale

Carolina Institute for Developmental Disabilities: https://cidd.unc.edu/

SIS information video: https://www.aaidd.org/education/video-library

2. MH/SA Care Coordination

MH/SA Care Coordination maximizes the efficient and effective use of resources for high risk /high need members. MH/SA Care Coordination will provide the following activities:

1. Monitor service provision based on Person-Centered Planning and sound clinical guidelines;
2. Ensure that eligible members are receiving the right amount of the most appropriate services at a given point in time;
3. Collaboration to transition members from more restrictive services/supports to more natural ones in the community;
4. Determine need and eligibility for Care Coordination interventions;
5. Make referrals to the LME/MCO Child system of Care coordination services;
6. Assist in connecting members with supports needed as transition between services occur;
7. Make referrals and assist with support services such as housing, transportation, interpretation services, and jail diversion;
8. Contact and collaborate with providers regarding improving service plans and make suggestions regarding evidence-based choices that might assist the member in achieving desired goals;
9. Work closely with Community Care of North Carolina (CCNC) and providers of services to ensure that members receive integrated care;
10. Assist in the reduction of inappropriate use of crisis services.

**Your responsibilities as a Sandhills Center contracted provider regarding Care Coordination includes:**

1. Work collaboratively with the Care Coordinator;
2. Provide information pertinent to the development of an Individual Service Plan (Person Centered Plan) or directly participate in the planning process;
3. Maintain systems that allow for routine evaluation of progress made on goals/plan with documentation in the member’s record that this has been completed;
4. Collaborate with member’s, family members, and the LME/MCO to assure continuity of care and that there is no disruption of service;
5. Comply with North Carolina Continuity of Care statute (GS 122C-63) which requires sixty (60) day notice by the provider to the LME/MCO of intent to close a facility or discharge a member who may be in need of continuing care as determined by the LME/MCO;
6. Allow designated LME/MCO staff to participate in any treatment team and discharge planning meetings regarding members served.
7. Allow LME/MCO staff to review documentation related to the provision of member services;
8. Allow LME/MCO staff immediate direct access to any LME/MCO referred or funded member or any member served;
9. If requested, provide at least twenty-four (24) hours prior notice to the LME/MCO of the date, time and place of any treatment team or discharge-planning meeting regarding a member.

3. Integrating Behavioral Health and Physical Services

Sandhills Center integrates behavioral health and physical health services to help ensure that members receive the right care in the right setting, rather than receiving care that is fragmented and that leads to an exacerbation of symptoms in both areas. Sandhills Center adheres to DHHS mandates to keep a working relationship between the Local Management Entities-Managed Care Organizations, North Carolina Community Care Networks, and the providers of behavioral health services in North Carolina to ensure that members have their physical health needs and their behavioral health needs addressed using “integrated” models.

DHHS’ expectations have since been reinforced and more clearly defined in a strategic plan for the statewide implementation of a relationship between the three entities. In order to comply, Sandhills Center has initiated on-going discussions and work groups internally and jointly with its contract providers and representatives of the three CCNC regions that cover our service area. Initiatives developed to ensure that behavioral health members in our area receive holistic care include but are not limited to:

- A Sandhills Center Community Care of North Carolina Taskforce;
- Information sharing related to the promotion of integrated care;
- Monthly meetings with each of the three Sandhills Center area CCNC Networks (Community Care of the Sandhills, Partners of Community Care & Community Care of Greater Mecklenburg);
• Review of priority lists of high risk patients-assignment of Care Coordination responsibilities for identified members;
• A care coordination model that includes giving best-practice suggestions to providers regarding special health care needs recipients;
• Procedures for providers to obtain informatics data on people with complex care needs;
• Extending care coordination efforts to include provider participation in multidisciplinary team reviews.

Sandhills Center’s contract providers are expected to engage in treatment planning and involvement with NC CCNC in order to ensure that the people we support have access to and receive integrated care.

4. Assurance of Confidentiality

Sandhills Center Care Coordination staff adheres to federal and state guidelines that govern confidentiality and HIPAA regulations during interactions with external stakeholders. The confidentiality of members’ individually identifiable health information is assured as staff complies with the Federal Health Insurance Portability and Accountability Act of 1996 (HIPAA); Federal Law governing Confidentiality of Alcohol and Drug Abuse Records, 42 CFR, Part 2; NC Confidentiality Rules for MH/DD/SAS; and accreditation standards.

5. Transitions to Community Living Initiative at Sandhills Center

The state of North Carolina entered into a Settlement Agreement with the United States Department of Justice in 2012 to shift persons with serious mental illnesses from living in institutions to living in the communities of their choice in the least restrictive settings possible.

In keeping with the settlement agreement and the directives handed down to the Local Management Entities/Managed Care Organizations (LME/MCOs), Sandhills Center implements the Transitions to Community Living Initiative by offering:

• Access to community-based supportive housing including housing placement and financial assistance for rent and tenancy supports;
• Access to community-based behavioral health services;
• Access to supported employment;
• In-reach activities performed by Certified Peer Support Specialists;
• Quality assurance and quality improvement;
• Diversion activities and pre-admission screening.

The Transitions to Community Living Initiative is available to a specific targeted population. Initial contacts are made with program eligible individuals via certified Peer Support Specialists. The Peer Support/In-Reach Specialists engage, educate, and support efforts to inform and educate adults from the target population about community-based mental health services and supported housing options.

6. Continued Access to Practitioners

Upon termination of a practitioner’s contract, Sandhills Center allows members receiving treatment for a chronic or acute behavioral health condition to continue to receive services through the current period of active treatment, or for 90 calendars days, whichever is less. Sandhills Center works with practitioners
who are no longer under contract to develop a reasonable transition plan for each member in active treatment.

**H. Quality Management**

The Quality Management Department has oversight for quality assurance and improvement activities throughout the Sandhills Center system. The department supports a Global Continuous Quality Improvement system that includes all network providers. Quality of Care concerns.

**Your responsibilities as a Sandhills Center contracted provider are to:**

1. Cooperate fully with any review, investigation, inquiry/follow-up and audit.
2. Provide to Sandhills Center requested records and documentation needed to resolve issues. All requested information should be provided within the timeframe specified. The timeframe will vary based on the circumstances. Failure to provide these documents will result in a referral to the Network Committee for a possible sanction including potential termination of contract.
3. Maintain systems, procedures and documentation that demonstrate compliance with all applicable federal, state and local rules, laws and practices, including:
   a. Conducting self-monitoring activities for compliance;
   b. Develop and implement, within given timelines, plans of corrections and/or paybacks with any area found out of compliance during Sandhills Center monitoring activities.
4. Comply with North Carolina state rules for service records, confidentiality and record retention in order to meet treatment record standards.
5. Ensure all billing submitted for payment is supported by documentation that meets all requirements for billing a service. Conduct self-monitoring activities for compliance and develop/implement plans of correction for any areas of non-compliance identified. Self-initiate paybacks for services billed in error or without supporting documentation.
6. Notify Sandhills Center of any concerns or grievance you have in regards to the services provided by the LME/MCO. Work with Sandhills Center on the generation of solutions to issues.
7. Participate in ongoing training opportunities as applicable. Maintain services at an optimal level to meet member needs by providing services in accordance with Sandhills Center Practice Guidelines.
8. Develop and implement a system of continuous quality improvement, which includes, at a minimum, the development of systems to self-evaluate services, systems to evaluate data collected and identify needed areas of improvement, implement strategies to address areas of improvement and continual evaluation and refinement of processes.
9. Develop/implement systems to assess services to ensure members are achieving outcomes.

**Sandhills Center’s responsibilities to providers are to:**

1. Participate in provider credentialing & re-credentialing applications to the Sandhills Center Provider Network and make recommendations for the establishment of a contract.
2. Coordination of a system of continuous quality improvement for Sandhills Center and the network that includes ongoing evaluation and planning in relation to needed areas of improvement in the service delivery system.
3. Ensure that all appropriate follow-up has been completed and that the rights of members have been protected.

5. Ensure publication and availability of the review and monitoring standards for the Sandhills Center.

**Provider / Practitioner Performance Review**

1. QM reviews any Type A or Type B citations/violations/sanctions a provider may receive from the Division of Health Service Regulation (DHSR) and determines the impact of the citations/violations/sanctions on the members served by the provider.

2. QM compiles results of all monitoring reviews (Grievances, Quality of Care Concerns, Incident Reports and Routine results) with the DHSR reports to compile the provider profile. The Sandhills Center Network Operations Committee will review the citations/violations/sanctions and approve application of sanctions based on the Sandhills Center Provider Sanction Procedure and Grid. (Attachment 3).

**I. Finance**

The Finance Department manages the financial resources of the LME/MCO. This includes management of accountability, availability of funds, claims processing and payment. The Finance Department is responsible for ensuring compliance with General Statute 159 (The Local Government Fiscal Control Act) and other general accounting requirements. The Finance/Reimbursement Department supports providers through training and through its Claims Specialist representatives.

**Your Responsibilities as a Sandhills Center Contracted Provider are to:**

1. Verify member insurance coverage at the time of referral; or admission; or each appointment; and on a quarterly basis.
2. Bill all first and third party payers prior to submitting claims to Sandhills Center.
3. Report all first party required fees and third party payments and denials on the claim.
4. Submit Clean Claims electronically within ninety (90) days of the date of service unless otherwise stated in your contract.
5. Identify all billing errors to the Sandhills Center Finance Department.
6. Manage your agency’s accounts receivable.
7. Submit all documentation, which is required for federal, state, or grant reporting requirements. This includes, but is not limited to, required member enrollment demographics that must be reported to the State of North Carolina by Sandhills Center.

**Sandhills Center’s Responsibilities to Providers are:**

1. Certify funding for all contracts in accordance with G.S. 159. The Finance Department will review and approve all financial commitments made by Sandhills Center.
2. Monitor retroactive Medicaid eligibility and recovery of funds.
3. Manage claims processing to achieve timely payment for providers.
4. Issue payments and remittance advices (RAs) on paid and denied claims.
5. Assist the Quality Management Department with review of financial reports, financial statements, audits and accounting procedures.
6. Recover funds based on audit findings.
7. Audit providers for Coordination of Benefits (COB).
J. Information Technology

The Sandhills Center information system must support both members and providers. Sandhills Center maintains a web site that provides information to members about available services, individual provider agencies, provider performance, LME/MCO events and operations, and links to other websites. This web site includes a provider search function so members can select criteria (such as county, disability, service), and identify providers that offer these services.

Secure web based portals are available for providers to submit service authorization requests, upload crisis plans, submit billing, and review status of claims submitted. This supports all providers in their billing and only requires the use of a personal computer and high-speed internet connection. Providers may elect to submit their claims using the HIPAA Standard Electronic Transaction Set. This can be accomplished in two ways: first through the web portals in Sandhills Managed Care Software System or by using a secure FTP with Sandhills Center.

Below is a summary of the critical functionalities that our Sandhills Managed Care Software System provides:

- The Sandhills Managed Care Software System has a web portal for providers to search for members, submit authorizations and submit billing for processing.

Providers can send standard HIPAA compliant transaction claims, or they can use the Sandhills Center web based Portals and enter their claims directly.

All calls are answered by a live person. When a member or family member calls the 1-800 number, a Customer Service Representative will answer, use Sandhills Managed Care Software System to log the call, perform a brief risk screening, and gather information on the member and their problem or concerns. The Customer Service Representative uses a scripted procedure to assure that all calls are handled the same way and the correct information is obtained.

If at any time the caller presents an emergency or clinical need, the Customer Services Representative will connect the caller to a licensed clinician by a “warm transfer” procedure. Callers are never put on hold. Clinical staff is always available to handle calls that require their involvement.

Members are always offered a choice of providers when scheduling an appointment. The Call Center Licensed Clinicians complete a Screening Triage and Referral (STR) assessment and may set up a three-way call with a crisis service provider and caller to assure a smooth transition is made. The found in the Sandhills Center Managed Care Software System so that current clinical information is available at the time of the appointment Sandhills Center Software System manages enrollments, services requests authorizations, claims and payment approvals for approved services.

K. Sandhills Center Chief Medical Officer/Chief Clinical Officer

Sandhills Center’s Chief Medical Officer/Chief Clinical Officer is a board certified psychiatrist and is responsible for the overall clinical management of services to members including authorization of services and utilization management. The Chief Medical Officer/Chief Clinical Officer also serves as co-chair of the Quality Management Committee.
Other responsibilities of the Chief Medical Officer/Chief Clinical Officer include collaboration with the Sandhills Center's network providers, medical providers in the community, and state and community hospitals as well as development of clinical best practice guidelines and preventive health projects for Sandhills Center's members.

**Treatment Philosophy and Community Standards of Practice**

Sandhills Center providers are our partners and provide both clinical interventions and support services that are essential for the achievement of positive individual and system outcomes. Treatment and services should consist of evidence-based and best practice models that result in real life outcomes, support empowerment and self-determination, and aid the recovery of the member.

**L. Stakeholder Involvement**

**Involvement in Sandhills Center System Management**

Sandhills Center has a comprehensive system of strategies and activities in order to ensure engagement of its members, family members, advocates, providers, and community agencies. This involves a number of committees, forums, meetings, etc. that bring Sandhills Center staff, members/family members, providers and stakeholders together to address problems and concerns, provide important feedback to Sandhills Center around its performance, and to assist in pro-active planning. Community stakeholders generally include the following:

1. DSS
2. School Districts
3. Juvenile Justice
4. Public Health
5. Partnership for Children
6. Law Enforcement
7. Advocacy Organizations
8. Comprehensive Community Provider Representation
9. Consumer and Family Advisory Committee Representation

Forums with involvement of these stakeholders have served and continue to serve a critical purpose in helping Sandhills Center understand challenges and problems, community priorities, and to provide information to the community about Sandhills Center initiatives and activities.
M. Operational Committees

Sandhills Center Board of Directors

Sandhills Center CEO

- Executive Leadership Team
- External & Quality Programs
- Corporate Compliance & Internal Audit
- Clinical Advisory Committee
- Critical Incidents

Quality Management Committee

- Global CQIC
- Care Management Utilization Management

Health Network

- Clinical Leadership Team
- Network Leadership Council
- Credentialing Committee
- Consumer & Family Advisory Committee
- Clients Rights Committee

Customer Services
N. Corporate Compliance and Internal Audit Program and Plan

Sandhills Center places emphasis on regulatory and compliance issues that affect Sandhills Center’s external and internal operations. The Corporate Compliance and Internal Audit program establishes the following framework for the Sandhills Center Board, staff and Network Providers:

1. Designation of a Corporate Compliance Officer and a Corporate Compliance and Internal Audit Committee accountable to the Chief Executive Officer and the Board of Directors. Both the Corporate Compliance Officer and the committee direct efforts to ensure compliance and implement the corporate compliance program;

2. Development, implementation, annual review and approval of a Sandhills Center Corporate Compliance and Internal Audit Plan;

3. Incorporation of accreditation standards, applicable state and federal laws and regulations, Department of Health and Human Services contractual obligations and sound ethical business practices in directing Sandhills Center Board and staff, delegated entities, network providers and other involved with operational practices;

4. Identification and response to federal, state, and local laws and regulations that may apply to business practices, relationships and methods of conducting business;

5. Promotion of organizational culture to encourage and support ethical conduct and ongoing commitment to compliance with all applicable local, state and federal requirements;

6. Reasonable oversight by Sandhills Center Board of Directors for the development and implementation of an annually reviewed and approved Corporate Compliance and Internal Audit Program and Plan;

7. Development and implementation of ongoing education and training for Board members, program and administrative staff, delegated entities, advisory committees, network providers, and members to address obligations for adherence (and consequences of non-adherence) to applicable compliance requirements;

8. Development and implementation of standards and procedures for ongoing monitoring to identify potential risk areas and operational issues, non-compliant conduct by staff, delegated entities, or contract providers as well as mechanism(s) to respond to identified issues;

9. Development and implementation of a process for all persons to report alleged compliance issues directly or anonymously;

10. Enforcement of standards through documented disciplinary mechanisms, guidelines and policies and procedures;

11. Analyses of any misconduct to determine systemic issues and formulation of plans for corrective action to address identified areas of non-compliance;

12. Coordination with contract providers to ensure effective compliance in areas where activities of Sandhills Center and contract providers overlap;
13. Implementation of regular reviews (at least annually) of the overall compliance efforts of Sandhills Center to ensure that operational practices reflect current compliance requirements and address goals for improving organizational operations.

14. Coordination with DHB, DMH, and other LME/MCOs to ensure contract compliance, timely submission of required reports, and effective communication;

15. Management of both internal and external project designed to improve overall operations for Sandhills Center as well as the provider network and member services; and

16. Oversight of Health Information Management including HIPAA compliance and retentions schedules.

O. Program Integrity Overview

The Program Integrity (PI) Team began operation in January 2013. The team works under the supervision of the Corporate Compliance Officer and the Chief Medical Officer/Chief Clinical Officer, and in close coordination with Quality Management and Monitoring. (Reference – 10A NCAC 22F).

1. Scope of Work

Develop, implement and maintain methods and procedures to detect, investigate and resolve cases involving fraud, abuse, error(s), overutilization or the use of medically unnecessary or medically inappropriate services. This includes, but is not limited to:

a) Investigate allegations of billing for services not provided, providing illegal kickbacks, operating in locations not endorsed or credentialed by the LME/MCO and various other violations of DHB policy and applicable rules or law.

b) Coordinate with other Sandhills Center departments including QM, Network, Finance and Medical Records. The team also coordinates as needed with external agencies, including DHB, the Medicaid Investigations Division (MID) and other LME/MCOs.

c) The PI staff participates in a monthly PI forum to discuss procedures and standardization between LME/MCOs and participates in a quarterly meeting with DHB and MID to discuss specific cases and issues that affect LME/MCOs.

2. Team Composition

The team consists of four positions – the Director, Investigator, Clinical Analyst and Data Analyst

a) The PI Director is responsible for overseeing the team’s activities, assisting with investigations, and coordinating with other departments or agencies.

b) The Lead Investigator works with the team to screen and investigate cases. Focus is on regulatory violations (reviewing cases for potential violations of policy, rule, or law).

c) The Clinical Analyst works with the team to review cases from a clinical perspective, including reviewing for medical necessity and assisting with witness interviews.
d) The Data Analyst performs data mining necessary to identify potential cases, develops random samples for audits or investigations, and conducts claims analysis of providers under review. The Data Analyst assists with investigations and interviews as needed.

3. Process Summary

a) Cases are referred through grievances, data mining, routine monitoring, audits, UM, care coordination and other sources.

b) Referrals are screened to determine whether they fall within the scope of Program Integrity. Cases are also reviewed by the Chief Legal Officer/Corporate Compliance Officer, and Chief Medical Officer/Chief Clinical Officer.

c) Data mining may be used to generate leads and obtain additional information on referred providers.

d) PI investigations may include a review of consumer, personnel, and/or financial records, paid claims analysis, interviews of members and staff, site reviews, and evidence from other sources.

e) The Clinical Analyst reviews member records for evidence of medical necessity.

f) The findings are compiled into a written report to be reviewed by the Chief Legal Officer/Corporate Compliance Officer and Chief Medical Officer/Chief Clinical Officer.

g) If the investigation reveals evidence of fraud, the case is referred to the DHB for further review, and any additional LME/MCO actions are conducted in coordination with the DHB.

h) Potential outcomes include recoupment of improper billing, administrative sanctions, referral to DHB, contract termination, or any combination thereof. Providers may also be placed on prepayment review status to prevent ongoing loss by the LME/MCO.
SECTION 3: PROVIDER/PRACTITIONER NETWORK

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   9. Sandhills Center Quality Improvement and Utilization Management Programs
  10. Licensure Requirements
  11. Credentialing and Re-Credentialing
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E. Cultural Competency Plan (Attachment 1)
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H. Network Provider Dispute Resolution
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N. Network Development Plan
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A. Introduction

Health Network Program

The primary goal of the Network Program is to develop a network that meets the needs of members in the catchment area through a network of providers and practitioners who have developed expertise in evidence-based best practices and are culturally competent. The Network Program consists of three sections, the Network Development/Contracts Section, the Network Management/Credentialing Section, and the Network Monitoring Section.

Network Development/Contract’s activities are, but not limited to:
1. Conducts an annual Community Needs Assessment & Gap Analysis for service planning
2. Conducts Request for Proposals (RFP) Process when new service(s) are needed & facilitates implementation of the new service(s).
3. Develops & manages the contract process.
4. Ensures new providers have access to provider orientation.
5. Maintains an email distribution list & sends out communication bulletins, updates, etc.
6. Issues Letters of Support for 27G.5600 residential, as part of the NC DHSR licensure process.
7. Process requests for Client Specific contracts if appropriate service provider is not in the network to meet medical necessity needs of member.
8. Process Provider Payment Agreements requests typically for hospitals that are out of the network.
9. Offer provider support by way of the “Provider Help Desk” by responding to questions and directs providers to other resources if necessary; and shares information & resources, provides technical assistance & resolves issues and concerns.
10. Manages Provider Relative/Legal Guardian Processes

The Provider Help Desk can be contacted via email at: providerhelpdesk@sandhillscenter.org or by phone at 1 (855) 777-4652 toll free.

Network Management/Credentialing’s activities are, but not limited to:
1. Manages provider credentialing & re-credentialing;
2. Monitors providers for compliance of their contract;
3. Maintains provider information in the Sandhills Center Managed Care Software System;
4. Maintains provider sanctions processes, Appeals & Reports;
5. Monitors CAQH compliance process for LIPs/LPs.

Network Provider Monitoring activities are, but not limited to:
1. Ensures compliance, efficiency and accountability through monitoring of documentation and clinical processes –
   a. Medicaid & State Funded MH/DD/SA services;
   b. DHB mandated Post Payment monitoring for all Licensed Independent Practitioners (LIPs), Provider Agencies, unlicensed AFLs & Supervised Living;
   c. Health & Safety Initial Inspection/Issues; as well as onsite reviews for member health and safety concerns.
   d. On site monitoring of grievances, incidents and quality of care concerns when needed.

Monitoring tools are found at Sandhills Center website https://www.sandhillscenter.org/for-providers/provider-forms/
B. Network Credentialing/Re-Credentialing Process

Sandhills Center is committed to ensuring that the network is comprised of qualified agencies, facilities and licensed independent practitioners/licensed practitioners, and recognizes the importance of behavioral health services to meet the needs of its members. Agencies include specialty providers. Facilities include but are not limited to inpatient psychiatric and substance abuse treatment facilities, Psychiatric Residential Treatment Facilities, and Facility Based Crisis programs. Sandhills Center credentials all facilities in our provider directory which include inpatient, private, and community based hospitals. Sandhills Center does not credential facilities such as acute inpatient facilities such as hospitals, skilled nursing facilities, freestanding surgical centers, or home health agencies, whose primary services are not related to the treatment of behavioral health disorders.

Types of practitioners credentialed and re-credentialing

Credentialing requirements apply to:
- Practitioners who are licensed, certified or registered by the state to practice independently.
- Practitioners who have an independent relationship with the organization.
  - An Independent relationship exists when the organization directs its members to see a specific practitioner or group of practitioners, including all practitioners whom members can select as primary care practitioners.
- Practitioners who provide care to members under the organization’s medical benefits.

The criteria above apply to practitioners within the following settings:
- Individuals or group practices.
- Facilities.
- Telemedicine.

Licensed independent practitioners, as well as practitioners within contracted agencies, are required to be credentialed initially, and re-credentialing every three years. These licensed independent practitioners/licensed practitioners include, but are not limited to, psychiatrists and other physicians, licensed clinical social workers, licensed or state certified clinical psychologists including doctoral or master’s level, licensed clinical mental health counselors, licensed clinical addiction specialists, master’s level clinical nurse specialists or psychiatric nurse practitioners who are nationally or state certified or licensed, and physician assistants. Occupational Therapists (OT), Physical Therapists (PT), board certified behavior analysts, and Speech Therapists (ST) are also credentialed and re-credentialing for specialized consultative services, and Applied Behavior Analysis (ABA) services.

All network practitioners are independently licensed and operate within the scope of his/her license or certification. Sandhills Center, under State mandate and guidance, establishes credentialing and re-credentialing criteria for each type (agency, facilities, and licensed independent practitioners/licensed practitioner & hospitals) and category of network providers. Criteria for network participation is reviewed and approved by the Sandhills Center Credentialing Committee and/or the Chief Medical Officer/Chief Clinical Officer. The credentialing plan includes verification of the professional qualifications of its providers/practitioners in the credentialing criteria and qualifications of participating providers’ organizations, and maintains written descriptions of the credentialing procedures. The submission of applications during the initial credentialing and re-credentialing processes are described in the Sandhills Center Credentialing Plan.
Sandhills Center has the responsibility to evaluate providers and practitioners in a fair, accurate, and non-discriminatory method, recognizing that providers and practitioners have the responsibility for managing the behavioral healthcare of members whose eligibility originates within the Sandhills Center catchment area. In order to achieve this, Sandhills Center has developed and implemented credentialing and re-credentialing procedures to evaluate providers (agencies, facilities and hospitals) and practitioners. The recruitment of providers/practitioners, and subsequent credentialing and re-credentialing processes and decisions are made based on objectives of the Division of Health Benefits (DHB), and Division of Mental Health (DMH) directed measurable criteria and verification of credentials for each provider/practitioner type. Decisions are made without consideration for an individual’s race, ethnic/national identity, gender, age, sexual orientation or patient type (e.g., Medicaid) in which the provider specializes. Sandhills Center implements a credentialing program that addresses non-discrimination against providers in high risk/high cost patient specialties. The Credentialing applications, criteria, and instructions for applying to the network are posted in the Provider Section of Sandhills Center’s website at https://www.sandhillscenter.org/for-providers/.

The Sandhills Center Credentialing Plan is approved by the Credentialing Committee, and is reviewed and updated annually. The plan defines the roles and responsibilities of the Credentialing Committee Management and the Chief Medical Officer/Chief Clinical Officer. The plan describes how submitted information is verified, maintained, and stored.

All service providers/practitioners are required to obtain membership in the Sandhills Center Provider Network through the credentialing process. Sandhills Center ensures all providers/practitioners are credentialed before they provide care to members. The credentialing and re-credentialing process includes submission of an application, verification of credentials, review of any adverse actions or sanction activity, onsite review, and review of qualifications and current competency. Pursuant to DMH contract, Section 6.4.1, Sandhills Center shall use the same written policies and procedures for credentialing and re-credentialing of state-funded providers as are required for Medicaid providers.

1. Network Application Process

All agencies, facilities, licensed independent professionals, and associate level licensed professionals (solo and agency employed LPs, who wish to be a member of the Sandhills Center network must officially request permission to apply for network participation through Sandhills Center’s request to join the closed Network process (providerjoin). Exceptions to join the network are considered on a case by case basis determined by current geographical and clinical area of needs. Service exceptions are listed on the Sandhills Center website under, “For Providers/Enrollment and Credentialing”, however, interested providers are strongly advised to contact Network Operations to determine current identified needs. If the provider/practitioner believes their request meets exception criteria, they will submit a
Request to Join Network form to include letter of justification, which demonstrates the value that this change would bring to the Sandhills Center Network. Requests should include a list of specialty areas of practice, years of experience, and number of Sandhills Center members currently served, or an estimate on number who will be served, and current referral sources. Requests should include a copy of an updated resume (and in the case of an agency request, all resumes for practitioners who will practice with you). Requests that sufficiently meet an area of need will be reviewed by clinical staff to determine if submission of a credentialing application is appropriate. This process is also utilized for requests to add sites or services to a current Sandhills Center contract.

The Credentialing / Applications, criteria and instructions applying to the network are posted on the Provider Section of the Sandhills Center website at www.sandhillscenter.org. Applications are appropriate to provider type: agency, facility, and licensed independent practitioner/licensed practitioners, and require specific information including but not limited to:

Agencies/Facilities (Excludes Hospitals)
1. Agency/Facility license(s) (if applicable);
2. Shall identify ownership of the entity. A list of all owners by name, social security number, date of birth and address of all persons with 5% or more interest and a list of all parent, sister, and subsidiary entities in the entire chain of ownership, including an organizational flow chart, up to the ultimate owner of the holding company;
3. Shall furnish a list of the names, dates of birth, social security numbers and addresses of all managing employees as defined at 42 CFR 455.101, including, but not limited to members of the Provider’s Board of Directors;
4. Shall disclose if it is affiliated by contract or otherwise with any other provider;
5. Submission of the “Trading Partner Agreement” is required for the agency / facility and for billing agents / clearing houses, if applicable;
6. Certificate of Liability Insurance coverage and verification that the individual provider is listed among those covered under the policies. If the provider is not named on the certificate of insurance, a letter from the agency provider or insurance company indicating the provider is covered under the policies is required;
7. Professional Liability Claims History;
8. History of sanctions (Medicare, Medicaid programs including paybacks, lawsuits, payouts and pending);
9. History of Disciplinary Activity;
10. Accreditation status: Confirmation that the provider has been reviewed and approved by an accrediting body, if applicable. Sandhills Center collects a copy of the specific sources used to confirm the provider’s accreditation. 1) applicable accrediting body for each type of organizational provider, 2) agent of the applicable accrediting body and 3) copies of credentials – i.e. accreditation report or letter from the accrediting body to the provider. Sandhills Center does not accept an attestation from a provider regarding the provider’s accreditation status.
11. Sandhills Center conducts an onsite quality assessment if there is no accreditation status. The assessment includes criteria for each type of provider, and a process ensuring that the provider credentials their practitioners. If the provider has satellite facilities that follow the same policies and procedures as the provider, Sandhills Center may limit site visits to a main facility. State or federal review in lieu of a site visit: Sandhills Center may substitute a CMS or state quality review in lieu of a site visit under the following circumstances:
   - The CMS or state review is no more than three (3) years old. If CMS or state review is older than three (3) years, then Sandhills Center conducts its own onsite quality review.
Sandhills Center obtains a survey report or letter from CMS or the state, from either the provider or from the agency, stating that the facility was reviewed and passed inspection. The report must meet Sandhills Center’s quality assessment criteria or standards.

12. Sandhills Center is not required to conduct a site visit if the state or CMS has not conducted a site review of the provider and the provider is in a rural area, as defined by the U.S. Census Bureau. There is no prescribed time frame for gathering data to use for assessing providers.

13. History of names if the entity has done business under another name(s) or is using a “doing business as” (d/b/a) name;

14. Disclosure of any physical, mental, or substance abuse condition that could / has, without reasonable accommodation, impeded the ability to provide care according to accepted standards of professional performance or posed a threat to the health or safety of members;

15. A signed and dated statement attesting that the information submitted with the application is complete and accurate and authorizes Sandhills Center to collect any information necessary to verify the information in the application;

16. Agency/Facility must furnish a completed original signed and dated W9 Tax Payer Request for Tax ID # and Certification.

17. LP’s work look back period for work history (at least five [5] years) for LPs within an agency. Physicians who are not “Board Certified” must provide an official certified copy of educational transcripts from the highest level of education;

18. Provider gives information related to physical disabilities accessibility. If the provider’s site location is not equipped to serve members with physical disabilities, then the provider must include a plan to accommodate those members with physical disabilities, and submit the plan with the application. 42 CFR § 438.206.

Licensed Independent Practitioner LIP = Solo Practitioner & LP = Licensed Practitioner within agency

1. A copy of a current and valid Professional License;

2. Certificate of Liability Insurance coverage and verification that the individual practitioner is listed among those covered under the policies. If the practitioner is not named on the certificate of insurance, a letter from the agency or insurance company indicating the practitioner is covered under the policies is required;

3. Solo practitioners who employ three (3) or more employees must provide proof of Worker’s Compensation or Employer’s Liability insurance (WC/EL). See Insurance Attestations form in the practitioner application. If applicable, shall identify ownership of the entity. A list of all owners by name, social security number, date of birth and address of all persons with 5% or more interest, and a list of all parent, sister, and subsidiary entities in the entire chain of ownership, including an organizational flow chart, up to the ultimate owner of the holding company.

4. If applicable, shall furnish a list of the names, dates of birth, social security numbers and addresses of all managing employees as defined at 42 CFR 455.101, including but not limited to members of the provider’s Board of Directors.

5. Current Federal DEA Certification (for MD’s, Physician Assistants & Psychiatric Nurse Practitioners);

6. South Carolina Controlled Drug Substance Certification & DEA information, if applicable (for those LIP prescribers who hold a South Carolina License);

7. Copy of National Provider Identifier Certification (NPI #);

8. A licensed provider’s on–call designee shall be a member of the network or approved by Sandhills Center, and must have the same credentials or higher;

9. Professional Liability Claims History. At initial credentialing, practitioners attest to any loss of license and/or felony convictions since their initial licensure. At re-credentialing, practitioners attest to any loss of licensure and/or felony convictions since the last credentialing cycle;
10. History of Sanctions (Medicare, Medicaid programs including paybacks, lawsuits, payouts and pending)

11. Submit at least 2 references;

12. Shall provide languages spoken proficiently;

13. Shall provide areas of specialty or certificate from the Specialty Board, if applicable;

14. History of loss or limitation of privileges or disciplinary activity. At initial credentialing, practitioners attest to any loss or limitation of privileges or disciplinary actions since their initial licensure. At recredentialing, practitioners attest to any loss or limitation of privileges or disciplinary actions since the last credentialing cycle.

15. Hospital affiliations or privileges, including non-privileged clinicians (LIP/LP must address plan for admitting patients). At initial credentialing, practitioners attest to any loss or limitation of privileges or disciplinary actions since their initial licensure. At recredentialing, practitioners attest to any loss or limitation of privileges or disciplinary actions since the last credentialing cycle.

16. Submission of the “Trading Partner Agreement” is required for the solo practitioner and billing agents / clearing houses, if applicable;

17. Disclosure of any physical, mental, or substance abuse condition that could / has, without reasonable accommodation, impeded the ability to provide care according to accepted standards of professional performance or posed a threat to the health or safety of members

18. A signed and dated statement attesting that the information submitted with the application is complete, accurate, and authorizes Sandhills Center to collect any information necessary to verify the information in the application

19. Licensed Independent Practitioner (Solos Only) must furnish a completed original signed and dated W9 Tax Payer Request for Tax ID # and Certification;

20. LIP’s/LPs work look back period for work history (at least five [5] years); Gaps in work history – Credentialing specialist document their review of the practitioner’s work history and note any gaps on the checklist – i.e. signatures or initials of staff who reviewed the work history and the date of the review. If a gap in employment exceeds six months, the practitioner clarifies the gap in writing. If the gap in employment exceeds one year, the practitioner clarifies the gaps in writing.

21. Physicians who are not “Board Certified” must provide an official certified copy of educational transcripts from the highest level of education; Board certification, if applicable. Board certification must verify current certification status of practitioners who state they are board certified. The expiration date of the board certification must be documented in the credentialing file. If a practitioner has a “lifetime” certification status and there is no expiration date for certification, then verification of the current status must be documented in the credentialing file along with the date of verification.

22. Practitioner gives information related to physical disabilities accessibility. If the practitioner’s site location is not equipped to serve members with physical disabilities, then the practitioner must include a plan to accommodate those members with physical disabilities and submit the plan with the application.

23. Lack of present illegal drug use. LIP/LP attest as to whether or not they have the ability to perform their job; impairment or limited ability to practice; perform with reasonable skill and safety; pose a risk to members

Hospitals
1. A copy of the current and valid Facility License;

2. If applicable, shall identify ownership of the entity. A list of all owners by name, social security number, date of birth and address of all persons with 5% or more interest and a list of all parent, sister and subsidiary entities in the entire chain of ownership, including an organizational flow chart, up to the ultimate owner of the holding company.

3. If applicable, shall furnish a list of the names, dates of birth, social security numbers and addresses of all managing employees as defined at 42 CFR 455.101, including, but not limited to members of the provider’s Board of Directors.
4. List all Psychiatric Facilities operated by the Hospital and covered by the Hospital’s accreditation;
5. Certificate of Liability Insurance coverage and verification that the individual provider is listed among those covered under the policies. If the provider is not named on the certificate of insurance, a letter from the agency provider or insurance company indicating the provider is covered under the policies is required;
6. Accreditation status to include a list of all Psychiatric Facilities operated by the Hospital and covered by the Hospital’s accreditation (Inpatient, PRTF, Intensive Outpatient, Partial Hospitalization, Outpatient); Confirmation that the provider has been reviewed and approved by an accrediting body, if applicable. Sandhills Center collects a copy of the specific sources used to confirm the hospital’s accreditation. 1) applicable accrediting body for each type of organization, 2) agent of the applicable accrediting body and 3) copies of credentials – i.e. accreditation report or letter from the accrediting body to the provider. Sandhills Center does not accept an attestation from a provider regarding the provider’s accreditation status.
7. National Provider Identifier (NPI #);
8. Copy of National Plan and Provider Enumeration System (NPPES) letter;
9. Letter of Attestation for False Claims Act Education. Out-of-Network and Out-of-State Hospitals must submit the Letter of Attestation at the time of application. Hospitals seeking to contract with Sandhills Center shall execute a Letter of Attestation for False Claims Act Education for submission with their signed contract;
10. Copy of most current “Rate Notification for DRG, Rehabilitation, Psychiatric, Inpatient DRG Specific RCC Letter” from the North Carolina Department of Health and Human Services Division of Health Benefits;
11. Submission of the “Trading Partner Agreement” is required for hospitals and for billing agents / clearing houses if applicable;
12. Disclose adverse actions by Medicaid, Medicare, or other insurance agencies related to inpatient behavioral health;
13. A signed and dated statement attesting that the information submitted with the application is complete and accurate and authorizes Sandhills Center to collect any information necessary to verify the information in the application to the applicant’s knowledge;
14. LP’s work look back period for work history (at least five [5] years) for LPs within a hospital
15. Physicians who are not “Board Certified” must provide an official certified copy of educational transcripts from the highest level education;
16. Provider gives information related to physical disabilities accessibility. If the provider’s site location is not equipped to serve members with physical disabilities, then the provider must include a plan to accommodate those members with physical disabilities and submit the plan with the application.

a. Specific Provider Information Required

In an effort to avoid providers having to submit information for the Sandhills Center credentialing process that they may have submitted as a result of a previous request, Sandhills Center credentialing staff brings together information already on file in reviewing credentialing applications. However, information submitted for credentialing cannot be over 180 days old. Sandhills Center credentialing staff reviews provider files prior to requesting credentialing information to determine what is needed from the provider.

b. Sandhills Center Notification to Applicant

Upon receipt of an initial or recredentialing application, the applicant is notified of their rights to be informed of the status of their application, upon request, review information submitted to support their credentialing/recredentialing application and correct erroneous information.
• Verification of receipt of the application packet;
• Status of the application and documentation submitted, informing the provider that the application appears to be complete or states the application and materials are being returned due to missing information;
• Applicant is provided with LME/MCO contact names and numbers;
• Applicant is encouraged to contact the assigned Credentialing Specialist regarding questions or concerns about the credentialing process and/or status of the application.

Where discrepancies exist between information provided in the submitted application and information received from other sources of primary verification, the applicant is emailed requesting clarification, rationale and/or explanation of the discrepancy. If the practitioner/provider fails to submit information clarifying discrepancies, the credentialing specialist sends notification of request(s) via email or certified mail to the practitioner/provider. Requests for additional and/or clarifying information are made at a maximum of two (2) attempts.

- Information submitted by applicants to clarify discrepancies is reviewed and a determination is made to stop or proceed with the credentialing process. When the process is stopped, the application and supporting documentation is filed and notification is sent providing the reason for stopping the process to the applicant/provider via certified mail. If the applicant submits clarifying information that addresses the issues in question, the credentialing process continues.

- If the discrepancy is related to member safety parameters, the credentialing process is stopped.

- For applicants that fail to submit clarifying information within the established timeframe, the credentialing process is stopped and the credentialing specialist notifies the applicant in writing via electronic mail and/or certified mail.

The Chief Medical Officer/Chief Clinical Officer and the Credentialing Committee reserve the right to consider missing, conflicting and/or misleading information in its decision making even after the provider has corrected or clarified information.

Sandhills Center implements a credentialing program that addresses non-discrimination against providers in high risk/high cost patient specialties.

(c) Verification of Information and Sources

Sandhills Center recognizes the importance of verifying credentialing information from the primary sources. The type of information and the sources used varies by provider type (agency/facility, licensed independent practitioner/licensed practitioner, hospitals) including but not limited to the following:

Agencies/Facilities
1. License;
2. NC Department of the Secretary of State Articles of Organization or Articles of Incorporation;
3. Medicare & Medicaid sanctions/exclusions;
4. State Exclusions List (SEL);
5. NC Tracks enrollment, including active status in the NC Medicaid Health Plan;
6. National Plan & Provider Enumeration System (NPI) registration;
7. License Restrictions or Sanctions;
8. Social Security Number Verification (Owner);
9. Criminal record check of owners 5% or greater (if applicable). Applicant signs SBI authorization and returns to Sandhills Center with application submission;
10. Confirmation that the provider has been reviewed and approved by an accrediting body, if applicable. Sandhills Center collects a copy of the accreditation report or letter from the provider. Sandhills Center does not accept an attestation from a provider regarding the provider’s accreditation status.
11. Malpractice History & Adverse Actions for LPs within agencies – National Practitioner Data Bank (NPDB).
12. If a facility is not accredited then the most recent (within the past 3 years) CMS State review documentation is required (in lieu of a site visit). Sandhills Center reserves the right to conduct a site visit utilizing State-mandated criteria for a Health and Safety inspection, and does not accept an attestation from a provider regarding the provider’s accreditation status.

**Licensed Independent Practitioners/Licensed Practitioners**

1. College/University website verification or a certified copy of original transcripts from the college/university for the highest degree obtained unless Sandhills Center has verified the designated licensure board performs Primary Source Verification;
2. A current and valid professional license to practice;
3. Board Certification (if applicable);
4. Current Federal DEA Certification for LIP/LP prescribers;
5. State DEA for those South Carolina licensed prescribers;
6. National Plan & Provider Enumeration System (NPI) registration;
7. Medicare & Medicaid sanctions/exclusions;
8. State Exclusions List (SEL);
9. Malpractice history & adverse actions – National Practitioner Data Bank (NPDB);
10. NC Tracks enrollment including an active status in NC Medicaid Health Plan (Solos only);
11. License Restrictions or Sanctions;
12. Hospital Privileges;
13. Residency (if applicable);
14. Social Security Number is verified against Death Master file;
15. Authority to Release of Information SBI – Background Check (Solo Practitioners ONLY)
16. Verification of specialties criteria is included in the application packet.
17. Gaps in work history- Credentialing specialists document their review of the practitioner’s work history and note any gaps on the checklist i.e. initials of staff who reviewed the work history and the date of the review. If a gap in employment exceeds six months, the practitioner clarifies the gap in writing.

**Hospitals**

1. License;
2. Medicare & Medicaid sanctions/exclusions;
3. State Exclusions List (SEL);
4. NC Tracks enrollment including an active status in NC Medicaid Health Plan;
5. Confirmation that the provider has been reviewed and approved by an accrediting body, if applicable. Sandhills Center collects a copy of the accreditation report or letter from the provider. Sandhills Center does not accept an attestation from a provider regarding the provider’s accreditation status.
6. National Plan & Provider Enumeration System (NPI) registration;
7. Drug Enforcement Agency, if applicable;
8. Federal DEA certification for prescribers;
d. Response Time to Applicant Inquiries

If an applicant contacts the Sandhills Center Credentialing staff inquiring about the status of the application, the credentialing staff addresses the applicant’s concerns/questions within 2 business days.

e. Additional Review

Sandhills Center conducts additional review and investigations of credentialing applications where the credentialing process reveals factors that may impact the quality of care or services to members. Parameters for further investigation and/or denying or terminating the credentialing process may include, but are not limited to:

- Submission of inaccurate or misleading information on the application;
- Inability of Sandhills Center to complete the credentialing/re-credentialing process due to the applicant’s failure to provide relevant information;
- Currently or previously censured or excluded or sanctioned by Medicare/Medicaid;
- History of malpractice claims judged to be excessive by the Clinical Advisory Committee; (Professional liability claims history as defined as cases that are settled and have resulted in an adverse judgment against the provider);
- History of practicing without a valid license and/or registrations/certifications;
- Current or previous loss of, or revocation of, or restrictions to DEA certificate;
- Current physical or mental health condition that may significantly impair the practitioner’s ability to practice within the full scope of the licensure and qualifications or may impose a risk of harm to members;
- Current or history of chemical dependency or substance abuse;
- Current or history of felony convictions;
- Any current or previous loss of, or revocation, or restrictions to, or sanctions, or actions to professional license;
- Any current or previous loss of hospital privileges;
- History of practice trends that raise concerns regarding the provider ethics, boundary issues, quality of care and/or practice standards;
- History of significant patient grievances documented by licensing authority and/or healthcare facility;
- History of acts of fraud, deceit, dishonesty or moral turpitude;
- Quality issues as reported by National Practitioner Data Bank, licensing boards or prior work.

2. Collection & Maintenance of Network Provider Disclosure of Information on Ownership & Control

Sandhills Center is required through its contract with DHB to collect and maintain network provider applicants’ disclosure information regarding ownership and control of interest for the purpose of verifying their exclusion status of federal and state programs.

Provider disclosure of information on ownership and control is collected and maintained by the Network Operations Department through the credentialing & re-credentialing procedures, continuous monitoring processes and primary source verification to ensure that Sandhills Center does not pay Federal or State funds to excluded persons or entities.

Applicants must identify (by name, social security number, date of birth and address) all persons with an ownership or control interest of the entity as defined at 42 CFR § 455.101. A list of all owners with 5% or
more interest and a list of all parent, sister, and subsidiary entities in the entire chain or ownership, including an organizational flow chart, up to the ultimate owner of the holding company shall be provided.

Applicants must furnish Sandhills Center a list of the names, dates of birth, social security numbers and addresses of all managing employees as defined at 42 CFR § 455.101, including, but not limited to members of the applicant’s Board of Directors.

Disclosures from any provider or disclosing entity is due at any of the following times:
   a. Upon the provider or disclosing entity submitting the provider application.
   b. Upon the provider or disclosing entity executing the provider agreement.
   c. Upon request of the Medicaid agency due the re-validation or enrollment process
   d. Within 35 days after any change in ownership of the disclosing entity.

Providers who submit a Notice of Change Request form for a change in ownership must also submit a new W-9 on the most recent request for Taxpayer Identification Number and Certification form. See 42 CFR § 455.104 (c) (1) (iv) https://www.irs.gov/forms-pubs/about-form-w9.

a. Disclosure of Criminal Convictions

Sandhills Center requires all providers, including managing employees and persons with an ownership or control interest in the provider, to disclose any criminal convictions related to Medicare, Medicaid, or Title XIX programs at the time they apply or renew their applications for participation in the closed network, or at any time upon request by Sandhills Center. In order to verify this information, SANDHILLS CENTER requires all providers to disclose names, social security numbers, dates of birth, addresses and any other information necessary to complete a criminal background check for each managing employee and person with an ownership and control interest in the provider at the time they apply or renew their application for participation in the closed network or at any time upon request.

b. Criminal Background Checks of Providers and Persons with Controlling Interest

Sandhills Center requires, at credentialing and re-credentialing, that providers managing employees and persons with an ownership or control interest of five (5%) or more in a provider complete a background check including fingerprinting, if fingerprinting is required under State law, or by the level of screening based on risk of fraud, waste or abuse as determined for that category of provider. NC Tracks is responsible for collection and maintenance of fingerprinting.

c. Excluded Providers

Credentialing Specialists check the exclusion status of the provider, persons with an ownership or control interest in the provider, and agents and managing employees of the provider, including the State Exclusion List (SEL), HHS OIG’s list of Excluded Individuals/Entities (LEIE) and the System of Award Management (SAM) no less frequently than monthly to ensure that Sandhills Center does not pay Federal and State funds to excluded persons or entities.

Collection of provider disclosure information is done through the credentialing and re-credentialing process. This information is requested in each type of the provider application.

If the provider is identified as excluded, their contract is terminated or if the provider is initially applying for participation in the network, the applicant is denied.
3. Provider Selection andQualifications

Sandhills Center sets quality of care and quality of service criteria for all providers/practitioners with whom it contracts consistent with State and Federal rules and regulations governing the subject of behavioral health and medical professions. These criteria are incorporated into the credentialing criteria upon which providers and practitioners are reviewed. Quality of care criteria reflect the degree to which the services provided to member’s increase desired clinical outcomes and are consistent with current professional knowledge.

Quality of service criteria addresses issues such as hours of operation, cleanliness of office, responsiveness of staff, and special accommodations provided, etc.

The framework for the credentialing criteria is based upon service definitions established by DHB and or DMH. Sandhills Center’s Chief Medical Officer/Chief Clinical Officer has reviewed the criteria and identified that the process was clinically sound and utilizes best practice guidelines when selecting providers and practitioners to be credentialed.

- Provider/practitioner maintains hours of operation, which conform to the service definition.
- Provider/practitioner makes available information about a primary contact person, address, phone numbers, email address for all site locations.
- Provider/practitioner gives information about specific populations served (e.g., age range, gender, clinical group such as developmental disability, mental health, or substance abuse).
- Provider/practitioner gives information about specific areas of clinician expertise/certified specialties (e.g., psychological testing, anger management, grief and loss, trauma focused) if any.
- Provider/practitioner makes available information regarding focus of treatment (eating disorders, anxiety/phobias, depression, Attention Deficit etc.).
- Provider/practitioner gives information about accommodations they are able to provide such as hearing impaired assistance or language interpretation.
- Provider/practitioner gives information related to handicapped accessibility. Providers/practitioners must have adequate access to all services covered under the contract for all members, including those with limited English proficiency or physical and/or mental disabilities. If providers/practitioners cannot accommodate those members, they must include a plan on how they would accommodate those members and submit the plan with the application.
- Provider/practitioner must deliver services in a culturally competent manner to all members, including those with limited English proficiency and diverse cultural and ethnic backgrounds.

Closed Provider Network

The closed network is composed of providers and practitioners that offer quality services, demonstrate competencies in best practices and outcomes for persons served, ensure health and safety for members and demonstrate ethical and responsible practices. Through oversight of network providers and practitioners, Sandhills Center demonstrates its commitment to the achievement of positive outcomes for members, member satisfaction and accountability for the well-being of members.

Although the Network is closed, Sandhills Center will consider a Request for Proposal Process (RFP) to solicit proposals from prospective qualified, responsible providers/practitioners to fulfill a described service need(s). Sandhills Center will also accept requests to join or add a service through the request to join the

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closed network (providerjoin) process in the case where a provider or service meets exceptions criteria. Exceptions to the closed network are listed on Sandhills Center’s website, and are determined by ongoing gaps analysis, Care Coordination and Call Center reports, as well as recommendations from the Clinical Leadership Team, when appropriate. Prior to issuance of a contract, the providers/practitioners selected through the RFP, or approved through the “providerjoin” process, must be credentialed according to the above referenced Credentialing Plan.

On occasion Sandhills Center will terminate a contract with a provider/practitioner whose performance endangers members, or who fails to maintain quality of care criteria described in this document. This is not an exhaustive list of situations in which Sandhills Center may limit provider/practitioner network participation.

Non-discrimination

Sandhills Center shall comply with the requirements of 42 CFR § 438.214 regarding the selection and retention of providers and practitioners, the credentialing and re-credentialing of providers and practitioners, non-discrimination in the selection of providers and practitioners, and the prohibition of contracting with excluded providers and practitioners. Sandhills Center does not base credentialing decisions on an applicant’s race, ethnic/national identity, gender, age, or sexual orientation. Sandhills Center shall not discriminate, solely on the basis of the provider’s/practitioners license or certification, for the participation, reimbursement, or indemnification of any provider/practitioner who is acting within the scope of his or her license or certification under applicable State law. Sandhills Center shall not discriminate against particular providers or practitioners that serve high-risk populations or specialize in conditions that require costly treatment. Sandhills Center shall not employ or contract with providers/practitioners excluded from participation in Federal health care programs under either Section 1128 or Section 1128A of the Social Security Act.

Sandhills Center does not discriminate against providers/practitioners that serve high-risk populations or specialize in conditions that require costly treatment. If medically necessary treatment is required, but specialty services are not available in-network, Sandhills Center shall arrange for these services to be provided out-of-network in accordance with 42 CFR § 438.206 and Section 6.5 – Customer Services. Sandhills Center shall adequately and timely cover these out-of-network services for as long as Sandhills Center is unable to provide them in-network. Sandhills Center ensures that no incentive is given to providers/practitioners, monetary or otherwise, for withholding medically necessary services.

Selection and Retention

Sandhills Center applies these criteria consistently to all providers and practitioners.

When Sandhills Center is accepting applications for participation in the network, Sandhills Center considers the following information as part of the qualification and selection process, to the extent available and applicable to each provider type:

a.  Record of the provider’s/practitioner’s experience and competency. Stability of past operations is important. An assessment of the provider agency’s past record of services, compliance with applicable laws, standards and regulations, the qualifications and competency of its staff, the satisfaction of consumers and family members served, systems of oversight, adequacy of staffing infrastructure, use of best practices, and quality management systems will be evaluated by Sandhills Center prior to credentialing/enrollment and at regular intervals thereafter.
b. To the extent that such information is quantifiable, evidence of consumer friendly services and attitudes, including how member and families are involved in treatment and services. Providers shall have a good system of communication with members.

c. Evidence that the provider/practitioner has the clinical infrastructure, either through their own agency or through collaboration with other providers/practitioners, to address challenges in meeting specific client needs (such as challenging behaviors or medical problems).

d. Capacity of the provider to respond to emergencies for assigned members according to the availability standards for emergent needs as defined in Attachment S – Access and Availability Standards and the service definition requirements for First Responder capacity. Services, which must have First Responder capacity, are identified in Medicaid Clinical Coverage Policy 8A, “Enhanced Mental Health and Substance Abuse Services” which can be accessed on the DHB website at https://medicaid.ncdhhs.gov/providers/clinical-coverage-policies/behavioral-health-clinical-coverage-policies. If required, an adequate clinical back up system shall be in place to respond to emergencies after hours and on weekends.

e. Evidence that the provider has in place accounting systems sufficient to ensure fiscal responsibility and integrity; and

f. Evidence that agency-based provider staff meet the qualifications to provide behavioral health and developmental disability services, as defined in Medicaid Clinical Coverage Policy, Section 8, and in the Innovations Waiver. The policy and waiver can be accessed at the DHB website at https://medicaid.ncdhhs.gov/providers/clinical-coverage-policies/behavioral-health-clinical-coverage-policies.

If Sandhills Center declines to credential, enroll or contract with an applicant for initial participation in the provider/practitioner network, it shall give the affected provider written notice of the reasons for its decision, but Sandhills Center is not required to offer appeal rights.

If Sandhills Center issues a competitive Request for Proposal, Sandhills Center shall develop and utilize a scoring process to assess the provider’s competencies specific to the requirements of the Request for Proposal, the service definition, and enrollment requirements as delineated above.

Retention

Retention of agency-based providers depends on the performance of the agency as measured against identified indicators and benchmarks as described above, as well as Sandhills Center’s Network Development Plan and needs as identified in the annual assessment described in Section 6.4 – Access and Availability of Services. As part of the retention process, Sandhills Center may consider any of the following, to the extent available, in addition to other criteria established by Sandhills Center in accordance with the Network Development Plan (including but not limited to service demand and fiscal sustainability):

a. Data collected through Sandhills Center Utilization Management Program;
b. Data collected through Sandhills Center Quality Management Program;
c. Data collected through Sandhills Center Customer Services Program;
d. Data collected through the Grievance and Appeals process;
e. Data collected through the monitoring, investigation and audit activities;
f. Member satisfaction survey results;
g. The results from other quality improvement activities; and

h. A review of the provider’s compliance program required by Section 6401 of the Patient Protection and Affordable Care Act and the False Claims Act.

4. Credentialing Committee

   a. Credentialing Committee Membership

   The Credentialing Committee is a peer-review body with members from the range of practitioners and providers participating in the organization’s network to make recommendations, provide advice and expertise regarding credentialing decisions.

   Sandhills Center ensures that Credentialing Committee membership is broad enough that appropriate clinical peer input with knowledge of service specific standards of care are available when reviewing credentialing and recredentialing applications and practitioner or provider disputes and appeals related to professional conduct or competence.

   b. Provider Representation

   The Credentialing Committee membership is comprised of active practicing licensed clinicians that mirror the network composition in addition to Sandhills Center LME-MCO employees, licensed non-network healthcare practitioners residing within the LME-MCO’s geographic area, and Sandhills Center LME-MCO licensed clinical leadership staff. The Chairperson of the committee is the Sandhills Center Chief Medical Officer/Chief Clinical Officer. Meetings are convened at least quarterly and/or as needed. A voting majority of the Credentialing Committee shall consist of committee members who are not Sandhills Center LME-MCO staff.

   The Credentialing Committee is a rotating membership composed of licensed independent practitioners—MD’s, practicing psychologists, LCSW’s, LCAS’s, LCMHC’s, and PLC’s—who are representative of our provider network with regards to discipline, specialty, clinical competencies, geographic locations, and agency size.

   c. Time Frame for Review

   Credentialing applications are not to be submitted to the Credentialing Committee or the Chief Medical Officer/Chief Clinical Officer for review if the provider’s/practitioner’s signature and date on the application is greater than 180 days old, or if primary or secondary source verification information collected is more than six (6) months old.

   d. Confidentiality of Information

   The Credentialing Committee members are trained on the confidentiality of credentialing information and the need to maintain the confidentiality of information presented and discussed in committee reviews. To further protect confidentiality and promote objectivity in the review process, credentialing information is introduced to the Credentialing Committee and/or Chief Medical Officer/Chief Clinical Officer in a summary fashion with providers deemed “unclean” identified only by an assigned number and the services(s) for which the provider is seeking a contract. The provider’s/practitioner’s name is listed if the approved application is “clean” when presented to the Chief Medical Officer/Chief Clinical Officer. All authorized credentialing staff are required to sign a confidentiality statement upon
completion of confidentiality training.

e. Time Frame for Determination

Once the Credentialing Committee and/or the Chief Medical Officer/Chief Clinical Officer has reviewed and made a determination of a provider’s application, the provider is notified in writing of the decision within ten (10) business days.

f. Application Approval

If the Credentialing Committee and/or the Chief Medical Officer/Chief Clinical Officer approved the application, the applicant is notified by mail or e-mail by the assigned Credentialing Specialist. The applicant is advised that recommendation is being made to the Sandhills Center Board of Directors to establish a contract with the applicant for the services they have been approved to provide.

g. Application Denial

Initial credentialing decisions regarding a provider’s entry into the Sandhills Center Network are final. Reconsideration only applies for adverse actions taken against a provider who is already a contracted provider with Sandhills Center. Re-credentialing applications have the right to appeal. Re-credentialing applications that have been denied may use the appeals process as described in policies and procedures N NM-13 through N NM-17. See Section 12 of this manual.

Applicants who are reviewed and denied access to the network are notified in writing by the Chief Medical Officer/Chief Clinical Officer. The written notification includes the basis for the denial.

h. Notification to Provider

Notification is sent to those participating providers eligible for re-credentialing approximately 90 days prior to expiration of credentialing. Such notification includes the re-credentialing application along with an attestation indicating the provider’s continued compliance with credentialing criteria.

i. Review of Application and Performance Data

Upon receipt of the Re-credentialing Application, the Credentialing staff follows the procedures outlined in Plan sections “Credentialing Application, Credentialing Confidentiality, Review of Credentialing Information, Credentialing Communication Mechanisms, Primary Source Verification, Member Safety Credentialing Investigation, Credentialing Application Review, Credentialing Timeframe, and Credentialing Determination Notification”. In addition, the Quality Management department obtains the performance data necessary to review against Re-credentialing Criteria.

5. Participating Provider Credentials Monitoring

Sandhills Center ensures that all participating providers (agencies, facilities, licensed independent practitioners/licensed practitioners and hospitals) maintain continuing compliance for network participation. The following processes are used by Sandhills Center to monitor participating providers:

a. For Agencies/Facilities (Except Hospitals)
DHB mandated post payment monitoring is also completed once every two years on all providers.

To ensure the health, safety, and appropriate clinical care of members, grievance review follow-up and investigations are completed to determine if circumstances exist that require appropriate preventions and interventions be put into place for members in relation to serious occurrences. All grievances are reviewed to determine if an on-site investigation is warranted. Potential health and safety issues directly affecting members will prompt an on-site investigative review.

All Providers and Practitioners are reviewed periodically to ensure that clinical standards of care and medical necessity are being met. These reviews can be either routine or focused. Routine utilization review may include but not be limited to:

- Evaluations of services across the delivery spectrum;
- Evaluations of members by diagnostic category or complexity level;
- Evaluations of providers by capacity, service delivery; and
- Best-practice guidelines and evaluations of utilization trends.

Focused reviews may be generated by findings of a routine review.

1. Monitoring of Disciplinary Actions
   Disciplinary actions published by the NC Division of Health Service Regulation are produced periodically and are reviewed by the Quality Management staff. Credentialing Specialists consult the US DHHS Office of Inspector General’s List of Excluded Individuals and Entities (LEIE) [https://oig.hhs.gov/exclusions/exclusions_list.asp](https://oig.hhs.gov/exclusions/exclusions_list.asp), the Medicare Exclusion Databases (MED), and the Systems for Award Management (SAM) [https://sam.gov/SAM/pages/public/searchRecords/search.jsf](https://sam.gov/SAM/pages/public/searchRecords/search.jsf) (Note: You can no longer access the System for Award Management (SAM) using Internet Explorer (IE) Versions older than IE11. You either need to upgrade to an Internet Explorer version of IE11 or higher, or access SAM with another supported browser type (Chrome, Firefox, Safari, etc.) to ensure that providers who are excluded from participation in Federal programs are not enrolled in Sandhills Center network. In accordance with 42 CFR § 455.436, Sandhills Center will search the State Exclusion List (SEL) [https://medicaid.ncdhhs.gov/providers/excluded-providers](https://medicaid.ncdhhs.gov/providers/excluded-providers) (which is related to other screening methods in accordance with 42 CFR § 455.452), Social Security Administration’s Death Master File (SSADMF), the National Plan and Provider Enumeration System (NPPES), LEIE and the SAM upon enrollment, re-enrollment, credentialing, re-credentialing of network providers, and shall search the LEIE and the SAM at least monthly thereafter.

2. Monitoring Activities
   a) Insurance monitoring is conducted based on the expiration date with the provider being notified 30 days prior to expiration and requested to submit an updated certificate.
   b) License monitoring (if applicable) is conducted based on the expiration date with the provider being notified 30 days prior to expiration and requested to submit an updated license.
   c) Accreditation status is verified through the State & via online through the accrediting organization. If the provider is not fully accredited by the accrediting agency, the Credentialing Specialist monitors the progress of accreditation until the provider is fully accredited.
   d) Incident and grievance report data received from the Customer Services Department is reviewed on a quarterly basis by the Network Committee and the Network Leadership Council.
   e) Provider Performance Monitoring – A newly contracted Provider enters the Performance system on a Routine status. Routine Monitoring is defined as “meeting compliance-based standards
only” and is completed once every two years on all providers not reviewed by DHRS on an annual basis. A Post Payment Review is also completed once every two years on all providers.

3. **Monitoring of Agencies/Facilities Outside of the Sandhills Center Catchment Area**
   a) Post payment reviews will be completed outside our catchment area on all agencies/facilities for Sandhills Center members.

   b. For Licensed Independent Practitioners

1. **Monitoring of Licensed Independent Practitioners/Licensed Practitioners enrolled with Sandhills Center**
   (a) License monitoring is conducted based on the expiration date with the provider being notified 30 days prior to expiration and requested to submit an updated license.
   (b) Board certification is checked on line with the appropriate licensure board on a monthly basis.

2. **Monitoring of Disciplinary Actions**
   Credentialing Specialists consult the US DHHS Office of Inspector General’s List of Excluded Individuals and Entities (LEIE) [https://oig.hhs.gov/exclusions/exclusions_list.asp](https://oig.hhs.gov/exclusions/exclusions_list.asp), the Medicare Exclusion Databases (MED), and the Systems for Award Management (SAM) [https://sam.gov/SAM/pages/public/searchRecords/search.jsf](https://sam.gov/SAM/pages/public/searchRecords/search.jsf) (Note: You can no longer access the System for Award Management (SAM) using Internet Explorer (IE) Versions older than IE11. You either need to upgrade to an Internet Explorer version of IE11 or higher, or access SAM with another supported browser type (Chrome, Firefox, Safari, etc.) to ensure that providers who are excluded from participation in Federal programs are not enrolled in SANDHILLS CENTER network. In accordance with 42 CFR § 455.436, Sandhills Center will search the State Exclusion List (SEL) [https://medicaid.ncdhhs.gov/providers/excluded-providers](https://medicaid.ncdhhs.gov/providers/excluded-providers) (which is related to other screening methods in accordance with 42 CFR § 455.452), Social Security Administration’s Death Master File (SSADMF), the National Plan and Provider Enumeration System (NPPES), LEIE and the SAM upon enrollment, re-enrollment, credentialing, re-credentialing of network providers, and shall search the LEIE and the SAM at least monthly thereafter.

3. **Insurance Monitoring**
   Insurance monitoring is conducted based on the expiration date with the provider being notified 30 days prior to expiration and requested to submit an updated certificate.

4. **Provider Performance Monitoring**
   DHB mandated post payment monitoring is also completed once every two years on all providers.

   Sandhills Center monitors and investigates all reported practitioner grievances and adverse incidents. At least every six months, practitioner grievances and adverse incidents are analyzed to identify any trends or concerns. When issues are identified, this analysis is presented to the Credentialing Committee for discussion prior to being forwarded to Network Committee for possible sanctions.

5. **Monitoring of Licensed Independent Practitioners Outside of the Sandhills Center Catchment Area**
   Post Payment reviews are completed outside our catchment area on all Licensed Independent Practitioners (Solos Only) for Sandhills Center members.
c. For Hospitals*

1. Activities
Monitoring activities include but are not limited to primary source of verification of the hospital accreditation status, a review of the hospital’s current national accreditation report if provided, review of Sandhills Center utilization management data and care coordination data related to the hospital and a review of the hospital’s status with Medicare/Medicaid. These activities follow the re-credentialing process, and occur every three years.

*The North Carolina Administrative Code (10 A NCAC 27 G.0602) defines the extent of monitoring of the provision of public services by area authorities or county programs based on the category of the provider.

The provider category defines the type of facility in which a member receives services. Hospitals fall into Category C, which is excluded from routine monitoring by area authorities/county programs.

2. Monitoring of Disciplinary Actions
Disciplinary actions published by the NC Division of Health Service Regulation are produced periodically and are reviewed by the Quality Management staff. Credentialing Specialists consult the US DHHS Office of Inspector General’s List of Excluded Individuals and Entities (LEIE) [https://oig.hhs.gov/exclusions/exclusions_list.asp](https://oig.hhs.gov/exclusions/exclusions_list.asp), the Medicare Exclusion Databases (MED), and the Systems for Award Management (SAM) [https://sam.gov/SAM/pages/public/searchRecords/search.jsf](https://sam.gov/SAM/pages/public/searchRecords/search.jsf) (Note: You can no longer access the System for Award Management (SAM) using Internet Explorer (IE) Versions older than IE11. You either need to upgrade to an Internet Explorer version of IE11 or higher, or access SAM with another supported browser type (Chrome, Firefox, Safari, etc.) to ensure that providers who are excluded from participation in Federal programs are not enrolled in Sandhills Center network. In accordance with 42 CFR § 455.436, Sandhills Center will search the State Exclusion List (SEL) [https://medicaid.ncdhhs.gov/providers/excluded-providers](https://medicaid.ncdhhs.gov/providers/excluded-providers) (which is related to other screening methods in accordance with 42 CFR § 455.452), Social Security Administration’s Death Master File (SSADMF), the National Plan and Provider Enumeration System (NPPES), LEIE and the SAM upon enrollment, re-enrollment, credentialing, re-credentialing of network providers, and shall search the LEIE and the SAM at least monthly thereafter.

3. Other Monitoring Activities
a) Insurance monitoring is conducted based on the expiration date with the provider being notified 30 days prior to expiration and requested to submit an updated certificate.

b) License monitoring is conducted based on the expiration date with the provider being notified 30 days prior to expiration and requested to submit an updated license.

6. Alteration of Practitioner’s Credentialed Status

Sandhills Center maintains standards for Licensed Independent Practitioner (LIP) or Licensed Practitioner (LP) participation that will ensure competent, effective, and quality care for each member. Sandhills Center maintains the right to sanction, suspend, and/or terminate a practitioner for activity, actions, and/or non-actions, which are contrary to Sandhills Center standards of practice or law of the land.

a. Conditions that may affect a practitioner’s credentialing status include:
• LIP/LP fails to maintain compliance with the credentialing and re-credentialing criteria.
• LIP decides not to execute a practitioner contract.
• LIP’s/LP’s general area of practice or specialty, in the opinion of the Chief Medical Officer/Chief Clinical Officer and/or Clinical Advisory Committee, involves experimental or unproved modalities of treatment, or therapy not widely accepted in the local medical community.
• LIP has breached any material term of his/her practitioner contract, including failure to comply with Medical Management or Quality Improvement requirements.
• LIP/LP has contact with a patient of a sexual or amorous nature, or violation of other clinician/patient boundaries.

b. Disciplinary Actions

Disciplinary actions that can be taken by Sandhills Center’s Chief Medical Officer/Chief Clinical Officer and/or Network Committee related to credentialing include:

1. **Sanctions/Suspension:** These can include, but not be limited to, any one or combination of actions:
   - Plan of Correction
   - Membership or Group Activity Freeze
   - On-Site Monitoring
   - Censure Letter
   - Payback for Services Rendered

2. **Termination** of credentials may occur for any of the following reasons:
   - Breach of contract
   - Refusal to comply with Sanction or Suspension conditions
   - Failure to get re-credentialed
   - Failure to maintain license
   - Extremely serious violations related to Member Health and Safety
   - Potential Fraud and Abuse

*NOTE: Plans of Correction related to performance, and financial billing audits do not require committee approval before issuance.*

c. Determination and Notification of actions taken against a practitioner’s credentials

After respective review, a disciplinary action may be recommended by the Chief Medical Officer/Chief Clinical Officer and/or the Credentialing Committee to the Network Committee. The Chief Medical Officer/Chief Clinical Officer has the right to suspend a practitioner for up to fifteen (15) business days pending review by the Network Committee where potential adverse medical outcome will affect a member or the general member population.

Communication of the results of the Network Committee’s decision to initiate an action/sanction, and the timelines for such implementation, is provided to the following Sandhills Center departments: Quality Management, Care Coordination, Corporate Compliance, Information Technology, Finance, and Executive Leadership. Reports are made to the appropriate authorities as applicable and required by state and federal agencies by the Chief Medical Officer/Chief Clinical Officer, or designee. The range of
actions that may be taken to improve practitioner performance before termination is recommended by Network Committee.

A letter indicating the findings of the Network Committee’s recommendation regarding actions or sanctions is sent by certified mail, registered receipt to the Principal(s) of the participating provider or practitioner serving as notification of the action, or sanctioning activity. A date of the initiation of any sanctioning activity to be applied is included in the letter. The letter also references the dispute resolution process offered by Sandhills Center and its applicability.

7. Credentialing and Re-Credentialing & Participating Provider Quality Monitoring

Sandhills Center has established quality of care and quality of service criteria for all providers with whom it contracts utilizing a set of re-credentialing criteria. In addition to this criteria, performance data is gathered by Sandhills Center through its Network Monitoring and Quality Management processes that may include but are not limited to: monitoring activities, member grievance data and member incident report data and through its Care Management/Utilization Management Department, including paid and denied claims data.

Sandhills Center re-credentials providers and practitioners every three years. Each file contains the Credentialing Committee decision date. The 36-month recredentialing cycle begins on the date of the previous credentialing decision. The 36-month cycle is the month, not to the day. The following describes the re-credentialing process. Providers are considered to be re-credentialed unless otherwise notified.

   a. Notification to Provider/Practitioner

   Notification is sent to those participating providers/practitioners eligible for re-credentialing approximately 90 days prior to expiration of credentialing. Such notification includes the Re-credentialing application along with an attestation indicating the provider’s/practitioner’s continued compliance with credentialing criteria.

   b. Review of Application and Performance Data

   Upon receipt of the Re-credentialing Application, the credentialing staff follows the procedures outlined in Plan sections “Credentialing Application, Credentialing Confidentiality, Review of Credentialing Information, Credentialing Communication Mechanisms, Primary Source Verification, Member Safety Credentialing Investigation, Credentialing Application Review, Credentialing Timeframe, and Credentialing Determination Notification”. In addition, the Credentialing staff obtains the performance data necessary to review against Re-credentialing Criteria.

   c. When Credentialing or Re-Credentialing Status Expires

   If a provider/practitioner does not successfully complete the credentialing/re-credentialing process with Sandhills Center Network Operations Department and their credentialed / re-credentialed status expires, then their participation in our Network is considered “voluntary” terminated. This applies to agencies/facilities, contracted LIPs, and hospitals. LPs within agencies are end-dated in Alpha.

   Sandhills Center’s Network is currently closed. Please see the website for exceptions where there may be service gaps depending upon current access & availability data.

   If the provider/practitioner chooses to participate in the network, and is approved to join as an exception, then they must complete an initial provider application and re-submit the application along with all supporting documentation to their credentialing specialist.
8. Changes in Provider/practitioner Status

Changes in provider/practitioner status encompass changes in licensures, privileging, claims and legal status. It also includes personnel changes, information updates, and contract terminations, whether voluntary or for cause.

Pursuant to DHB Contract Sections 6.9 and 6.10, Sandhills Center shall give each member written notice of any “significant change” at least thirty (30) days before the intended effective date of the change; make good faith efforts to give notice within fifteen (15) calendar days after Sandhills Center receives notice that DHB or provider/practitioner has terminated the Provider Agreement or within fifteen (15) calendar days after Sandhills Center terminates the written agreement.

Providers/practitioners shall notify the Networks Operations Department in writing within one (1) business day of any changes in their status, including, but not limited to:

- Changes in licensure status
- Changes in privileging status with other accrediting organizations
- Pending citations
- Pending malpractice claims, etc.

Providers/practitioners shall notify the Network Operations Department in writing within seven (7) days of personnel changes or information updates. This may include, but is not limited to:

- Changes in ownership
- Change in management
- Proposed address changes
- Opening of new locations
- Changes in capacity
- Inability to accept new referrals
- Any proposed acquisitions
- Any proposed mergers
- Any pending investigations for Medicaid fraud

Matters regarding serious quality of care or service issues.

a. Provider/Practitioner Closures

In the event a provider/practitioner is closed by a governing body of the State due to a serious quality of care or service issue(s), Sandhills Center is notified and the provider is required to submit transition plans for each member to the Care Coordination Department.

b. Provider Terminations

In the event Sandhills Center has information that a provider appears to pose as a serious quality of care or service issue to a member(s), Sandhills Center implements a procedure N-NM 17a “Participating Provider Suspension Mechanism for Consumer Safety” to immediately suspend a participating provider. If the results of an investigation are substantiated, sanctions, including termination of the contract can occur.
The provider is notified of the decision and the dispute resolution process will be made available to the provider.

Members shall be notified via mail per the assigned Provider Network Credentialing Specialist of the effective termination date of the provider as well as Sandhills Center contact information to assist with the transition if needed. The provider will also be expected to submit written documentation of the member’s transition plan to include; the name of the new provider accepting the referral as applicable, the member’s name and patient ID number. This applies to providers who are terminated for cause and providers who voluntarily terminate their contract.

### Mandatory Terminations and Denials

In accordance with 42 CFR § 455.416, Sandhills Center must with respect to enrollment in the Closed Provider Network, and DHB must, with respect to enrollment in the NC Medicaid Program:

- a. Terminate the enrollment of any Provider where any person with a five percent (5%) or greater direct or indirect ownership interest if the Provider did not submit timely and accurate information, or cooperate with any screening methods required under this subpart;

- b. Deny enrollment or terminate the enrollment of any Provider where any person with a five percent (5%) or greater direct or indirect ownership interest in the Provider has been convicted of a criminal offense related to that person’s involvement with the Medicare, Medicaid, or title XXI program in the last ten (10) years, unless DHB or Sandhills Center determines that denial or termination of enrollment is not in the best interests of the Medicaid program or Sandhills Center Provider Network, and DHB or Sandhills Center documents that determination in writing;

- c. Deny enrollment or terminate the enrollment of any Provider that is terminated on or after January 1, 2011, under title XVIII of the Act or under the Medicaid program or CHIP of any other state;

- d. Terminate the Provider’s enrollment or deny enrollment of the Provider if the Provider, or a person with an ownership or control interest, or who is an agent or managing employee of the Provider fails to submit timely or accurate information, unless DHB or Sandhills Center determines that the termination or denial of enrollment is not the best interests of the Medicaid program, Sandhills Center Provider Network, and DHB or Sandhills Center documents that determination in writing;

- e. Terminate the Provider’s enrollment if the Provider, or any person with five percent (5%) or greater direct or indirect ownership interest in the Provider, fails to submit sets of fingerprints in a form and manner to be determined by DHB within thirty (30) calendar days of a CMS or a DHB request, unless DHB or Sandhills Center determines that termination or denial of enrollment is not in the best interests of the Medicaid program, and DHB or Sandhills Center documents that determination in writing; or

- f. Terminate or deny enrollment if the Provider fails to permit access to Provider locations for any site visits required under 42 CFR § 455.432, unless DHB or Sandhills Center determines that the termination or denial of enrollment is not in the best interest of the Medicaid program or Sandhills Center Provider Network, and DHB or Sandhills Center documents that determination in writing.
Other Terminations and Denials

In accordance with 42 CFR § 455.416, Sandhills Center may terminate or deny the Provider’s enrollment in Sandhills Center Provider Network if Sandhills Center, CMS or DHB:

a. Determines that the Provider has falsified any information provided on documentation submitted related to screening, credentialing or enrollment in the Sandhills Center Closed Provider Network or the NC Medicaid Program, including but not limited to the enrollment, credentialing, or re-credentialing applications; or

b. Cannot verify the identity of any Provider applicant;

In the event Sandhills Center terminates a Provider’s enrollment in Sandhills Center’s Provider Network for any reason set forth in 42 CFR § 455.416 and 42 CFR § 455.432, Sandhills Center shall also terminate the Provider’s written agreement with Sandhills Center.

c. Contract Renewals

If a provider is terminated due to serious quality of care or service issue(s), their contract is also terminated and will not be renewed.

d. Member Notice of Provider Termination & Transition of Member(s)

It is a requirement by state and federal laws that providers must develop and implement a transition plan for each member. In cases where a member is at risk for serious quality of care or service issue(s), the provider must notify Sandhills Center that an emergency placement has been arranged within 24 hours of the placement. Providers are required to submit the transition plan(s) to the Care Coordination Department.

When DHB or Sandhills Center terminates a provider agreement with a network provider, or a Provider terminates a provider agreement, Sandhills Center shall give written notice of the termination to all members who have been receiving services from the terminated provider within fifteen (15) calendar days after Sandhills Center receives notice that DHB or Provider has terminated the provider agreement, or within fifteen (15) calendar days after Sandhills provides notice of termination to the Provider.

9. Credentialing Delegation

Sandhills Center may delegate credentialing/re-credentialing functions to any external vendor(s) and/or contractor(s) through a written agreement. Sandhills ensures that credentialing/re-credentialing activities are conducted according to Sandhills Center’s requirements and are consistent with URAC standards. Sandhills Center retains authority to make the final credentialing determination regarding any provider.
Sandhills Center Credentialing Process Flow Chart

Sandhills Center is a closed network. A provider/practitioner may submit a request to Network Management to contract with the LME/MCO; Network Management notifies Network Development of the request.

If it is determined the service(s) is not needed, the Network Development Manager notifies the prospective provider in writing.

If it is determined the service(s) is needed, the Network Development Manager notifies Network Management.

The Network Management Manager assigns the provider/practitioner to a Credentialing Specialist.

The assigned Credentialing Specialist notifies the provider/practitioner in writing with instructions on how to apply to the LME/MCO Network.

The provider/practitioner submits the application and required materials.

The assigned Credentialing Specialist reviews the application & materials submitted.

The assigned Credentialing Specialist completes the primary source verification. If complete, a secondary review is conducted by another Credentialing Specialist.

The Credentialing Specialist verifies if a Health & Safety visit is required with Network Provider Monitoring and notifies the provider in writing of the status of the application.

Network Provider Monitoring coordinates a Health & Safety visit with the provider, if required. If the onsite review is approved, Network Provider Monitoring notifies the Credentialing Specialist who then places the applicant on the "Network Provider Application Report".

If the On Site Review yields areas of concern, the application is "Pended" for a Plan of Correction.

The Network Management Manager submits the clean applications for review to the QM Director; the QM Director submits them to the Chief Medical Officer/Chief Clinical Officer for approval. Applications deemed "NOT Clean" are reviewed by the Credentialing Committee.

A blind copy of an Adverse Action Grid is presented to the Credentialing Committee for possible actions being taken on providers/practitioners. The Credentialing Committee will have an open discussion to offer feedback to Network Committee.

If approved, the applicant is notified in writing.

If the credentialing process reveals factors that would impact the quality of care or services to members, the credentialing process is stopped with the applicant denied participation in the Network. If denied, the applicant is notified in writing.

If approved, the Adverse Action Grid is forwarded to Network Committee for discussion and vote.
The provider/practitioner is requested to submit a recredentialing application & required supporting documentation to Sandhills Center by a notification letter sent via email or certified mail return receipt 3 months prior to the expiration of their credentialing status.

Provider/practitioner submits recredentialing application & required materials within 60 days of receipt of request. Upon receipt of the recredentialing application & supporting documentation, the provider/practitioner is notified via email.

The Credentialing Specialist conducts an initial review of the recredentialing application & required supporting documentation. (Note this includes PSV, SBI & H & S review, if applicable).

If not approved by the Credentialing Committee, the provider/practitioner is notified by the Committee in writing and provided instructions on the appeals process.

If the recredentialing application and/or required documentation are not received by the due date stated in a letter sent by the Credentialing Specialist, the provider/practitioner has voluntarily terminated their contract with Sandhills Center.

Where primary source verification indicates that clarifying information is needed, the provider/practitioner is notified via electronic or certified mail of the concerns.

If incomplete, the Credentialing Specialist notifies the provider/practitioner in writing (email or certified letter).

If the recredentialing application is not received, the provider/practitioner is considered as voluntarily terminating their contract with Sandhills Center.

If complete, a secondary review of all documentation is conducted by another Credentialing Specialist.

If approved, the Adverse Action Grid is forwarded to Network Committee.

Once the secondary review is approved & completed the provider/practitioner is listed on the next Network Provider/Practitioner Application Report.

A blind copy of an Adverse Action Grid is presented to the Credentialing Committee for possible actions being taken on providers/practitioners in the network. The Credentialing Committee conducts an open discussion to offer feedback to Network Committee.

The Credentialing Specialist notifies the provider via certified mail within 10 business days of the committee approval. All LPs w/agency are notified via email.

QM reviews the provider’s /practitioner’s profile for the past 5 years & reviews the results with the Chief Medical Officer/Chief Clinical Officer. For those with outstanding QM issues, a report is submitted & reviewed by the Credentialing Committee for a recommendation.

QM reviews the provider’s /practitioner’s profile for the past 5 years & reviews the results with the Chief Medical Officer/Chief Clinical Officer. For those with outstanding QM issues, a report is submitted & reviewed by the Credentialing Committee for a recommendation.

If approved through the Credentialing Committee, the Credentialing Specialist notifies the provider via certified mail within 10 business days of the committee approval. All LPs w/agency are notified via email.

Note: A provider may give written notification of voluntary termination (to include a transition plan for members). The notification of the voluntary termination may be given prior to the expiration of the credentialed status.
**C. Provider Communications Plan**

Sandhills Center promotes and encourages open channels of communication and active participation with the provider network in order to:

- ensure that providers are aware of information necessary to the provision of behavioral health services to members, and
- Comply with Sandhills Center’s administrative and clinical requirements and procedures.

Sandhills Center develops and implements a formal communications plan, which describes the provider relations program, including the strategies and processes for communications with providers in the network. The Provider Communications Plan is reviewed and revised annually and updated during the fiscal year as needed.

The Plan includes but is not limited to:

- Orientation of new providers;
- Updates of network activities;
- Mechanisms for securing provider manual;
- Changes in fee schedules and contracting provisions;
- Information on how to obtain benefits, eligibility, grievance and appeals information. Sandhills Center does not oversee medication formularies;
- Provider Dispute Resolution Process;
- Mechanisms for Sandhills Center to receive suggestions and guidance from participating providers about how the provider network can best serve members;
- Assistance for participating providers and their staff regarding provider network issues.

In order to ensure that open communication and adequate provider / LME/MCO relations are maintained, the following procedures are followed:

1. Sandhills Center’s Provider Communications Plan (Plan) is part of the Provider Manual. [https://www.sandhillscenter.org/for-providers/trainings-events/provider-orientation/](https://www.sandhillscenter.org/for-providers/trainings-events/provider-orientation/)

2. Network Development is responsible for developing, updating, and distributing the Plan. The Plan is presented to the Health Network Committee, Network Leadership Council and Quality Management Committee for review and input. It is reviewed and updated typically during the final quarter of the fiscal year.

3. The Provider Communications Plan consists of the following seven major segments:
   a. Provider Orientation;
   b. Provider Manual;
   c. Network Leadership Council & Clinical Advisory Committee;
   d. Provider Code of Ethics;
   e. Sandhills Center Website;
   f. Quarterly Provider forums, and
   g. Training, Consultation and other Technical Support.
1. Provider Orientation

Orientation procedures are as follows:

a. Sandhills Center informs potential providers of the orientation requirement during the credentialing/contracting process.

b. **New Provider Orientation:** Orientation materials consist of the 1) the Provider Manual posted on the Sandhills Center website, 2) information about the Provider Help Desk (1-855-777-4652), which offers technical assistance for providers, and 3) additional orientation materials developed by Sandhills Center program/departments that are posted on the Sandhills Center website under Provider Orientation. An overview of these orientation resources is shared when the executed contract is mailed to the provider.

c. **Annual Orientation:** In collaboration with Sandhills Center programs/departments, the Training Coordinator plans and facilitates the annual orientation events for all network providers during the last quarter of the fiscal year. In an effort to provide convenient provider access, this orientation is typically presented in person, or may be posted on the Sandhills Center website in lieu of face-to-face presentations. Electronic notice of the annual orientation schedule and agenda topics are sent to providers in a timely fashion and posted on the Sandhills Center website. Provider participation in the in-person annual orientation is documented and maintained through sign in sheets. For website-only orientation, providers are notified of the availability of website materials through Sandhills Center’s provider email list serve. The expectation is that all applicable provider staff will actively view materials, and will contact the Network Operations Director with any questions or concerns.

d. Orientation agendas are planned to provide network providers with the information necessary to comply with all applicable requirements/standards, including but not limited to:

   - Overview of Sandhills Center’s mandate and function; information regarding Sandhills Center’s administration;

   - Overview of Sandhills Center website and how to find information on website, including:
      1) Mechanisms for securing DHB and DMH/DD/SAS updates, Sandhills Center provider updates, and updates of network activities;
      2) Mechanisms for locating and/or securing Provider Manual;
      3) Location of information concerning technical assistance, training announcements, frequently asked questions from the Provider Help Desk, and Sandhills Center Personnel Contact Information for provider questions;
      4) Changes in fee schedules and contracting provisions;
      5) Information on how to obtain benefits, eligibility, grievance and appeals information. Sandhills Center does not oversee medication formularies;
      6) Provider Dispute Resolution Process;
      7) Mechanism for Sandhills Center to receive suggestions and guidance from participating providers about how the provider network can best serve members.
• Participating Provider/Practitioner Responsibilities, including, as needed;
  1) Member Rights and Responsibilities;
  2) Eligibility information;
  3) Clinical criteria;
  4) Use of Electronic Slot Scheduler;
  5) Authorizations and utilization review;
  6) Care management requirements;
  7) Documentation requirements;
  8) Access and Availability criteria;
  9) First Responder Responsibilities;
 10) Billing and Claims;
• Quality Management;
• Service Monitoring;
• Primary Source Verification by Network Management credentialing staff;
• State and Federal Requirements;
• Cultural Competency;
• Credentialing and re-credentialing procedures, and
• Sanctions, Disputes and Appeals.

2. The Provider Manual

The Division of Health Benefits (DHB) requires Sandhills Center to develop a Provider Manual (Manual) that informs network providers and potential providers of Sandhills Center’s processes, procedures, deadlines and requirements. Sandhills Center is dedicated to providing a manual that is user-friendly, contains up-to-date information, is written in clear concise language, and is easily accessible.

The manual is a viable part of Sandhills Center’s Communications Plan. The manual covers Sandhills Center’s purpose, mission, and treatment philosophy and community standards of practice, as well as:

• Introduction and Overview of Sandhills Center
• Governance and Administration
• Provider Network
• Contracts
• Member Rights and Empowerment
• Benefit Package
• Access, Enrollment and Authorization of Services
• Service Definitions and Criteria
• Resources for Providers
• Getting Paid
• Standards and Corporate Compliance
• Reconsideration Review Process for Providers
• Covered Services
• Glossary of Terms
• Acronyms

Sandhills Center ensures the Provider Manual is kept current through the following processes:
1. Network Operations is responsible for updating and maintaining the Provider Manuals for Medicaid and IPRS funded services, and to have the manual and updates posted on the Sandhills Center website.

2. Sandhills Center Program and Department Directors send information regarding their updated policies and/or procedures at least annually or as revisions are needed, to Network Operations for inclusion in the Provider Manual.

3. Information received from the Division of Health Benefits and the Division of Mental Health, Developmental Disabilities and Substance Abuse Services is added to the Provider Manual as needed.

4. Network Operations presents the Provider Manual to the Network Committee and the Quality Management Committee for review and approval on an annual basis and during the fiscal year if revisions are made.

5. Network providers are notified electronically when changes are made to the manual and also on an annual basis during the final quarter of the fiscal year.

6. Upon written request, hard copies of the Provider Manual can be made available to providers.

7. Network Operations will inform providers of revisions to the manual at Quarterly Provider Forums.

3. The Network Leadership Council, Clinical Advisory and the Credentialing Committees

Sandhills Center implements a formal strategy to involve network providers in committees that address clinical and provider payment policies (URAC NM-5). It recognizes the importance of network provider input and participation in decision making, in order to promote a collaborative environment between the LME/MCO and providers.

**Network Leadership Council (NLC)**

The overall purpose of the Network Leadership Council is to ensure that provider perspective is represented in the Sandhills Center Health Network management processes decision making, and in building and maintaining a diverse provider network that meets the requirements of the State, members, federal and accreditation standards.

NLC membership consists of network providers, Sandhills Center staff, representatives from the Consumer and Family Advisory Committee (CFAC), and the Community Care of NC (CCNC). The Council is co-Chaired by a participating provider and a Sandhills Center Network Operations staff member.

Providers serving on the Council are expected to represent other providers delivering the same or similar services and not their own individual agency/practices. Provider representation must directly reflect network composition and may include individuals in either managerial/leadership and/or clinical roles, in each disability area and both large and small providers.

The scope of responsibilities of the Network Leadership Council include the following:

- Recommend new service initiatives to address service needs/gaps and participate in provider recruitment and retention activities to build and maintain network sufficiency;
- Provide input regarding the Sandhills Center Service Needs, Gaps and Provider Capacity Strategic Plan;
- Offer information and make recommendations for the use of emerging best practices;
- Provide input regarding the Annual Provider Training Plan;
• Assist in the development, approval and annual review of the Sandhills Center Cultural Competency Plan;
• Review Provider Satisfaction Survey results and make recommendations to address areas of concern;
• Review and make recommendations for the Provider Communications Plan annually;
• Review and make recommendations for the Provider manual and web site;
• Review reports and data on provider related performance and quality management activities and provide input/recommendations;
• Review and approval of the Provider Code of Ethics;
• Conduct an annual self-assessment process and evaluation;
• Offer recommendations for provider monitoring and quality indicators;
• Receive regular updates regarding on-going projects, and the latest information on pending changes from state and local organizations;
• Review provider network performance against stated goals;
• Provide feedback and recommendations for staff education and training needs;
• Provide feedback and recommendations on clinical outcomes, clinical decision support tools, clinical criteria and the selection and use of evidence based, best practices and clinical practice guidelines through the Clinical Advisory Committee;
• Review reports and data on provider related performance and quality management activities and provide input/recommendations.
• Review and approval of the Provider Code of Ethics;
• Conduct an annual self-assessment process and evaluation;
• Offer recommendations for provider monitoring and quality indicators;
• Receive regular updates regarding on-going projects, and the latest information on pending changes from state and local organizations;
• Review provider network performance against stated goals;
• Provide feedback and recommendations for staff education and training needs;
• Provide feedback and recommendations on clinical outcomes, clinical decision support tools, clinical criteria and the selection and use of evidence based, best practices and clinical practice guidelines through the Clinical Advisory Committee;
• Ensure that any changes in provider contract, contractual requirements, rates and administrative requirements are discussed in detail with providers and that all providers are given an advanced 30-day notice of these and other changes unless specifically prohibited by law and statue or contractual requirements.

Clinical Advisory Committee (CAC)

The Sandhills Center Clinical Advisory Committee was established to provide a forum for discussion and approval of clinical treatment practices and community standards of care that are used in the Sandhills Center provider network.

Clinical Advisory Committee membership is comprised of active practicing licensed clinicians that mirror the network composition in addition to Sandhills Center LME-MCO employees, licensed non-network healthcare practitioners residing within the LME-MCO’s geographic area, and Sandhills Center licensed clinical leadership staff. The Chairperson of the committee is Sandhills Center’s Chief Medical Officer/Chief Clinical Officer.

Sandhills Center Clinical Advisory Committee Scope of Responsibilities and Duties:
1. Review of Evidenced based clinical practice guidelines in conjunction with recommendations from Sandhills Center Integrated Care partners.
2. Review clinical decision support tools/utilization management criteria
3. Review of Customer Services clinical triage and referral processes
4. Identification of training needs of providers
5. Evaluation of service utilization as related to clinical guidelines
6. Evaluate data from Quality Management audits, Gaps Analysis and other data tools as resources for monitoring and effective clinical guidelines implementation.
7. This Committee is the primary gate keeper for consideration of new/innovative services and rate changes for services that adhere to clinical practice continuums of services and emerging best practices.
Recommendations regarding such are provided to the Sandhills Center Chief Medical Officer/Chief Clinical Officer who will ultimately decide which rate changes and new/innovative services will be forwarded to the CEO for consideration.

**Credentialing Committee**

**Credentialing/Re-Credentialing Functions:**

- Review overall direction of the credentialing program, including review and approval of credentialing/re-credentialing policies/procedures
- Review and approval of credentialing/re-credentialing criteria for services
- Review and approval and/or disapproval of providers requesting enrollment in the network through credentialing/re-credentialing enrollment procedures
  
  a. The Credentialing Committee has delegated authority to the Chief Medical Officer/Chief Clinical Officer to approve “clean” credentialing applications as defined as: **Credentialing/Re-Credentialing applications with no open actions from any regulatory body/law enforcement agency and credentialing applications with no closed/resolved actions from any regulatory body/law enforcement agency within the last five (5) years.** The previous definition also applies to matters of re-credentialing in addition to having no negative entries in the provider profile system.

  b. The definition of an “unclean” application for credentialing & re-credentialing is any application with adverse actions of five (5) years or younger & COMPLETED QM issues. Unclean credentialing & re-credentialing applications are discussed monthly by the Credentialing Committee & minutes documented. The credentialing is composed ONLY of non-Sandhills Center members of the CAC who hold active & unrestricted licensure in their field & these members are the only ones casting votes on credentialing/re-credentialing matters. The Chief Medical Officer/Chief Clinical Officer chairs the committee and in the case of a tie vote, the Sandhills Center Chief Medical Officer/Chief Clinical Officer casts the deciding vote.

- Evaluate the effectiveness of the credentialing program.

**Provider Dispute/Appeals Functions:**

- Review and approval of provider disputes/appeals policies/procedures
- Review of provider disputes and appeals related to professional conduct or competence
- Complete annual assessment of provider dispute resolution activities

The Credentialing Committee membership is comprised of active practicing licensed clinicians that mirror the network composition in addition to Sandhills Center LME-MCO employees, licensed non-network healthcare practitioners residing within the LME-MCO’s geographic area, and Sandhills Center LME-MCO licensed clinical leadership staff. The Chairperson of the committee is the Sandhills Center Chief Medical Officer/Chief Clinical Officer. Meetings are convened at least quarterly and/or as needed. A voting majority of the Credentialing Committee shall consist of committee members who are not Sandhills Center LME-MCO staff.

The Credentialing Committee is a rotating membership composed of licensed independent practitioners—MD’s, practicing psychologists, LCSW’s, LCAS’s, LCMHC’s, and PLC’s—who are representative of our provider network with regards to discipline, specialty, clinical competencies, geographic locations, and agency size.
4. Provider Code of Ethics (Attachment 2)

The Sandhills Center provider/practitioner network shall facilitate an open exchange of ideas, share values, goals, vision, and promote collaboration and mutual accountability among providers. The provider network strives to achieve best practices to empower individuals served to achieve their personal goals.

- Assure that staff adheres to the code of ethics.
- Provide support to other member agencies.
- Advocate for the further development of resources on a local and state level for individuals served.

Sandhills Center (Sandhills Center) supports and encourages a network community, which has an expectation that providers will adhere to the highest ethical standards.

5. Sandhills Center Website

Sandhills Center maintains a website to disseminate and continually update information for members, providers, stakeholders and the community. The website includes a “For Providers” section that can be accessed through the homepage. Information on the website for providers includes, but is not limited to: (Also, see helpful links at https://www.sandhillscenter.org/helpful-links/)

1. Links to the Division of Health Benefits and the Division of Mental Health, Developmental Disabilities and Substance Abuse Services for access to Medicaid Bulletin Digests, Communication Bulletins, Implementation Updates, Regulations, etc.
2. Action Alerts and Budget Updates;
3. Incident and Death Reporting forms and instructions;
4. Service Definitions;
5. Fraud and Abuse;
8. Training opportunities;
9. Sandhills Center Provider Directory;
10. Sandhills Center Provider Manual;
11. Instructional manuals and forms;
13. Quarterly Provider Forums dates and agendas;
14. Sandhills Center memoranda, and
15. Links to:
   a. The Division of Health Service Regulation; https://www.ncdhhs.gov/divisions/dhsr;
   b. SAMHSA; https://www.samhsa.gov/;
   c. NAMI; https://naminc.org/;
   d. The North Carolina Council of Community Programs https://ncdcd.org/ and
   e. Other information and resources as needed.

6. Quarterly Provider Forums

Provider Forums are typically held four (4) times each year and are coordinated and facilitated by the Training Coordinator. Sandhills Center administrative and clinical staff present program updates, review significant changes in state and federal requirements, and provide other information that will assist network
providers in achieving compliance with requirements to remain in good standing with both Sandhills and the State. Outside subject matter experts may be part of these forums as well.

Sandhills Center’s Executive Management and Department Directors provide input to the Training Coordinator regarding topics to be covered during the forums. Additionally, input and concerns voiced by members and network providers are reviewed for consideration as possible agenda items.

Provider Forums are informative and interactive, providing an opportunity for network providers to ask questions, obtain clarification and voice concerns. Evaluations are completed by participants. Summaries are prepared with oversight of the Training Coordinator and shared with forum presenters in an effort to improve future forums. A training event is held immediately following the quarterly forum, when possible.

7. Training, Consultation, and other Technical Support

a) Provider Training

Sandhills Center is committed to having a trained LME/MCO workforce & provider network. Under the direction of the Training Coordinator, an annual training plan is developed, consisting of training to promote the use of evidence-based practices, assist providers in meeting technical requirements and meet state, federal and accrediting body requirements. It reflects the needs & priorities of Sandhills Center and its providers. It is formatted to show the training topic, the source of the training request(s), target audience and anticipated training date. This plan is an addition to the Sandhills Center’s agency-wide new employee and annual orientations. Training is offered in work units to meet unit / individual job specific requirements, and training / technical assistance is offered by specific Sandhills Center departments.

Consideration of the following contributes to the development of this plan:
1. NC Division of Health Benefits (DHB) training requirements;
2. NC Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS) training requirements;
3. URAC training requirements;
4. Sandhills Center Local Business Plans Local & Statewide Initiatives (2017-2019);
5. Sandhills Center Staff Training Policies and Procedures;
6. Provider Manual;
7. Provider Communications Plan;
8. Cultural Competency Plan;
9. Quality Management Plan;
10. Requests from Sandhills Center departments, including those based on Quality of Care Concerns, Provider Performance Trends and Quality Improvement Project outcomes;
11. Sandhills Center Annual Services Needs/Gaps Strategic Plan;
12. Provider Satisfaction Survey summary;
13. Clinical Leadership Team (CLT);
14. Network Leadership Council (NLC);
15. Consumer and Family Advisory Committee (CFAC);
16. Sandhills Center Clinical Practice Guidelines;
17. Global Continuous Quality Improvement Committee (GCQIC);
18. Annual Training Needs Assessment which includes:
   a. Training Assessment completed by network providers;
   b. Meetings with Sandhills Center leadership;
   c. Requests from training evaluations and quarterly provider forums.
Sandhills Center offers a broad scope of training for its providers through the Sandhills Center region. The Training Coordinator researches trainers and manages training activities to meet state, federal and URAC requirements and to assist in meeting provider training needs. This is accomplished with the assistance of the AHECs, NC Council of Community Programs and other statewide resources. Training is funded by Sandhills Center, with no cost to network providers.

Training events are typically scheduled to occur two times each month. Additional topics may be added as training needs are identified.

Examples of training topics and activities include the following:

1. MH/IDD/SA Evidence Based Practice Training;
2. Dialectical Behavioral Therapy;
3. Cognitive Behavioral Therapy;
4. Service Documentation Training;
5. Person Centered Thinking Training;
6. Ethics Training;
7. Clinical Supervision Training;
8. Cultural Competency Training;
9. Crisis Response & Intervention Plan Training;
10. Program Consultation with Subject Matter Experts;
11. Peer Support Specialist Training;
12. ICD-10 Training;
13. Comprehensive Clinical Assessment Training;
14. Service Specific Training, such as Psychosocial Rehabilitation Training;
15. Trauma Informed Care Training.

b) Technical Assistance

Sandhills Center offers technical assistance to providers in navigating the behavioral health services system, and guidance regarding the requirements and expectations of the State and Sandhills Center.

Network Operations receives the information gathered from the Division of Health Benefits and the Division of Mental Health, Developmental Disabilities and Substance Abuse Services websites and promptly sends it to network providers via electronic transmission.

Network Development/Contracts maintains a comprehensive provider email distribution list of network providers. Network providers maintain and update their own internal lists.

Provider Help Desk Coordinators, the designated contact for providers in need of technical assistance, will:

1. Respond to provider’s requests within two (2) business days by contacting the subject matter expert within the organization and responding to provider, or by directing the provider to the subject matter expert;
2. Post provider questions and answers on the website on a monthly basis, and
3. Monitor website to ensure information posted for providers is current and accurate
D. Behavioral Health Provider Network Requirements

1. Nondiscrimination:
   a. Compliance with all provisions of the Americans with Disabilities Act (ADA);
   b. Compliance with Provider Code of Ethics;
   c. Compliance with all Federal and State laws which require equal opportunity in employment and bar illegal employment discrimination on the grounds of race, gender, religion, sexual orientation, gender identity, national origin or disability.

2. On-Call Coverage:
   a. On-Call Coverage requirements as follows: Providers shall have the capacity to respond to emergencies for assigned members according to the availability standards for emergent needs and service definitions for First Responder capacity as identified in Medicaid Clinical Coverage Policy 8A, “Enhanced Mental Health and Substance Abuse Services”. If required, an adequate clinical back up system shall be in place to respond to emergencies afterhours and on weekends.

3. Access and Availability Requirements:
   Compliance with Access and Availability Requirements consistent with the severity and intensity of the needs of individual members:
   a. Availability:
      1. Timely response to emergency, urgent and routine treatment of members:
         • Emergency Services: Providers must ensure face-to-face emergency services within two hours after a request for emergency care is received by the Provider staff from Sandhills Center or directly from a member; the provider must provide face-to-face emergency care immediately for life threatening emergencies;
         • Urgent Need Services: Providers must ensure initial face-to-face assessments and/or treatment within 48 hours after the date and time a request for urgent care is received by Provider staff from Sandhills Center or directly from the member; and
         • Routine Need Services: Provider must ensure initial face-to-face assessments and/or treatment within 14 calendar days of the date a request for routine care is received by Provider staff from Sandhills Center or directly from a member;
         • Telephone Calls: must be returned within one hour; twenty-four hours a day, seven (7) days a week;
         • Emergency Referrals: respond to within one hour, twenty-four hours a day, seven (7) days a week.
      2. Appointment Wait Times: Services are available to members as follows:
         • Scheduled appointment: within one hour of scheduled appointment;
         • Walk-ins: within two (2) hours after the member’s arrival. If that is not possible, staff must schedule an appointment for the next available day.
         • Emergencies: Sandhills Center staff shall ensure that members are provided face-to-face emergency care within two hours after the request for care is initiated by Sandhills Center or directly by the member to Sandhills Center; Providers must provide face-to-face emergency services within two hours after a request for emergency care is received by the Provider staff from Sandhills Center or directly by the member; life threatening emergencies
shall be managed immediately.

(Appointment Wait Times are for Medicaid services only)

3. Afterhours Emergency and Referral: Services are available to members as follows:
   - Sandhills Center provides a toll free telephone emergency and referral line available twenty-four (24) hours per day.
   - Return calls to members: Telephone inquiries made by members after hours for access/information must be responded to within one (1) hour of receiving the call.

4. The member has a right to a second opinion from a qualified health care professional within or outside the network at no cost to the member. Upon request, Sandhills Center shall provide a member with one second opinion from a qualified health care professional selected by Sandhills Center, at no cost to the member. The second opinion may be provided by a provider that is in-network or one that is out-of-network. Sandhills Center shall not be required to provide a member with a third or fourth opinion.

b. **Accessibility:**

1. Distance/Travel Time: Services are accessible to members within 30-minute drive time or 30 miles distance for urban areas or 45 minutes/miles for rural areas. Longer distances are allowed for facility based or specialty providers.

2. Facility Accessibility: Contracted network provider facilities must be accommodating for members with physical or mental disabilities. Sandhills Center requires providers have reasonable accommodations, in accordance with 42 CFR § 438.206 and the ability to communicate with limited English proficient members in their preferred language and the ability to ensure physical access, reasonable accommodations, culturally competent communications, and accessible equipment for Medicaid members with physical and/or mental disabilities.

4. No-Reject Requirements:

   a. No-Reject Requirements: Providers shall have a “No-Reject” policy for referrals within the capacity and parameters of their competencies. Providers shall agree to accept all referrals meeting criteria for services they provide when there is available capacity.

5. Notification of Address Change or Other Demographic or Practice Information:

   a. To avoid a delay in reimbursement of submitted claims, providers must notify Sandhills Center to update any demographic or practice information such as:
      - Physical/practice address changes;
      - Telephone/Fax/Email address changes;
      - Name changes;
      - Social Security Number;
      - National Provider Identification;

Failure to report changes in a timely manner can adversely affect participation in the network and may result in claims payments being delayed.
6. Adverse Incident Reporting:
   a. Reporting adverse incidents (e.g., deaths of a member, self-inflicted harm, violent or assaultive behavior by or towards a member, injuries due to an accident in a behavioral health treatment setting, etc.).

7. Quality Review Site Visits:
   a. Participation and cooperation in quality review site visits.

8. Sandhills Center Inquiries:
   a. Timely response to Sandhills Center inquiries.

9. Sandhills Center Quality Improvement and Utilization Management Programs:
   a. Compliance with Sandhills Center’s Quality Improvement and Utilization Management programs.

10. Licensure Requirements:
    a. Providers shall keep current all facility and independent practitioner (professional) licenses. Failure to maintain licensure may result in contract termination.

11. Credentialing and Re-Credentialing:
    a. Compliance with credentialing and re-credentialing requirements including reporting material changes relating to credentialing or re-credentialing (i.e., any actions against any licenses, any change in business address, any legal action commenced by a member, any initiation of bankruptcy or insolvency, etc.).

12. Insurance Requirements:
    a. Providers shall maintain insurance from a company, which is licensed and authorized to do business in the State of North Carolina by the North Carolina Department of Insurance. Specific insurance requirements are included in the LME/MCO Provider contract.

13. Clinical/Medical Judgment:
    a. Sound clinical/medical judgment in the treatment of members

14. Maintenance of Appropriate Services:
    a. Maintenance of appropriate services to members despite payment determinations - The relationship between a provider and the members under the provider’s care should not be altered due to any changes between the provider and Sandhills Center. The provider must always exercise the best medical/clinical judgment in the treatment of members. Sandhills Center’s payment determinations do not serve as a directive to discontinue medically necessary treatment. Payment determinations do not absolve the provider from rendering medically necessary services.
To minimize having difficulties such as the above, providers must:

1. Verify member eligibility and benefits prior to rendering services;
2. Preauthorize care when required;
3. Provide quality services that are medically necessary to members;
4. Provide continuous care for members or arrange for on-call coverage;
5. Ensure equal treatment of all Sandhills Center members;
6. Notify Sandhills Center of possible discharge problems.

15. Quality Cost Effective Services:
   a. Rendering services in a quality cost effective manner in accordance with generally accepted medical standards and all applicable laws and regulations

16. Cultural Competence:
   a. Cultural competence and the adaptation of services to meet the specific cultural and linguistic needs of our members

17. Clinical and Business Records:
   a. Maintenance of treatment records that are current, detailed, organized and comprehensive;
   b. Participation in random treatment record audits;
   c. Documentation of treatment modalities;
   d. Documentation of timed services (start and stop times) when applicable;
   e. Maintenance of confidentiality of treatment and claims-related data concerning members and;
   f. Maintenance of any member records in accordance with federal and state regulations related to storage, transmission, and maintenance.

18. Member Rights and Responsibilities:
   a. Informing members under care of their rights and responsibilities;
   b. Respecting the rights and responsibilities of members being served.

19. Member Communication:
   a. Providers shall have a good system of communication with consumers;
   b. Providers shall demonstrate consumer friendly services and attitudes.

20. Clinical Infrastructure:

   Providers shall have the clinical infrastructure either through their own agency or through collaboration with other providers to address challenges in meeting specific member needs (such as challenging behaviors or medical problems).

21. Fiscal Responsibility and Integrity:

   Providers shall demonstrate that they have in place accounting systems sufficient to ensure fiscal responsibility and integrity.
E. Cultural Competency Plan (Attachment 1)

Sandhills Center geographically is made up of diverse demographic areas, from urban to extremely rural settings. Due to its ethnic diversity, Sandhills Center is tracking the linguistic capabilities of its Provider Network to meet the demographic needs of the population served. A Cultural Competency Plan is included in this manual and it, as well as the Gaps Analysis Report is posted on the Sandhills Center website at the following links:

Cultural Competency Plan:  https://www.sandhillscenter.org/about/regulatory-plans/
Gaps Analysis Report: https://www.sandhillscenter.org/about/performance-measures/

Sandhills Center maintains a closed provider network that provides culturally competent services by recognizing, respecting and responding to the unique and culturally defined needs of the populations served in the geographic area that goes beyond race or language identifiers. In order to achieve cultural competency, Sandhills Center requires providers to participate in its Cultural Competency Plan, which is developed and approved by the Network Leadership Council composed of members of the provider network. The Cultural Competency Plan ensures that Sandhills Center maintains a respectful service delivery network, free of offensive practices and conditions; recognizes each individual’s unique value, contribution and potential; and develops programs and services to meet identified needs of a culturally diverse population.

Cultural Competency training is mandatory annually for Sandhills Center Network Providers and is provided at orientation and once during the fiscal year. A Power Point presentation is also posted on the Sandhills Center website for individual agency/practitioner use. A Cultural Competency orientation is located on Sandhills Center’s website at https://www.sandhillscenter.org/for-providers/trainings-events/provider-orientation/, click on “Cultural Competency Orientation” link.

F. Provider Types

Sandhills Center contracts with the following types of providers: agency based service providers consisting of specialty providers, facilities, and licensed independent practitioners (solo and group practice). Contracts with independent licensed practitioners and professional practice groups are established to ensure members are offered choice when calling the Customer Services Department.

Sandhills Center maintains organizational flexibility in the development of its network by reserving the right to limit providers with whom it contracts based on need, quality of care or service criteria, etc.

These provider types are defined as follows:

1. Agencies

Specialty Providers are providers that specialize in a specific service, specific disability area, or both. These providers offer best practice service options to members such as Assertive Community Treatment Team, Multi-systemic Therapy, Mobile Crisis, Psychosocial Rehabilitation, Child Residential, Substance Abuse Intensive Outpatient, and Substance Abuse Detox.
2. Facilities (Medical 24-hour)

Sandhills Center credentials all facilities in our provider directory which include inpatient, private and community based hospitals. Institutions of Mental Diseases are freestanding psychiatric hospitals and State psychiatric hospitals that are reimbursed by Medicaid for members up to age 21 and 65 years or older.

Hospitals provide emergency room services and/or inpatient behavioral health and units that address psychiatric and/or substance abuse treatment.

Psychiatric Residential Treatment Programs (PRTF) provide non-acute inpatient facility care for members who have mental illness and/or substance abuse/dependency and need 24-hour supervision and specialized interventions.

Facility Based Crisis facilities provides an alternative to hospitalization for adults who have a mental illness or substance abuse disorder. This is a 24-hour residential facility with 16 beds or less that provides support and crisis services in a community setting.

3. Licensed Independent Practitioners/Licensed Practitioners

Licensed independent practitioners as well as practitioners within contracted agencies are required to be credentialed and re-credentialing. These licensed independent practitioners/licensed practitioners include but are not limited to psychiatrists and other physicians, licensed or state certified clinical social workers including master’s level, licensed or state certified clinical psychologists including doctoral or master’s level, licensed professional counselors and licensed clinical addiction medicine specialists, master’s level clinical nurse specialists or psychiatric nurse practitioners who are nationally or state certified or licensed, and physician assistants, Other behavioral healthcare specialists who are licensed, certified or registered by the state to practice independently. Occupational Therapists (OT), Physical Therapists (PT) and Speech Therapists (ST) are also credentialed and re-credentialed for specialized consultative services. All network practitioners are independently licensed and operate within the scope of his/her license or certification.

G. Location of Providers and Member Choice

a) Location

Most services will be accessible within 30 miles or 30 minutes for urban areas and 45 minutes or 45 miles for rural areas. However, some specialty services such as in-patient, child residential, etc. may be located outside these access standards.

Sandhills Center will annually evaluate the location of providers and types of services in its Gaps Analysis Study, and determine the need for additional providers. Sandhills Center also maintains geo-maps, which allow us to associate location of providers in relation to where members live within the catchment area.

b) Member Choice

The LME/MCO ensures that members have a choice of at least two providers for every service, except those services with very limited usage and where alternative providers cannot be recruited. The LME/MCO strives to ensure that members have a choice of evidenced based practices and treatments. Information shall be provided to members on available providers to support selection of a provider.
H. Network Provider Dispute Resolution

Scope of Dispute Resolution Procedure

The dispute resolution process is available only to Sandhills Center network providers for disputes of Sandhills Center decisions/actions related to Administrative Matters and those related to Professional Competence or Conduct. The Dispute Resolution process does not cover provider non-compliance with requirements identified in the contract as cause for termination. The procedure is consistent with URAC standards and North Carolina Department of Health and Human Services regulations.

The Dispute Resolution policy and procedure is reviewed at least annually, with the involvement of participating providers. The process for the Dispute Resolution is covered in Section 12 Reconsideration Review Process for Providers.

I. Quality of Care

Our responsibility is to assure the quality of services provided by the Sandhills Center network of providers and practitioners. Sandhills Center is accountable to the Division of MH/DD/SA and the Division of Health Benefits (DHB), in the management of both state and Medicaid services. In addition to state requirements, Medicaid waiver quality requirements are extensive and include:

- Health and Safety of Members;
- Rights Protection;
- Provider Qualifications;
- Member Satisfaction;
- Suicide Attempt and Suicide Incident Investigation and Monitoring;
- Assessment of Outcomes to Determine Efficacy of Care;
- Management of Care for Special Needs Populations;
- Preventive Health Initiatives;
- Clinical Best Practices.

Sandhills Center has numerous quality, satisfaction and financial reporting requirements related to our agreements with the Division of MH/DD/SA and DHB. An Intra-Departmental Monitoring Team evaluates Sandhills Center performance annually. An External Quality Review Organization (EQRO) monitors Sandhills Center annually, as per Medicaid regulations.

Sandhills Center understands the important role of quality management in protecting members and in promoting quality of care.

As part of the continuous quality improvement process, Sandhills Center operates a Global Continuous Quality Improvement Committee. This Committee includes Sandhills Center staff, members and providers.

The purpose of the Committee is to ensure that we are all working together to achieve system improvements, and to monitor the overall quality of services. Sandhills Center, alone, cannot maintain quality. This partnership is critical for success. The Sandhills Center Quality Management Committee develops a single Quality Improvement Plan for the Sandhills Center Network with input and feedback from the GCQI Committee and other relevant stakeholders. The plan identifies strengths, weaknesses and areas of improvement and includes a program description, work plan and annual report.
Annually, Sandhills Center makes available information about its GCQI performance to providers, practitioners, members and stakeholders on the Sandhills Center website. A printed copy of the information is provided upon direct request to Sandhills Center.

**Your Responsibilities as a Sandhills Center Contracted Provider/Practitioner are to:**

1. Ensure members meet medical necessity requirements for all services that your agency provides;
2. Provide medically necessary covered services to members as per your contract and authorized by Sandhills Center;
3. Provide culturally competent services and ensure the cultural sensitivity of staff members;
4. Strive to achieve best practice in every area of service;
5. Develop a cultural competency plan that is consistent with Sandhills Center’s Cultural Competency plan.
6. Have a clinical back up system in place to respond to emergencies on weekends and evenings for people that you serve, or serve as a first responder as outlined in the service definition and your contract;
7. Demonstrate member friendly services and attitude. The network provider and practitioner must have a system to ensure good communication with members and families;
8. Practitioners may freely communicate with members about all their treatment options regardless of benefit coverage;
9. Comply with the policies and procedures outlined in this manual, any applicable supplements, Sandhills Center Communications Bulletins and your Provider Contract, the General Conditions of the Procurement Contract, and applicable state and federal laws and regulations;
10. Practitioners and providers cooperate with QI activities to improve the quality of care and services and member experience. Cooperation includes collection and evaluation of data and participation in Sandhills Center’s Quality Improvement programs.
11. Provide services in accordance with all applicable state and federal laws;
12. Provide services in accordance with access standards and appointment wait time as noted in the General Conditions of the Procurement Contract;
13. Work with Sandhills Center to ensure a smooth transfer for any members that desire to change providers, or when you need to discharge a member because you cannot meet his/her special needs;
14. Document all services provided as per APSM 45 Service Records Manual and North Carolina State Rules;
15. Agree to cooperate and participate with all utilization review/management, quality management, review, appeal and grievance procedures;
16. Comply with the Credentialing Procedures of Sandhills Center that are outlined in the Sandhills Center Provider manual to become a Network Provider or practitioner;
17. Comply with Authorization and Utilization Management requirements of Sandhills Center;
18. Comply with the re-credentialing or re-qualifying procedure of Sandhills Center, which is outlined in the Sandhills Center Provider Manual;
19. Participate in member satisfaction surveys, provider satisfaction surveys, clinical studies, incident reporting, and outcomes requirements; and
20. Transfer all member records to Sandhills Center upon termination of the Sandhills Center provider contract.

**Sandhills Center’s Responsibilities to Network Providers / Practitioners are to:**

1. Provide assistance twenty-four (24) hours a day, seven (7) days a week to members, and potential members including crisis coordination;
2. Assist providers in understanding and complying with Sandhills Center policies and procedures, applicable policies and procedures of the Department of Health and Human Services and federal agencies including the Centers for Medicare and Medicaid, as well as the requirements of our accreditation agencies including, but not limited to URAC.

3. Provide technical assistance related to Sandhills Center contract requirements, Sandhills Center Provider Manual requirements, Department requirements of providers, the development of appropriate clinical services, quality improvement initiatives, or assist the provider in locating sources for technical assistance. Sandhills Center is not required to provide technical assistance in areas that would normally be considered standard operational activities of a provider agency or to providers that have shown by history not to be able to assimilate previous technical assistance provided.

J. Performance Reviews

All providers/practitioners in the network receive a post payment review at least once every two years, Alternative Family Living homes (AFL’s) are reviewed annually. The Sandhills Center Network Operations Department will maintain a master schedule of reviews and when these are due. Reviews are scheduled and coordinated by Network Provider Monitoring.

All Routine and Post Payment reviews use standardized score sheets, which are made available to providers/practitioners on the Sandhills Center’s website. All reviews include an exit conference with the network provider to discuss the outcome of the review. The reviewer(s) will explain findings and review scores for each area reviewed to include strengths and needs noted. Any follow-up to be completed by the Provider/Practitioner or Sandhills Center will be reviewed during the exit conference. Copies of review results are mailed to the provider within fifteen (15) business days of the review. Documentation will outline areas reviewed; scores achieved, and required follow up.

Providers/Practitioners are given an opportunity to provide feedback to Sandhills Center’s Network Provider Monitoring regarding the review process via a survey link included in the results letter they receive. The results are submitted to the Division of MH/IDD/SAS and are reviewed by State Staff.

The provider/practitioner may present any additional information not located during the review process before or during the exit conference and, if applicable, scores will be altered at that time. After the review is concluded, any additional information located will be included in the plan of correction and will not be used to change any established scores.

K. Health & Safety Reviews

If a health and safety site visit is required for the new service, Network Provider Monitoring shall schedule at the request of the credentialing specialist. Any site requested to be added to the contract for the new service will be reviewed on all applicable areas. The credentialing application cannot be completed without an approved health and safety review. During the site visit, Sandhills Center will evaluate the provider applicant’s readiness to provide services according to the requirements outlined in state regulations, the service definition, Sandhills Center Practice Guidelines and the Sandhills Center contract. Any time the address changes for unlicensed services or LIPs, a health and safety review will be completed at the new address. Initial health and safety site visits are not completed for DHSR licensed sites, or those facilities that are overseen by an accrediting body.
Providers must have adequate access to all services covered under the contract for all members, including those with limited English proficiency or physical and/or mental disabilities. Sandhills Center requires network providers to provide physical access, reasonable accommodations, and accessible equipment for members with physical and/or mental disabilities. Provider must deliver services in a culturally competent manner to all members, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation or gender identity.

Standard Health and Safety reviews are conducted as a part of the credentialing and re-credentialing process for all providers designated as moderate to high-risk level at the request of the Network Operations Credentialing staff, or the Network Operations Contracts staff for client-specific contracts. Standard Health and Safety reviews can also be requested by the Care Coordination department in the event of a member transfer from one Alternative Family Living (AFL) home to another. Upon receiving request, Network Provider Monitoring will schedule and conduct a Health and Safety review. The completed report of findings will be mailed and/or emailed to the provider, as well as the requesting department. Network Provider Monitoring will determine if a POC is needed, and will monitor the POC process until the case closes, or is sent to Network Committee for consideration of possible further action.

At the close of a PI investigation, the Program Integrity Director can request that Network Provider Monitoring put a POC in place. A request for a POC based from the PI investigation findings will be mailed directly to the provider. Network Provider Monitoring tracks the POC process until the case closes, or is sent to Network Committee.

L. Onsite Quality Site Assessments

Quality assessments are conducted to ensure the provider is in good standing with State and Federal regulatory bodies, and confirms that providers have been reviewed and approved by an accrediting body. Sandhills Center evaluates the quality of providers before it contracts with a provider and at least every 36 months thereafter. Behavioral health care providers include inpatient, residential and ambulatory – i.e. psychiatric hospitals and clinics, addiction disorder facilities and residential treatment centers for psychiatric and addiction disorders.

If a provider does not have an accreditation status, an onsite quality assessment is performed by Network Monitoring. Sandhills Center’s Network Monitoring section uses criteria that is specific to each type of provider and ensures that providers credential their practitioners.

If a provider has satellite facilities that follow the same policies and procedures as the provider, Sandhills Center may limit site visits to a main facility. Sandhills Center may accept CMS or State reviews in lieu of a site visit under the following circumstances:

- The CMS or State review is no more than three (3) year old. If the CMS or State review is older than three (3) years, then Sandhills Center conducts the onsite quality review.

- Sandhills Center obtains a survey report or letter from CMS or the State, from either the provider or from the agency, stating that the facility was reviewed and passed inspection. The report must meet Sandhills Center’s quality assessment criteria or standards.

Sandhills Center’s Credentialing Specialists maintains records of quality assessments performed on each provider.
M. Monitoring the Provision of Evidence Based Best Practice Services

An evidence-based best practices library is posted on the Sandhills Center website. EBP assessment worksheets are completed during provider reviews by Network Provider Monitoring staff. Of those charts reviewed for EBP, a random sampling is chosen for clinical evaluation by the Clinical Monitoring Manager (CMM). If there is limited documentation to support use of EBPs, additional charts may be requested by the CMM. Results are used to offer technical assistance to the provider, either on-site or by phone or by mail, when appropriate.

Worksheets are developed with the assistance of the Chief Medical Officer/Chief Clinical Officer and/or his/her designees and vetted through the Clinical Advisory Committee, the Clinical Leadership Team, Network Committee and Quality Management Committee.

Providers are introduced to EBPs in Provider Forums and through provider training. Network Provider Monitoring staff are trained in the use of the worksheets and implementation dates are set.

New topics may be added upon recommendation from the Chief Medical Officer/Chief Clinical Officer and the Clinical Leadership Team.

N. Network Development Plan

Sandhills Center Network Development Planning Process is to ensure that members have timely access and availability to behavioral health services. Goals for access and availability are established based on the Department of Health and Human Services requirements and reflect national and community standards. Access goals are defined by geographic dispersion by travel time and distance. Availability goals are defined by time based on intensity of need. In addition, there are provider specific goals related to hours of operation. Data for each is tracked and reported separately.

Additionally, Sandhills Center ensures a choice of at least two providers for each service except for specialty or facility based providers, as approved by DHB.

Sandhills Center will ensure the presence of an adequate number and mix of qualified, competent, credentialed, well-oriented and trained provider facilities, agencies, organizations and independent practitioners that are accessible and available at all times to meet the medically necessary needs of our community.

Sandhills Center will review information on a quarterly and annual basis to ensure that the network has remained stable and the standards for access and availability are being met. The annual review and analysis of the Provider Network is more extensive in nature. Additionally, analyses are completed whenever there is a significant change in Sandhills operations that would affect adequate capacity and services including changes in services, in geographic service areas, payments or enrollment of a new population.

In completing the analyses, Sandhills Center will consider:

a. Anticipated membership numbers, characteristics, and needs, including the cultural and language needs of members;
b. Anticipated service utilization;
c. Numbers and types of providers required to provide the contracted services, including training, experience, and specialization;
d. The number of network providers who are not accepting new referrals; and

e. The geographic locations of providers and recipients, considering travel distances, travel times, means of transportation, and physical access for recipients with disabilities.

Sandhills Center will submit to DHB written reports of findings of the Provider Network analyses. Whenever network gaps are identified, the Sandhills Center will submit to DHB a network development plan within a timeframe specified by DHB.

If specialty services are Medically Necessary but are not available in-network, Sandhills Center will arrange for these services to be provided out-of-network. Sandhills Center will ensure that the services are adequately and timely covered. These out-of-network services will be provided for as long as they are unable to be provided in-network.

Sandhills Center Network Development Plan is a configuration of the following components:

a. **Sandhills Center Annual Assessment of Service Needs, GAPS, and Provider Capacity Strategic Plan**: The assessment of access and availability of services throughout the Sandhills Center area is a vital part of Network Development. One of the tools that Sandhills Center uses to measure network sufficiency is the Annual Needs/Gap Assessment.

b. **Sandhills Center Accessibility and Availability Standards**: Outlines the manner in which the Sandhills Center approaches the assessment, planning, and implementation of service needs and gaps in services.

1. **Accessibility**

   • **Geographic Location**: The provider network for all covered in-plan services must be geographically accessible to Medicaid members as to non-Medicaid members.

   • **Distance/Travel Time**: Services are accessible to members within a 30-minute drive time or 30 miles distance for urban areas and 45 minutes or 45 miles for rural areas. Longer distances as approved by DHB are allowed for facility based or specialty providers.

   • **Facility Accessibility**: Contracted network providers’ facilities must be accommodating for members with physical and/or mental disabilities. Sandhills Center requires providers to have reasonable accommodations, in accordance with 42 CFR §438.206 and the ability to communicate with limited English proficient members in their preferred language and the ability to ensure physical access, reasonable accommodations, culturally competent communications, and accessible equipment for Medicaid members with physical and/or mental disabilities.

   • **Member Services**: Members have 24/7 toll-free telephone access to the Customer Services Department to provide assistance, information and education.

   • **Support Services**:  
     a. **Transportation**: Sandhills Center will provide assistance to members with transportation needs to medically necessary services through public/private means. This availability is communicated to members.
b. **Interpreters:** To ensure that members can effectively communicate with Sandhills Center and providers, language interpretation services are made available to by telephone and/or in person. TDD (telecommunication devices for the deaf) is available for persons who have impaired hearing or communication difficulties.

- **Hours of Operation:** Providers are required to offer hours that are no less than those offered to commercial members or comparable to Medicaid fee-for-service, if the provider serves only Medicaid members, Health Network gathers and maintains information regarding providers’ operational hours.

2. **Availability:**
   
   (a) **Appointments:** Services are available to members as follows:
   
   - **Emergency Services:** Provider must ensure face-to-face emergency services within two (2) hours after a request for emergency care is received by Provider staff from Sandhills Center or directly from a member; the Provider must provide face-to-face emergency care; immediately for life threatening emergencies;
   
   - **Urgent Need Services:** Providers must ensure initial face-to-face assessments and/or treatment within 48 hours after the date and time a request for urgent care is received by Provider staff from Sandhills Center or directly from a member;
   
   - **Routine Need Services:** Providers must ensure initial face-to-face assessments and/or treatment within fourteen (14 calendar days) of the date a request for routine care is received by Provider staff from Sandhills Center or directly from a member.

   (b) **Office Wait Time:** Services are available to members as follows; *(Please note: Office wait times apply to Medicaid funded services only)*
   
   - **Scheduled appointments:** Sixty minutes after the appointed meeting time;
   
   - **Walk-ins:** within two (2) hours after the member’s arrival. If that is not possible, staff must schedule an appointment for the next available day;
   
   - **Emergencies:** Sandhills Center staff shall ensure that members are provided face-to-face emergency care within two (2) hours after the request for care is initiated by Sandhills Center or directly by the member to Sandhills Center; Providers must provide face-to-face emergency services within two hours after a request for emergency care is received by the Provider staff from Sandhills Center or directly by the member; life threatening emergencies shall be managed immediately.

   (c) **Afterhours Emergency and Referral:** Services are available to members as follows:
   
   - Sandhills Center provides a toll free telephone emergency and referral line available twenty-four (24) hours per day.
   
   - Return calls to members: Telephone inquiries made by members after hours for access/information must be responded to within one (1) hour of receiving the call.

   (d) **Second Opinion:** The member has a right to a second opinion from a qualified health care professional within or outside the network at no cost to the member. Upon request, Sandhills Center shall provide a member with one second opinion from a qualified health care professional selected by Sandhills Center, at no cost to the member. The second opinion may be provided by a provider that is in-network or one the is out-of-network. Sandhills Center shall not be required to provide a member with a third or fourth opinion.
O. Relative / Legal Guardians

For those providing Innovations Waiver Services only. *(Medicaid Funds Only.)*

Sandhills Center is committed to ensuring that there is a consistent process to carry out review and disposition of requests from Network Providers and Employers of Record to employ relatives/legal guardians (who live in the home of the Innovations waiver participant) to provide Innovations waiver services to their family member, in accordance with the Innovations waiver policy.

The biological or adoptive parent of a minor child, step-parents of a minor child, or spouse of a waiver participant **may not be paid** to provide the waiver service to a waiver participant. Other relatives, including legal guardians, may be hired to provide the waiver service subject to specifications in the service definition. Relatives and legal guardians of children, who are **not the biological or adoptive parent** of the minor child, or step-parents of a minor child, may provide the service subject to specifications in the service definition.

Legal Guardians, parents of **adult participants**, and other relatives **must live in the same home of the participant**.

The 40 Hours or Less Form, Over 40 Hours RDSE Application and Out of State Travel Requests are located on Sandhills Center website at the following link: [https://www.sandhillscenter.org/for-providers/innovations-waiver-for-providers/](https://www.sandhillscenter.org/for-providers/innovations-waiver-for-providers/)

**Procedures**

1. Relatives/Legal Guardians living in the home of an adult Innovations waiver participant(s) may provide the service if, based on the documentation provided by Provider Agency/Employer of Record, there is evidence that the request meets the Innovations waiver requirements. Employers of Record and Managing Employers participating in the Individual Family Directed option may not be employed to provide waiver services.

2. Community Living and Support is the only waiver service that may be provided by a relative and/or legal guardian who resides in the home of the individual(s), age 18 or older.

3. Provider Agencies/Employers of Record **must** ensure the relative or legal guardian meet the provider qualifications for the service, per Innovations waiver requirements.

4. Providers must report all relatives/legal guardians that provide the waiver service on the 40 Hours or Less Form or the Over 40 Hours Application. If the relative/legal guardian provides 40 hours/per week or less the provider must complete the 40 Hours or Less Form for review by Network Operations. This form does not require approval. Once this form has been submitted by the provider, Network Operations will review for completeness, obtain relevant information from Care Coordination, and verify acknowledgement of the form / report.

5. If more than 40 hours are requested to be provided by the relative/legal guardian residing in the home of the participant(s), then approval must be obtained by the Care Coordination department. Justification needs to be provided as to why there is no other qualified staff to provide Community Living & Support, assurances of provider choice, and attestation that the participant(s) will not be isolated from their community. In exceptional situations, up to 56 hours per week may be approved by Care Operations.
Coordination. This is the total number of hours that one relative/legal guardian may provide regardless of the number of participants residing in the home. No new requests of more than 56 hours will be approved.

Please note that when an individual moves from their natural home and into the home of a relative that is not their parent, then this may be considered an AFL situation, and RDSE would not apply. RDSE only applies to an individual residing in their natural home.

6. Relatives who were providing more than 56 hours of service on 12/31/2015 may exceed the 56-hour limit and be approved to provide the amount of service that they were authorized to provide as of 12/31/2015, as long as the participant(s) continues to choose the relative/legal guardian as the staff member, there are no health and safety issues, and the participant(s) are not isolated from their community.

7. Sandhills Center Network Operations ensure compliance with the conditions of this policy through the prior approval process. Services delivered by relatives/legal guardians are monitored monthly. Care Coordinators monitor through on-site monitoring and documentation review to ensure that payment is made only for services rendered, and that the service is furnished in the best interest of the participant(s).

8. The ISP must contain documentation that the waiver participant(s) is in agreement with the employment of the relative/legal guardian and has been given the opportunity to fully consider all options for employment of non-related staff for waiver service provision.

9. The relative/legal guardian will not be reimbursed for any activity that would be provided to a person without a disability of the same age.

10. Provider agencies, Employers of Record and Agency with Choice in conjunction with the Managing Employer must monitor the relative/legal guardian’s provision of the service on-site and at a minimum of one time per month.

11. Annually thereafter, the 40 Hours or Less Form or the Over 40 Hours Application is resubmitted at least one month prior to the waiver participant’s birth month for review of continuing compliance with the policy.

12. All documentation regarding requests, extensions, reconsiderations, renewals, etc. for service provision by relatives/legal guardians will be maintained in a Provider Agency/Employer of Record file.

13. Prior to employing the relative/legal guardian, the Provider Agency/Employer of Record must submit the appropriate form or application to the Network Operations Department. Packets are accepted if the information is complete and documented on the correct application or form. All incomplete requests are denied and returned to the Provider Agency/Employer of Record. Only Sandhills Center request forms are accepted. Any additional information submitted is returned to the Provider Agency/Employer of Record. Forms or applications are as follows:

   - 40 Hours or Less Form (Does not require approval by Sandhills Center).
   - Over 40 Hours Application Verification of Relative/Legal Guardian as a Direct Support Employee Request. (Requires approval by Sandhills Center).
14. If issues arise concerning the qualifications of the relative/legally responsible person and/or the health/safety of the participant, a request for re-review can be initiated by the Care Management/Utilization Management Department, the Care Coordination Department Quality Management Department or the Network Operations Department based on their discovery of issues.

15. Network Monitoring verifies that Providers have complied with the process during their bi-annual state-mandated onsite review of the agency, or if issues are reported or discovered. Episodes of non-compliance may result in Medicaid paybacks by the Provider agency and/or potential sanctions. If during monthly care coordination routine monitoring, it is discovered that a relative/legally responsible person is providing the service and, but has not been approved or reported through the process, or the service is not being provided as approved, the issue will be referred to Network Monitoring for investigation.

16. Concerns/questions from Provider Agencies/Employers of Record regarding the process, or outcome of requests are addressed by the Network Development Manager.

17. Concerns/questions from relatives/legally responsible persons regarding understanding the policy and/or process are addressed by the Customer Services Department. As potential employees, questions from relatives/legally responsible persons regarding the outcome of the policy decisions or justification regarding these decisions are referred back to the provider agency for further explanation.

18. The Network Operations Department, in conjunction with Care Coordination, reviews the “Verification of Relative/Legal Guardian 40 Hours or Less Form” and the “Over 40 Hours Application” only in regard to compliance with the Innovations waiver requirements.

19. If the Over 40 Hours Application meets employment criteria, the Network Development Manager completes a Letter of Agreement noting any stipulations to the decision (i.e. - step-down plans) identified by the Care Coordination Department. The Network Development Manager notifies the Care Management/Utilization Management Department that the provider agency meets the criteria for the requested hours/daily units per week. The Utilization Management Department is responsible for service authorization.

20. The Letter of Agreement is sent to the provider agency via certified mail or secured email. A copy of the Letter of Agreement and any other specific recommendations regarding the request are maintained in a Provider Agency/Employer of Record file. A copy of the letter is sent to appropriate staff in Care Management/Utilization Management, Quality Management, Care Coordination, Customer Services, Network Operations and Corporate Compliance.

21. If the request does not meet the employment criteria, a certified letter or secured email is sent to the Provider Agency that specifies the reason for the denial, and advises the Provider that they have 90 days to introduce additional staff, employ new staff and/or make reductions in current staff hours (if applicable). A copy of the letter is sent to appropriate staff persons in Care Management/Utilization Management, Quality Management, Care Coordination, Customer Services, Network Operations and Corporate Compliance.

22. The Provider Agency/Employer of Record does not have the right to request reconsideration when it has been determined that employment criteria as required by the Innovations waiver have not been met.
23. The Provider Agency/Employer of Record shall have one (1) opportunity to resubmit a 40 Hours or Less Form or the Over 40 Hours Application with additional information. Requests beyond the first resubmission will not be reviewed.

24. Approval of a relative/legal guardian as provider is provider agency and service specific. If the relative/legal guardian as provider changes the waiver recipient’s services to a new Provider Agency, the new Provider Agency must submit a 40 Hours or Less Form or an Over 40 Hours Application to the Network Operations Department.

25. If the relative/legal guardian passes & a new relative/legal guardian is hired, a 40 Hours or Less Form or an Over 40 Hours Application must be submitted by the provider agency.

26. If the relative/legal guardian who is the primary caregiver dies and the back-up caregiver becomes the primary caregiver, then a 40 Hours or Less Form or the Over 40 Hours Application must be submitted by the provider agency.

27. Should the member die, or the county where their Medicaid originates from is changed to a county outside of Sandhills Center’s catchment area, the provider agency must notify Sandhills Center Care Coordination & Network Operations Departments.

**Extensions**

Provider Agencies/Employers of Record may request an extension of the 90-day transition period if they have difficulty locating staff by sending a written request to the Network Development Manager. Extensions are typically granted for up to 45 days, with the ability to renew one time in extraordinary circumstances. If the request to renew is granted, the Network Development Manager documents the extension in writing to the Provider Agency/Employer of Record.

**Reconsideration Review**

1. Provider Agencies and Employers of Record who have Over 40 Hours Application denied by the Care Coordination Department may request reconsideration of this decision through Network Operations, which oversees the process.

2. **Requests for reconsideration when the staff person does not meet the staffing qualifications for the service will not be accepted for reconsideration.**

3. The Network Committee is responsible for the review and disposition of requests for reconsideration of decisions made by the Care Coordination Department.

4. The Provider Agency/Employer of Record has seven (7) calendar days from the date they receive the denial to submit a Request for Reconsideration. Requests received after seven (7) calendar days will stand as initially determined by the Care Coordination Department.

5. The Network Development Manager will submit the Request for Reconsideration to the Network Committee.
6. The Network Committee comprehensively reviews the request. Additional information may be requested. Based on all information submitted, a disposition is reached regarding the request. This decision is final and there are no further avenues for review.

7. A letter or secured email is sent to the provider agency detailing the final disposition of the Network Committee.

All documentation submitted to or produced by the Network Committee are maintained in a Provider Agency/Employer of Record file and available for review by internal staff upon request.

**Annual Renewals**

1. Provider Agencies must submit a new 40 Hours or Less Form or Over 40 Hours Application annually.

2. Renewal Forms or Application must be submitted at least one month prior to the member’s birth month to ensure that the Provider Agency/Employer of Record is in compliance with the Innovations Relative/Legal Guardian as a Provider Policy.

3. Renewal Forms or Applications are processed like all other forms or application as noted in items 1-27 of this procedure.

Questions to consider prior to hiring a relative or family member.

1. Is this about the participant’s wishes, desires, needs or about supplementing a family member’s income?
2. As an adult, is it appropriate to still have mom & dad with the participant throughout the day?
3. If a family member supports an individual from birth onwards into adulthood, does the individual learn to adapt to different people and increase his/her flexibility & independence?
4. If a participant with a disability is always support by a family member, what happens when that caregiver ages/dies? Who else has knowledge of the participant?
5. Can a family member be a barrier to increased community integration or friendship development?
6. Does having the family member as direct support staff expand the participant’s circle of support or risk shrinking it?

**P. Incident Reporting and Response Information**

**What is an “Incident”?**

An “incident,” as defined in 10A NCAC 27G.0103(b)(32), is “any happening which is not consistent with the routine operation of a facility or service or the routine care of a member and that is likely to lead to adverse effects upon a member.” Therefore, Category A and B providers are required to report any adverse events that are not consistent with the routine operation of a facility or service or the routine care of a member.

There are three levels of response to incidents, based on the potential or actual severity of the event. The “Incident Response and Reporting Manual” provides detailed information regarding the definitions of each level, reporting responsibilities for each level, criteria for determining these levels and reporting requirements and timeframes.
Who must submit “Incident Reports”?

Providers of publicly funded services licensed under NC General Statutes 122C (Category A providers), except hospitals, and providers of publicly funded non-licensed periodic or community-based mental health, developmental disabilities and/or substance abuse services (Category B providers) are required to report incidents involving members receiving mental health, developmental disabilities and/or substance abuse services. Failure to do so, as required by the North Carolina Administrative Code 10A NCAC 27G.0600, may result in DHHS taking administrative actions against the provider’s license or authorization to provider services.

Hospitals and providers of services licensed under G.S. 131D or G.S. 131E (Category C providers) and individuals certified or licensed in North Carolina to provider only outpatient or day services (Category D providers) are not required to submit incident reports in IRIS.

Providers should also notify all other appropriate agencies such as any accrediting or regulatory agencies as required by all governing rules or statutes, including federal requirements.

How and Why are Reports Submitted?

Incidents are reported using the IRIS (Incident Response Improvement System) web based reporting system. IRIS ensures that serious adverse events are addressed quickly & incidents are studied to prevent future occurrences and to improve the service system.

See the Incident Reporting Technical Manual for step by step information on using the web based IRIS system.

Why do LME/MCO staff need to know about Incident Reporting?

Sandhills Center encourages network providers to report appropriate incidents in a timely manner and Sandhills Center staff may need to conduct monitoring and/or follow-up.

What is meant by “Level of Incident”?

The three levels reflect the incident’s threat to the health and safety of the member.
Level 1 = indicates no threat
Level 2 = temporary threat
Level 3 = permanent threat or public scrutiny (public awareness of the incident due to witnessing the incident or media coverage)
What are the State Rules Requirements?

Level 1 incidents are addressed by the provider internally, NOT entered into IRIS and reported to Sandhills Center quarterly.

Level 2 incidents must be documented & submitted in IRIS within 72 hours of learning of the incident (this does not mean 3 days); handled internally by the provider. Deaths from natural causes are Level 2 incidents.

Example of the 72 Hours Rule: An incident occurs at 10:30 Friday morning, you, the provider becomes aware of the incident at 11:00 AM. You have until 11:00 AM on Sunday to report the incident.

Level 3 must be submitted in IRIS within 72 hours (this does not mean 3 days) of the occurrence and verbally reported to Sandhills Center. Deaths from unknown causes and allegations of sexual abuse are Level 3 incidents. As additional information is learned, IRIS must be updated.

If the incident is a Level 3 Death, the provider must notify all agencies as required by law verbally within 24 hours and submit the IRIS report within 72 hours.

Incident Types

<table>
<thead>
<tr>
<th>1. Abuse, Neglect or Exploitation Allegation</th>
<th>6. Member Death</th>
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</thead>
<tbody>
<tr>
<td>2. Fire</td>
<td>7. Member Injury</td>
</tr>
<tr>
<td>3. Incidents of Concern to Community or Media Coverage</td>
<td>8. Restrictive Intervention</td>
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<tr>
<td>4. Medication Error</td>
<td>9. Suspension or Expulsion from services</td>
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<tr>
<td>5. Member Behavior</td>
<td>10. Unplanned member absence lasting more than 3 hours</td>
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What should I do as a provider, if the IRIS system is down?

If IRIS is unavailable, providers must meet the times for submission of an incident by faxing or emailing a hardcopy of the incident report to the proper agencies. Once the IRIS system is available, the provider must submit the information electronically.

See Sandhills Center website link for the paper form at:

https://www.sandhillscenter.org/for-providers/provider-forms/incident-reporting-and-response-information/

<table>
<thead>
<tr>
<th>For Guilford County Only</th>
<th>For all Other Counties:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Email: <a href="mailto:debbiep@sandhillscenter.org">debbiep@sandhillscenter.org</a></td>
<td>Email: <a href="mailto:christyw@sandhillscenter.org">christyw@sandhillscenter.org</a></td>
</tr>
<tr>
<td>Fax: (336) 389-6534</td>
<td>Fax: (336) 389-6535</td>
</tr>
</tbody>
</table>

Submission of Reporting Important Notes:

Download or print a copy of each incident report you submit for your records. Keep a copy of the incident report number in case you need to view the report later. Keep the incident report number in a secure location.

Print out the “Incident Response and Reporting Manual” and the “IRIS Technical Step by Step Manual” to have on hand. These manuals provide much more detailed information and there is also a “practice web site” for staff training.
Q. Block Grant Readiness

The Substance Abuse and Mental Health Services Administration (SAMHSA) administers two block grants for which Sandhills Center receives funding through the State of North Carolina: the Community Mental Health Services Block Grant (CMHSBG), and the Substance Abuse Prevention and Treatment Block Grant (SAPTBG).

Sandhills Center is committed to ensuring an efficient and effective service delivery system is in place to provide access to these services throughout our catchment area. Sandhills Center Provider Network Monitoring (NPM) completes ongoing, voluntary reviews of block grant program elements throughout the year. Based on a preannounced schedule; participating providers are requested to submit specific block-grant elements to the Network Provider Monitoring staff for desktop review. Submitted documentation is reviewed utilizing the NCDHHS block grant monitoring tool. Technical assistance is provided based on results of this review.

A Block Grant Readiness Review Plan is developed annually by Network Provider Monitoring (NPM). The annual plan is approved through Network Committee and Quality Management Committee. Once approved, the plan is sent to all block grant providers, announced at following provider forums, and posted on the Sandhills Center website. Sandhill Center Providers awarded access to block grant funds are requested to submit documentation for specified quarterly coverage dates for review by NPM. Additions may be made to the plan to accommodate the needs of the Network Monitoring staff in its monitoring efforts.

NPM conducts desktop reviews of submitted documentation utilizing the same NCDHHS Block Grant monitoring tool that is used during the annual State audit. As participation in this review is voluntary, any out of compliance elements will be addressed through written and/or verbal technical assistance.
SECTION 4: CONTRACTS

A. Agency and Licensed Practitioner Contracts

B. Client Specific Contracts/Single Case Agreements
A. Agency and Licensed Practitioners Contracts

Sandhills Center must enter into Procurement Contracts with Network Providers before any services can be authorized or paid. Network Providers are required to have a fully executed Sandhills Center contract, which lists services and approved sites prior to delivery of services to a Sandhills Center member.

The Sandhills Center Provider Manual and the North Carolina Innovations Technical Guide are incorporated into the contract by reference. All the Sandhills Center Contract Templates have been approved by the Secretary of the Department of Health and Human Services as required by G.S. 122C 142(a).

Your Responsibilities are to:

1. Review your Contract for accuracy and fully execute the Contract and return to Sandhills Center within thirty (30) days of receipt to assure continued payment for services.
2. Sign and have a fully executed Sandhills Center Contract Amendment for any material change to the original Contract;
3. Submit any required reports or data elements as required in the Contract to remain in “good standing”. Submit reports as required in attachments and adhere to reporting requirements;
4. Understand the obligations and comply with all terms of the Contract and all requirements in the Sandhills Center Provider Manual, and the North Carolina Innovations Technical Guide;
5. Notify Sandhills Center of any prospective changes in sites and assure that all Sandhills Center credentialing & re-credentialing requirements are met and that any contract amendments are in place prior to delivery of contracted services;
6. Attempt to first resolve any disputes with other network providers or Sandhills Center through direct contact or mediation;
7. Notify Sandhills Center in advance of any mergers or change in ownership since it may have implications for your contract status with Sandhills Center.

The provider has the right to enter into other contracts with any other LME/MCO or third party payers to provide MH/DD/SA services. Any subcontracts or assignments for program delivery shall be subject to all conditions of the contract. When a subcontractor meets the URAC definition of a delegated or partially delegated entity, prior approval by the Sandhills Center may be required.

B. Client Specific Contracts/Single Case Agreements

For some Sandhills Center Medicaid Members living in and outside the catchment area, there may not be an appropriate service provider in the network that meets access and availability standards for the specific service being requested. For all client specific contracts, the requested service must meet medical necessity criteria. Providers with client specific contracts are not considered full members of the Sandhills Center Network, and are not available as choices for other members.
SECTION 5: MEMBER RIGHTS AND EMPOWERMENT

A. Rights of Members
B. Civil Rights
C. Informed Consent
D. What Can I Expect in the Innovations Plan of Care Process?
   Medicaid funded services
E. Advocacy for Members
F. Psychiatric Advanced Directives (PAD)
G. Confidentiality
H. Second Opinion Medicaid funded services
I. Appeals Process Medicaid funded services
   1. Filing a Reconsideration Request
   2. Filing a State Fair Hearing Appeal
   3. Continuation of Benefits
J. Grievances
K. Client Rights Committee (CRC)
L. Consumer and Family Advisory Committee (CFAC)
M. Customer Services
N. Limited English Proficiency
A. Rights of Members

Free speech, religious freedom, and personal liberty are fundamental American rights. Personal privacy and confidentiality of personal information are personal rights. When people receive services/supports in the state’s public system, there are additional rights as well. State rules and state and federal laws spell out what these additional rights are.

Member’s Rights and Responsibilities

It is the policy and practice of Sandhills Center to assure your basic human rights. In addition, members have the right to:

1. Be treated fairly and with respect regardless of race, ethnicity, religion, mental or physical disability, sex, age, sexual preference, or ability to pay.
2. Participate in making their Service Plan and in decisions regarding their Health Care including the right to refuse treatment.
3. Receive information about Sandhills Center, its services, its practitioners and providers, and referrals for Specialty Care (including cost sharing, if any) and how to access Medicaid benefits that are not covered.
4. Receive information about their rights and responsibilities.
5. Be free from restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.
6. Request and receive a copy of their medical records. If their doctor or therapist decides that this would be harmful to their physical or mental well-being, they may ask that the information be sent to a doctor or professional of their choice.
7. Receive their services in a safe place.
8. Refuse services, unless the services are court-ordered.
9. Include any persons they wish in their treatment.
10. Have their protected health information kept private.
11. Obtain information in their own language or have it translated.
12. Receive oral interpretation services at no cost to the member.
13. File a grievance, or appeal without penalty.
14. Receive good care from providers who know how to take care of the member.
15. Participate with their practitioners in making decisions about their health care.
16. Choose a provider from the Provider Network.
17. Use their rights with no negative action by the NC Division of MH/DD/SAS or Sandhills Center and maintain the same civil and legal rights as anyone else.
18. Be treated with respect, including dignity and privacy.
19. Receive information on available treatment choices and alternatives, regardless of cost or benefit coverage, and to have these choices explained in a way they can understand them.
20. A State Fair Hearing about any action taken by Sandhills Center, including a service denial.
21. Recommend changes to Sandhills Center Policy and Procedures, including its member rights and responsibilities policy.
22. Get information on how to recommend changes in Sandhills Center Policy and Procedures.
23. Make written Advance Directives.
24. For a second opinion for treatment. To get a second opinion, call Customer Service at 1-800-256-2452 and request to speak to a staff member who can set up a second opinion within the network or arrange for one outside of the network at no cost to you. (Medicaid funded services only)
25. To report a suspected violation to the NC Department of Health and Human Services if they live in an Adult Care Home and believe there has been any violation of their rights.
**Member’s Responsibilities:**

They have the responsibility to:

1. Give information needed for the organization and its practitioners and providers to provide their care
2. Follow plans and instructions their providers.
3. Understand their health problems and participate in developing treatment goals that they, and their practitioner, agree on, as much as possible.
4. Know the name of their Clinical home and the staff working with them.
5. Schedule appointments during regular office hours when possible, limiting the use of Urgent Care and Emergency Room facilities.
6. Arrive on time for appointments.
7. Attend all scheduled appointments or call to cancel.
8. Tell providers if they have to cancel an appointment before the scheduled time.
9. Participate in creating their Service Plan.
10. Be aware of their rights. Take care of themselves.
11. Assist in moving towards their recovery.
12. Treat others with respect and work cooperatively with others.
13. Provide financial information and document their income.

Sandhills Center uses and discloses member protected health information (PHI) appropriately in order to protect member privacy. Members can request restrictions on use and disclosure of PHI. Members can request a report of disclosures of PHI.

If at any time a member believes that their member rights have been violated, they may contact the Office of Customer Services at 1 (800) 256-2452.

Members can report a grievance by calling 1 (800) 256-2452. The Sandhills Center Customer Services Department is also available by calling 1 (800) 256-2452 24 Hours a Day/7 Days a Week/365 Days a Year.

A copy of member rights & responsibilities can also be found on the Sandhills Center website at [https://www.sandhillscenter.org/for-consumers/member-handbook](https://www.sandhillscenter.org/for-consumers/member-handbook)

**B. Civil Rights**

Members are entitled to all civil rights including:

- To register and vote,
- To buy or sell property, own property,
- To sign a contract,
- To sue others who have wronged them,
- To marry or get a divorce,
- To procreate and raise children,
- If the member is adjudicated to be incompetent and has a court appointed guardian, the member keeps all legal and civil rights except those that are given to the guardian by the court.

Persons determined to be incompetent and that are assigned a court appointed guardian retain all legal and civil rights except those rights that are granted to the guardian by the court. The protection and promotion
of recipient rights is a crucial component of the service delivery system. All members are assured rights by law and it is expected that Providers will respect these rights at all times and provide members continual education regarding their rights as well as support them in exercising their rights to the fullest extent.

*North Carolina General Statutes (GS 122C 51-67) and the North Carolina Administrative Code (APSM 95-2) outline specific requirements for notification of individuals regarding their rights as well as operational policies and procedures that ensure the protection of rights.*

These statutes and regulations also outline the policy and operational requirements for the use and follow-up of restrictive interventions and protective devices.

It is expected that all Network Providers are knowledgeable of all outlined statutes and regulations regarding member rights and the use of restrictive interventions/protective devices and that providers develop operational procedures that ensure compliance. The Provider is also expected to maintain an ongoing knowledge of changes to the statutes and regulations and immediately alter operations to meet changes.

Each Network Provider Agency is expected to maintain a Client Rights Committee consistent with regulations outlined in North Carolina General Statue and Administrative Code. Providers are required to submit the minutes of their Client Rights Committee meetings to Sandhills Center on a quarterly basis.

Providers should de-identify any information that is not in relation to Sandhills Center members. Sandhills Center maintains a Client Rights Committee that is responsible as a sub-committee of the LME/MCO Board for the monitoring and oversight of Provider Client Rights Committee functions. The Sandhills Center Client Rights Committee receives routine reporting from Sandhills Center staff on the use of restrictive interventions, rights violations and incidents of abuse, neglect and exploitation within the Sandhills Center Network.

*Client Rights regulations are in NCGS 122C-4.51-67 and APSM 95-2 and APSM 30-1 and NCASC 27G.0504, 10A NCAC 27G.0103 and NC Council Communication Bulletin #30.*

Members have the right to ask for this information at any time:

1. A Member Handbook at least annually and as needed from Sandhills Center.
2. The name, location, and telephone number of the current providers in their service area that speak a language other than English and the name of the language(s) spoken.
3. The name, location, and telephone number of the providers in their service area.
4. Any limits of their freedom of choice among network providers.
5. A description of how “after-hours” and emergency coverage is provided.
6. A description of what is an emergency medical condition and what are emergency and post stabilization services.
7. The process for getting emergency services, including the use of the 911 telephone system or local emergency numbers.
8. The location of providers and hospitals that provide emergency/post stabilization services. The right to use any hospital or other setting for emergency care.
9. The right for a second opinion for treatment. (Without cost from a qualified health care professional within the network, or outside the network if necessary.)
10. The right to get emergency services without getting approval first.
11. The amount, duration and scope of their benefits.
12. The process for getting services, including approval requirements.
13. The right on how the member may get benefits from out-of-network providers.
14. The rules for post stabilization care services.
15. How and where to get services. How transportation can be provided.
16. The structure and operation of Sandhills Center
17. The grievance, appeal and fair hearing procedures and timeframes.
19. The information on how to develop Advance Directives.

For more information regarding member’s rights in a 24 hour facility and the rights of minors, see Sandhills Center’s “Member’s Handbook” at https://www.sandhillscenter.org/for-consumers/member-handbook.

To request any of this information, contact Sandhills Center “Provider Help Desk” at 1-855-777-4652 or email at providerhelpdesk@sandhillscenter.org.

C. Informed Consent

A person receiving services has the right to be informed in advance of the potential risks and benefits of treatment options, including the right to refuse to take part in research studies. The person has the right to consent to or refuse any treatment unless:

- It is an emergency situation;
- The person is not a voluntary patient;
- Treatment is ordered by a court of law;
- The person is under eighteen (18) years of age, has not been emancipated, and the guardian or conservator gives permission.

The Rights noted in this Manual are based on General Statutes 122C Article 3 and the Client Rights Rules, 10 NCAC 27C, 27D, 27E, 27F (APSM 95-2). Sandhills Center reserves the right to have more restrictive policies and procedures than state and federal rules and regulations.

D. What Can I Expect in the Innovations Plan of Care Process?

Medicaid funded services only

1. During the planning process, your Care Coordinator will explain the different services to you and work with you to develop your Plan of Care based on the services you wish to request. Your Care Coordinator will also explain the requirements in the Innovations Waiver around those services.

2. Your Care Coordinator will assure that your Plan of Care will include the services that you want to request, for the length of time that you want to request them. Your Plan of Care should be used to plan for the entire year, and services that you expect to need at any point during that year. If you expect to need services for the entire year, your Care Coordinator will assure that the plan requests those services for the entire year.

3. You must have a signed Plan of Care in order to receive services through the Innovations Waiver. That means that you need to sign a plan containing the level of services that you want to request, which may be different from the level of services that will be approved. Your Care Coordinator will draft the Plan of Care based on your wishes, will review the plan with you before you sign it, will answer any questions you have, and will make any changes to the plan that you request before you are asked to
4. If you wish to change or add services during the plan year, you may ask your Care Coordinator to help you request the change by writing an update to your Plan of Care at any time.

5. You (or your legally responsible representative) will need to sign the Plan of Care once it is complete. You will not be asked to sign a plan that does not contain the level of services that you want to request. If you expect to need those services all year, you will not be asked to sign a plan that does not request those services for the entire plan year.

6. The Care Management/Utilization Management Department of Sandhills Center will determine whether or not the services you request are medically necessary, not your Care Coordinator. A decision on your request for services in your Plan of Care will be made within 15 days unless more information is needed.

7. If any service requested in your Plan of Care is not fully approved (for example, a service is denied or is approved for fewer hours or for a length of time that is less than what you requested), you will receive a written explanation of that decision and information about how you can appeal.

8. Sandhills Center will not retaliate against you in any way if you appeal. Your Care Coordinator can assist you with the forms needed to file an appeal.

9. If some services are approved and some are denied, you can receive the services that were approved while you appeal the services that were denied. You may also make a new request for different services while your appeal is pending, if you wish to do so.

10. Your Plan of Care will include information on the period of time for which services are requested. If services that have been requested in your plan have been approved and then are later reduced, suspended or terminated before the approval period has ended, and you appeal that decision, you may be able to continue to receive services during an appeal. You will receive written notice about that process before any services are reduced, suspended or terminated.

E. Advocacy for Members

Sandhills Center will not prohibit or otherwise restrict a health care professional acting within the lawful scope of practice from advising or advocating on behalf of a member who is his or her patient.

Sandhills Center will not:

- Restrict a provider from advocating for medical care or treatment options including any alternative treatment that may be self-administered.
- Restrict a provider from providing information the member needs in order to decide among all relevant treatment options.
- Restrict a provider from providing information about the risks, benefits, and consequences of treatment or non-treatment options to the member;
- Restrict a provider from providing information to the member about his/her right to participate in decisions regarding his or her healthcare, including the right to refuse treatment, and to express preferences about future treatment decisions.

F. Psychiatric Advanced Directives (PAD)

In 1997, North Carolina developed a way for mental health treatment members to plan ahead for mental health
treatment they might want to receive if they experience a crisis and are unable to communicate for themselves or make voluntary decisions of their own free will. A statutory form for advance instruction for mental health treatment is provided by § 122C-77 of the North Carolina General Statutes. An Advance Directive for Mental Health Treatment allows members to write down treatment preferences or instructions if they have a crisis in the future and cannot make their own mental health treatment decisions.

The PAD is not designed for people who may be experiencing mental health problems associated with aging, such as Alzheimer’s disease or dementia. To address these issues, a general health care power of attorney is used.

A Psychiatric Advance Directives document can include a person’s wishes about medications, ECT, or admission to a hospital, restraints, and whom to notify in case of hospitalization. The PAD may include instructions about paying rent or feeding pets while the member is in the hospital. The member could also put in an advance instruction (e.g., "please call my doctor or clinician and follow his/her instructions.") that way if they are in an emergency room and unable to speak for themselves or confused. These instructions can be used as a means to help them at vital moments.

The member must sign the Advance Directive for mental health treatment in the presence of two (2) qualified witnesses. The signatures must be acknowledged before a notary public. The witnesses may not be the attending physician, the mental health treatment provider, an employee of the physician or mental health treatment provider, the owner or employee of a health care facility in which the member is a resident, or a person related to the member or the member’s spouse. The document becomes effective upon its proper execution and remains valid unless revoked.

If you are assisting a member in completing a Psychiatric Advance Directive, plan on several meetings to thoroughly think about crisis symptoms, medications, facility preferences, emergency contacts, preferences for staff interactions, visitation permission, and other instructions. Remind members to keep a copy in a safe place and provide copies to their family members, treatment team, doctor and the hospital where they are likely to receive treatment.

An Advance Directive can be filed in a national database or register with the North Carolina Advanced Health Care Directive Registry, which is part of the Department of the North Carolina Secretary of State [https://www.sosnc.gov/divisions/advance_healthcare_directives](https://www.sosnc.gov/divisions/advance_healthcare_directives). There is a $10.00 fee to register. The fee includes the registration, a revocation form, registration card and password.

Upon being presented with a Psychiatric Advance Directive, the physician or other provider must make it a part of the person’s medical record. The attending physician or other mental health treatment provider must act in accordance with the statements expressed in the Advance Directive when the person is determined to be incapable, unless compliance is not consistent with G. S. 122C-74(g), i.e. generally accepted practice standards of treatment to benefit the member, availability of the treatments or hospital requested, treatment in case of an emergency endangering life or health, or when the member is involuntarily committed to a twenty-four (24) hour facility and undergoing treatment as provided by law. If the doctor is unwilling to comply with part or all of the Advance Directive, he or she must notify the member and record the reason for noncompliance in the patient’s medical record.

Can a provider refuse to follow an Advance Directive?

Providers must follow the member’s instructions unless:

1. It is the provider’s opinion that the directive is not of benefit to you according to accepted community
practice standards of treatment;
2. The member’s Directives are not available;
3. The member’s Directives are against the law;
4. The member is committed to a 24 hour facility involuntarily and the treating physician and director of clinical services determine that the member’s condition is not likely to improve or the member is likely to harm himself/herself or others before the member has improved.
5. The directive is not an appropriate treatment in the case of an emergency and may endanger the member’s life or health.

If a provider determines part of the member’s advance directive cannot be followed, because of the reasons above, all other parts of the member’s instructions must be followed.

Members can choose someone they trust (like a family member) to make treatment decisions for them if they cannot make the decisions themselves. This surrogate decision maker has Health Care Power of Attorney and functions as an Agent to carry out instructions of PAD.

If the member does not have a PAD, the health care agent must make mental health decisions consistent with what the agent, in good faith, believes to be the wishes of the principal. The health care agent must be competent, at least eighteen (18) years of age, and not providing health care to the member for remuneration. The agent is not subject to criminal prosecution, civil liability, or professional disciplinary action for any action taken in good faith pursuant to an advance instruction.

Under the Health Care Power of Attorney, a person may appoint a person as their health care agent to make treatment decisions. The powers granted by this document are broad and sweeping and cannot be made by a doctor or a treatment provider under NC law.

Find more information and forms for Advance Directives at the following or call Sandhills Center Customer Services Dept. at 1 (800) 256-2452.

Call the Advance Health Care Directive Registry: 1 (919) 807-2167 or write to: Advance Health Care Directive Registry, P.O. Box 29622, Raleigh, NC 27626-0622.

<table>
<thead>
<tr>
<th>Helpful Website Links</th>
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<tbody>
<tr>
<td>DHB website page for Advance Directives</td>
</tr>
<tr>
<td>NC General Statutes web link for Advance Directives G.S. 122C-71 through 77 (Article 3, Part 2)</td>
</tr>
</tbody>
</table>

**G. Confidentiality**

The Network Provider shall ensure that all individuals providing services hereunder will maintain the confidentiality of any and all members and other information received in the course of providing services hereunder and will not discuss, transmit, or narrate in any form any member information of a personal nature, medical or otherwise, except as authorized in writing by the member or his legally responsible person or except...
as otherwise permitted by applicable federal and state confidentiality laws and regulations including N.C.G.S. 122C, Article 3, which addresses confidentiality of all confidential information acquired in attending or treating a member, and 42 CFR, Subchapter A, Part 2, which addresses confidentiality of records of drug and alcohol abuse patients.

Information can be used without consent to help in treatment, for health care operations, for emergency care, and to law enforcement officers to comply with a court order or subpoena. A disclosure to next of kin can be made when a member is admitted or discharged from a facility, but only if the person has not objected.

A minor has the right to agree to some treatments without the consent of his/her parent or guardian:

- For treatment of venereal diseases;
- For pregnancy;
- For abuse of controlled substances or alcohol; and
- For emotional disturbance.

If the member disagrees with what a physician, treating provider, clinician, or case manager has written in their records, the member can write a statement from their point of view to go in the record, but the original notes will also stay in the record for twenty-five (25) years.

If a person applies for a permit to carry a concealed weapon in North Carolina, the person must give consent for the details of mental health and substance abuse treatment and hospitalizations to be released to law enforcement.

Sandhills Center staff and contractors must ensure email encryption when transmitting data with members about their personal or health matters. Sandhills Center uses Zixmail for encryption. Each Provider must ensure encryption prior to transmitting any member related PHI data. If encryption is not available, member related information should be communicated by paper mail, face to face, telephone or over a secure electronic connection.

Confidentiality Rules (ASPM 45-1) were adopted in accordance with General Statute 1504-B.14C. Confidentiality and Privacy Practices are also based on the federal HIPAA regulations that went into effect April 14, 2003.

**H. Second Opinion (Medicaid funded services only)**

A Medicaid member has the right to a second opinion if the person does not agree with the diagnosis, treatment, or the medication prescribed. The Sandhills Center Clinical Operations Department will arrange for a second opinion.

Members are informed of the right to a second opinion in the Sandhills Center’s Member Handbook, which is sent to them when the individual is enrolled.

The role of the Network Provider is to be aware that this is a right of all Medicaid members and refer the Member to the Clinical Operations Department at Sandhills Center if a second opinion is requested.

**Decisions to Deny, Reduce, Suspend, or Terminate a Medicaid Service**

It is very important that providers understand the following rights so they may support the member’s request
or make the request on the member’s behalf (written consent must be shown). If the treating physician/practitioner/provider would like to discuss the case with the Sandhills Center CM/UM Manager or the physician/psychologist, please call 1 (800) 256-2452.

There are times when a member’s request for services is denied, and there are times when a current service is changed (i.e. terminated, reduced or suspended) by Sandhills Center Care Management Utilization Management.

- **Denial:** A denial could occur if the criteria are not met to support a new authorization request for a service. (Please see Section 8 Access, Enrollment and Authorization of Services to see the elements necessary for a proper request.) The Member/Guardian will receive a letter by U.S. Mail explaining this decision and how to request a Reconsideration. During this time, Sandhills Center will not provide the requested service in dispute.

- **Reduction, Suspension, or Termination:** Services a member is currently receiving may be reduced, suspended or terminated based on several different factors including not following clinical guidelines or not continuing to meet medical necessity for the frequency, amount, or duration of a service. The Member/Guardian will receive a letter by U.S. Mail at least ten (10) days before the change occurs explaining how to request a reconsideration. If the Member/Guardian requests a reconsideration by the deadline stated in the letter, the services may continue through the end of your original authorization.

## I. Appeals Process

Appeal rights for denied, reduced, suspended, or terminated services are the right of the member or legal guardian.

An appeal is a request for review of an adverse benefit determination as defined by 42 CFR § 438.400. Adverse benefit determinations that can be appealed are denials or limited authorization of a requested service (including the type or level of service); reductions, suspensions or terminations of a previously authorized service; the denial, in whole or in part, of payment for a service; the failure to provide services in a timely manner, as defined by the State; the failure of Sandhills Center to act within required review or appeal timeframes. The member or legally responsible person may file an appeal for any non-certification decision to deny, reduce, suspend, or terminate services. The provider or another member representative may file an appeal with written consent from the member or legal guardian.

Under North Carolina Medicaid, an individual who disagrees with an adverse benefit determination must first go through the internal appeal process, called a **reconsideration**, before proceeding to a State Fair Hearing through the Office of Administrative Hearings (OAH). The reconsideration outcome is determined by a health care professional who has appropriate clinical expertise in treating MH/SA/IDD conditions but who was not involved in the initial adverse determination nor is the subordinate of someone involved in the initial adverse determination.

For standard reconsiderations, it can take up to 30 calendar days for a reconsideration decision and notification to be made.

Expedited reconsiderations are granted when the standard timeframe could jeopardize the member’s health and safety. For expedited reconsiderations, it can take up to 72 hours for a reconsideration decision and notification to be made.

Members can request a 14-day extension to provide additional information related to the reconsideration. Sandhills Center can also request a 14-day extension to obtain additional information that may be in the member’s
best interest. If Sandhills Center extends the appeal timeframe, written notification will be provided to the member within two calendar days of the decision to extend the timeframe. Members may file a grievance if Sandhills Center extends the reconsideration timeframe.

1. **Filing a Reconsideration Request**

   To request a reconsideration, members must complete and return the reconsideration request by fax, mail, or by bringing the form to Sandhills Center in person. A reconsideration can also be requested over the phone; however, a verbal request **must** be followed-up with a written request (standard appeals only). A provider assisting a member must have written consent to act on his/her behalf during the appeal. Sandhills Center cannot accept a reconsideration request filed by a provider without either member consent or documentation that the member is unable to give consent.

   Members or their representatives have 60 days from the mailing date of the adverse determination letter to make a request for a reconsideration. Members have the right to review any information, including decision criteria that was utilized during the initial review or during the reconsideration process. They may also submit any additional information they believe will support the reconsideration request.

<table>
<thead>
<tr>
<th><strong>By Phone</strong>: 1 (800) 241-1073</th>
<th><strong>In Person</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>By Fax</strong>: 1 (336) 389-6543</td>
<td>201 N. Eugene Street, Suite A</td>
</tr>
<tr>
<td><strong>By Mail</strong>:</td>
<td>Greensboro, NC 27401</td>
</tr>
<tr>
<td>Sandhills Center</td>
<td>Or</td>
</tr>
<tr>
<td>Appeals Coordinator</td>
<td>185 Grant Street</td>
</tr>
<tr>
<td>P.O. Box 9</td>
<td>West End, NC 27376</td>
</tr>
<tr>
<td>West End, NC 27376</td>
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2. **Filing a State Fair Hearing Appeal**

   If a member disagrees with the reconsideration decision, he/she may submit an appeal to the North Carolina Office of Administrative Hearings within 120 days. Prior to being heard by an administrative law judge, the member will be offered the opportunity to participate in mediation. If the member accepts mediation, it must be completed within 25 days of the request. If the member either declines mediation or mediation is unsuccessful, the appeal will proceed to a hearing. If the mediation is successful, Sandhills Center must honor the terms of the mediation agreement.

   Members may represent themselves in the mediation and/or hearing process, hire an attorney, or ask a relative, friend or other spokesperson to speak on their behalf. If a person other than the member or legal guardian represents the member in the hearing process, Sandhills Center will ask for a signed consent to release information.

   After the hearing, an administrative law judge will make a decision regarding the case. Members can appeal the decision of the administrative law judge by filing a petition for judicial review in the superior court of the county of residence. Members must file this petition within 30 days of being served with the written copy of the administrative law judge’s final decision. Members may represent themselves in this process, or they may retain an attorney. If a member disagrees with the decision of the judicial review, he/she may retain an attorney and appeal the case in Superior Court.

3. **Continuation of Benefits**
In compliance with 42 CFR § 438.420, Sandhills Center will continue the member’s services during the appeal process if all of the following criteria are met:

a. The member or member’s representative files the appeal request within 60 days of the postmark (i.e. mailing date) on the adverse determination letter in compliance with 42 CFR § 402 and North Carolina Administrative Code;
b. The appeal involves the termination, suspension, or reduction of previously authorized services;
c. The services were ordered by an authorized provider;
d. The period covered by the original authorization has not yet expired; and
e. The member or member’s representative files for continuation of benefits within 10 calendar days of the postmark (i.e. mailing date) on the adverse determination letter or on or before the effective date of the proposed adverse action.

If the result of the State Fair Hearing is in Sandhills Center’s favor, the member may be financially liable for any services provided during the appeal process.

*It is very important that members read any adverse decision or appeal letters carefully and in their entirety. The letters include important information about deadlines for filing and continuation of benefits. Sandhills Center encourages providers to assist members in reviewing the letters and to either guide them through the appeal process or connect them with a Sandhills Center Appeals Coordinator who can assist them with the appeal process.*

**J. Grievances**

For Consumers: A grievance can be made when you are not satisfied with any aspect of the quality of your care or services (or lack of) for any reason. Your concerns could pertain to any provider or LME/MCO functions or staff.

Reasons for grievances could include such things as:

- The quality of care or services received or Access to any service;
- A disagreement about the service you receive or with the LME/MCO;
- The failure of a provider or LME/MCO to respect a person's rights, privacy or confidentiality;
- A provider or employee of a provider, or LME/MCO being rude, abusive to you, neglected, or exploited in any way.

Grievances can be made either verbally or in writing to any Sandhills Center staff at any time or by calling our Customer Service toll free at 1-800-256-2452; or you can write to Sandhills Center Customer Service, P.O. Box 9 West End, North Carolina 27376. A grievance may also be submitted via Sandhills Center’s website at https://www.sandhillscenter.org/for-consumers/grievance-form. You can also make a grievance in person at the Area office of the LME/MCO located at 185 Grant Street, West End NC 27376. Our staff provides assistance as needed in regards to your grievance.

For Providers: A grievance can be made when:

- You have a disagreement with the LME/MCO (non-utilization review results);
- You have a concern regarding coordination of care with other providers;
- You suspect there is potential fraud and abuse by another provider.
Upon Receipt of a Grievance:

The LME/MCO reviews the grievance and communicates in writing or phone to the grievant within five (5) business days of receipt a grievance has been received and will be investigated.

Grievances are either investigated by Sandhills Center and completed within 30 days or referred out to an external agency for review. For grievances investigated by Sandhills, Sandhills may extend the timeframe for grievance completion by fourteen (14) days if: the member requests the extension; or Sandhills demonstrates to DHB that there is need for additional information and the delay is in the best interest of the member.

When the grievance is referred by Sandhills Center to the State or local government agency responsible for the regulation and oversight of the provider, Sandhills Center will send a letter to the grievant informing him or her of the referral Sandhills Center shall contact the State or local government agency where the referral was made within eighty (80) business days of the date of receipt of the grievance to determine the actions the State or local government agency has taken in response to the grievance.

Appeal Process: If you are dissatisfied with the resolution of your grievant or concern, you may file an appeal by contacting Customer Service toll free at 1-800-256-2452 and the process will be explained to you in detail.

If the grievant is a member or member representative, the appeal must be received in writing within twenty (20) calendar days from the date of the resolution letter.

Sandhills Center will:

1. Convene an appeal review committee; and
   a. Members of this committee are individuals who were neither involved in any previous level of review or decision-making nor a subordinate of any such individual AND who if deciding any grievance, including those regarding denials of expedited resolution of an appeal, are individuals who have the appropriate clinical expertise, as determined by the State in treating the member’s condition or disease.

2. Issue an independent decision after reviewing the appeal review committee's recommendation. The decision shall be dated and mailed to the member or member representative (appellant) by Sandhills Center within twenty-one (21) calendar days from receipt of the appeal.

3. There is no further appeal process (DHB contract Attachment N)

K. Client Rights Committee (CRC)

The CRC has a responsibility to oversee Sandhills Center’s compliance with federal and state rules regarding consumer rights, confidentiality and grievances. The Sandhills Center CRC is made up of members, family members, and expert advisors who meet at least quarterly.

- The Sandhills Center Client Rights Committee reviews and monitors all trends in the use of restrictive interventions, abuse, neglect & exploitation, deaths and medications errors.
- The CRC also makes reports to the Sandhills Center Board of Directors and DHB/DMH.
- The CRC reviews grievances regarding services as an advisor to the Area Director/CEO.
- Members or family members that wish to apply to serve on the Client Rights Committee may call (336) 389-6200.

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L. **Consumer and Family Advisory Committee (CFAC)**

The Consumer and Family Advisory Committee (CFAC) membership consists of members and family members who receive mental health, substance abuse and developmental disabilities services.

The Sandhills Center CFAC has 21 members and represents all nine (9) counties in the Sandhills Center catchment area and all three disability areas. The Consumer and Family Advisory Committee (CFAC) is a self-governing committee that serves as an advisor to the Sandhills Center administration and Sandhills Center Board of Directors.

**Mission Statement:** The Consumer and Family Advisory Committee will recognize the contribution of members and their abilities and perspective through advocating for improvements in quality care; identifying barriers, service gaps and needs as they arise and recommending possible solutions; and be a liaison between the Local Management Entity-Managed Care Organization and the community.

**Vision Statement:** The Consumer and Family Advisory Committee will be an active and constructive partner and participate in state and local mental health system reform. CFAC represents the interests of members and families in the local and state systems of care, participating in the creation and maintenance of a local system in which members and families are an integral part of planning, management and evaluation activities. CFAC provides appropriate feedback to members and their families, the Board of County Commissioners, the LME/MCO and its providers and the State regarding system issues and compliance with the State.

The purpose of the CFAC is to ensure that members are involved in oversight, planning and operational committees of Sandhills Center.

This is accomplished through:

- Membership on the Sandhills Center Board of Directors
- CFAC representation on Sandhills Center operational committees as follows:
  - Network Leadership Council
  - Global Continuous Quality Improvement Committee
  - System of Care
  - Clinical Advisory Committee
  - Client Rights Committee

The Sandhills Center CFAC is self-governing and operates under its own by-laws. It is a strong voice at Sandhills Center and in the community. Members are very active, and are responsible for CFAC initiatives. Most CFAC initiatives are developed in collaboration with various Sandhills Center staff.

Sandhills Center maintains a strong and mutually supportive relationship with CFAC. This ongoing interaction has resulted in important involvement from members and family members across the Sandhills Center LME/MCO area and interaction with staff from across Sandhills Center is instructive for both staff and CFAC members.

The CFAC meets monthly (except December and July) on the third (3rd) Tuesday of the month at 6:15 p.m. Any member, provider, or family member can bring issues of concern to the CFAC’s attention by
calling the CFAC Liaison at 1- (800) 256-2452. CFAC members serve for a maximum of two (2) consecutive three (3) year terms. If providers know of individuals that would like to serve on this committee, please advise them to call the CFAC Liaison for an application at 1-(800) 256-2452.

**M. Customer Services**

The Customer Services Department is the main access point of Sandhills Center with a toll free number of 1 (800) 256-2452. Customer Services staff are responsible for triaging all calls and referring callers to appropriate departments of Sandhills Center. Customer Services staff serve as advocates for individuals and assists members with the appeals and grievances process. The department initiates and assists in activities that promote and support the empowerment of members.

The Customer Services Department participates in community education and the development of educational materials.

**Your Responsibilities as a Sandhills Center Contracted Provider are to:**

1. Assist members in making grievances by completing grievance form on the Sandhills Center website, talking to any Sandhills Center staff, in writing, or by phone at 1 (800) 256-2452.
2. Respond to inquiries from Customer Services Department about member issues and concerns.
3. Publicize and support LME/MCO sponsored opportunities for member training.
4. Facilitate adequate random sampling on state and LME/MCO surveys.
5. Inform Customer Services about events for members in your county.

**N. Limited English Proficiency**

Communication between members and their providers is fundamental for ensuring quality health care and developing trusting relationships. It is an important component of patient satisfaction, compliance, and outcomes. Although challenging for all populations, communication is especially a barrier for limited English proficient (LEP) members, and the lack of accurate oral interpretation with this population results in decreased quality of care, increased errors, greater disparities, and diminished access.

**Accessibility to services is more than getting into a building, it means being able to communicate effectively with the service provider in a way each member can easily understand.**

**Who is a Limited English Proficient (LEP) individual?**

Individuals who do not speak English as their primary language and who have a limited ability to read, speak, write, or understand English can be limited English proficient, or "LEP." Including those individuals who are deaf, hard of hearing, and individuals who speak a language other than English.

These individuals may be entitled to language assistance with respect to a particular type of service, benefit, or encounter.

**What are the relevant laws concerning language access for LEP individuals?**

Federal laws particularly applicable to language access include Title VI of the Civil Rights Act of 1964, and the Title VI regulations, prohibiting discrimination based on national origin, and Executive Order 13166 issued in 2000.
Title VI requires federally funded practitioners to make services linguistically available through translated materials and oral interpreters for members at no cost based in the General Terms and Conditions of your contract.

**Your responsibilities as a provider are, but are not limited to:**

1. Comply with Title VI of the Civil Rights Act of 1964;
2. Discuss with members any requests regarding their care;
3. Provide information the member needs in order to decide among all relevant treatment options;
4. Provide continual education to members regarding their rights and support them in exercising their rights;
5. Maintain on ongoing knowledge of changes to statutes, laws and regulations;
6. Provide information to the member about his/her right to participate in decisions regarding their health care, including the right to refuse treatment and to express preferences about future treatment;
7. Be knowledgeable of and develop procedures to ensure compliance with all statutes, laws and regulations regarding member rights and the use of restrictive interventions and devices;
8. Maintain a Client Rights Committee consistent with regulations in North Carolina’s General Statue and Administrative Code;
9. Provide information to the member about risks, benefits and consequences of treatment or non-treatment options;
10. Respect member’s rights;
11. Advocate for medical care and treatment options;
12. Be aware that requesting a second opinion is a right of all members and refer the member to Customer Services if requested;
13. Respect the wishes expressed in the Advance Directive of the member or other legal document and make it a part of the medical record;
14. Maintain confidentiality of all members and other information received in the course of providing services;
15. Avoid discussing, transmitting, or narrating any member information in any form – personal, medical or otherwise – unless authorized in writing by the member or legally responsible person.

Web links:

https://www.lep.gov/faqs/faqs.html

https://www2.ed.gov/about/offices/list/ocr/ellresources.html

https://www.hhs.gov/civil-rights/for-individuals/special-topics/limited-english-proficiency/index.html

https://ncitlb.org/

https://www.ncdhhs.gov/documents/sign-language-interpretertransliterator-directory

https://catiweb.org/
SECTION 6:  BENEFIT PACKAGE

A.  Eligibility
B.  Who is Eligible for Medicaid Services?
C.  Eligibility for Reimbursement by Sandhills Center
D.  Are Services from all Providers Covered?
E.  Enrollment for Members
F.  Service Definitions
G.  Treatment Planning Case Management
H.  Service Array
I.  Hospital Admissions
J.  Support Services
A. Eligibility

The Provider must not employ any policy or practice that has the effect of discriminating against members on the basis of race, color, or national origin.

B. Who is Eligible for Medicaid Services?

1. The NC MH/DD/SAS Health Plan (1915(b) waiver):

The following criteria must be met for an individual to be eligible for inclusion in the waiver:

a. Individuals must have Medicaid in a covered eligibility group. Covered eligibility groups include:
   1. Individuals covered under Section 1931 of the Social Security Act (TANF/AFDC)
   2. Optional Categorically and Medically Needy Families and Children not in Medicaid Deductible status (MAF)
   3. Blind and Disabled Children and Related Populations (SSI) (MSB)
   4. Blind and Disabled Adults and Related Populations (SSI, Medicare)
   5. Aged and related populations (SSI, Medicare)
   6. Medicaid for the Aged (MAA)
   7. Medicaid for Pregnant Women (MPW)
   8. Medicaid for Infants and Children (MIC)
   9. Adult Care Home Residents (SAD, SAA)
   10. Foster Care Children and Adoption
   12. Medicaid recipients living in ICF-IID Facilities
   13. Work First Family Assistance (AAF)
   14. Refugee Assistance (MRF)(RRF)

b. The individuals Medicaid County of Residence is:
   1. Anson
   2. Guilford
   3. Harnett
   4. Hoke
   5. Lee
   6. Montgomery
   7. Moore
   8. Randolph
   9. Richmond

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

NC Innovations Home & Community Based Waiver 1915(c) (Formerly PBH Innovations Waiver) may be enrolled at an earlier age.
2. The NC Innovations Waiver (1915 (c) waiver):

A person with intellectual disabilities and/or a related developmental disability may be considered for Innovations funding if all of the following criteria are met.

a. The individual is eligible for Medicaid coverage, based on assets and income of the applicant whether he/she is a child or an adult.
b. The individual meets the requirements for ICF-IID level of care as determined by the Sandhills Center Care Management/Utilization Management Department.
c. Lives in an ICF-IID facility or is at high risk for placement in an ICF-IID facility. High risk for ICF-IID institutional placement is defined as a reasonable indication that individual may need such services in the near future (one month or less) but for the availability of Home and Community Based Services.
d. The individual’s health, safety, and well-being can be maintained in the community with waiver support.
e. The individual requires Innovations waiver services.
f. The individual, his/her family, or guardian desires participation in the Innovations Waiver program rather than institutional services.
g. For the purposes of Medicaid eligibility, the person is a resident of one of the nine counties within the Sandhills Center’s catchment area: Anson, Guilford, Harnett, Hoke, Lee, Montgomery, Moore, Randolph, and Richmond counties.
h. The individual will use one waiver service per month for eligibility to be maintained.
i. Effective April 1, 2010, new NC Innovations participants must live with private families or in a living arrangement with six or fewer persons unrelated to the owner of the facility.
j. Qualifies for the Innovations Waiver and has been assigned a waiver “slot”.

C. Eligibility for Reimbursement by Sandhills Center

Members who have their services paid for in whole or in part by Sandhills Center must be enrolled in the Sandhills Center system. If you have any questions about a member’s eligibility, please call Customer Services 1 (800) 256-2452. Individuals who are at 100% ability to pay according to Sandhills Center’s sliding fee schedule or who have insurance coverage that pays 100% of their services, must not be enrolled into the Sandhills Center system. However, the person may still receive and pay for services from a provider independent of Sandhills Center’s involvement. Medicaid and State Funds should be payment of last resort. All other funding options need to be exhausted first.

Members with a Medicaid card from Anson, Guilford, Harnett, Hoke, Lee, Montgomery, Moore, Randolph, and Richmond counties are fully enrolled in the Sandhills Center system are eligible to receive either Basic Benefit Services, Basic Augmented Services, or Enhanced Services, which have been authorized by Sandhills Center.

Providers in Sandhills Center’s Closed Network are not allowed to charge or collect co-payments or deductibles from members receiving Medicaid covered services. Providers are not allowed to charge members for missed appointments.

Members who are not Medicaid eligible are required to provide income verification, which will be used to determine how much they will be required to pay. Providers are required to use Sandhills Center’s sliding fee schedule to calculate the fee. This schedule is based on Federal Poverty Guidelines, Member’s family income, and the number of dependents.
Medicaid regulations prohibit the use of Medicaid funds to pay for services other than General Hospital Care delivered to inmates of public correctional institutions, and Medicaid funds may not be used to pay for services provided for members in facilities with more than 16 beds that are classified as Institutions of Mental Diseases (IMD).

IMDs are hospitals such as the State Facilities because they are more than 16 beds and are not part of a general hospital. Members with private or group insurance coverage are required to pay the co-pay assigned by their insurance carrier.

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

D. Are Services from All Providers Covered?

Sandhill Center will allow use of an out of network service provider/practitioner if there is no appropriate in-network provider/practitioner to meet the member’s needs, with no benefit penalty. Unauthorized services from providers/practitioners not in the Sandhills Center Network are not covered unless it is an emergency. Some services may not be provided at the same time as others. For questions about services, call the Provider/Practitioner Help Desk at 1-855-777-4652 or email providerhelpdesk@sandhillscenter.org.

If a network provider is not available, the member may use a non-network provider with no benefit penalty. Members can contact the Call Center at 1-800-256-2452 if they have questions about a provider outside the Sandhills Center network or about specialty care that is not covered under the Sandhills Center health plan. EQR Recommendation II B.7

E. Enrollment for Members

It is important for all providers to ensure member enrollment data is up to date based on the most current Sandhills Center enrollment procedures and training. These documents can be found in the NC MH/DD/SAS Health Plan Operations Manual and/or under the For Providers section of the Sandhills Center website at https://www.sandhillscenter.org/for-providers/trainings-events/provider-orientation/ and click on “Alpha Provider University”.

If enrollment data is not complete prior to service provision, authorizations and claims may be affected. This could result in denial of authorizations requested and/or claims submitted for reimbursement. (See Section 10 Getting Paid for additional information.)

1. Service Eligibility - Services are divided into multiple service categories:

   a. Basic Services:

      The Basic Benefit package includes those services that will be made available to Medicaid-entitled individuals and, to the extent, resources are available, to non-Medicaid individuals. These services are intended to provide brief interventions for individuals with acute needs. The Basic Benefit package is accessed through Sandhills Managed Care Software System and can be Direct Billed without the submission of a Service Authorization Request (SAR) Form to an enrolled Sandhills Center provider. Once the Billing Process is accomplished, there are no prior authorization requirements for these services. Individuals/Members can access up to twenty-four (24) visits for Adults ages twenty-one (21)
and up and twenty-four (24) visits for ages for Children and Adolescents below age twenty-one (21) from the Basic Benefit package.

b. Basic Augmented Services:

The Basic Augmented Benefit package includes those services that will be made available to Medicaid-entitled individuals and, to the extent, resources are available, to non-Medicaid individuals meeting benefit plan criteria. A member requiring this level of benefit is in need of more than the automatically authorized twenty-four (24) visits in order to maintain or improve his/her level of functioning. An Authorization for the services available in this level will need to be requested through Sandhills Managed Care Software System and the submission of a SAR to Care Management/Utilization Management Department. Authorization is based on the member’s need and medical necessity criteria for the service requested.

c. Enhanced Services:

The Enhanced Benefit package includes those services that will be made available to Medicaid entitled individuals and to non-Medicaid individuals meeting Benefit Plan criteria.

Enhanced Benefit services are accessed through a person-centered planning process. Enhanced Benefit services are intended to provide a range of services and supports that are more appropriate for individuals seeking to recover from more severe forms of mental illness, substance abuse and intellectual and developmental disabilities with more complex service and support needs as identified in the person-centered planning process. The person-centered plan also includes both a proactive and reactive crisis contingency plan. Enhanced Benefit services include services that are comprehensive, more intensive, and may be delivered for a longer period of time.

An individual may receive services to the extent that they are identified as necessary through the person-centered planning process and are not duplicated in the integrated services offered through the Enhanced Benefit (e.g., Assertive Community Treatment). The goal is to ensure that these Individuals’ services are highly coordinated, reflect best practice, and are connected to the person-centered plan authorized by Sandhills Center.

2. Priority Populations:

Priority Population designation is for State-Funded services and for members receiving Medicaid services. The Provider, through review of screening, triage and referral information, must determine the specific Priority Population for the member according to the Division of MH/DD/SA Criteria. Each Priority Population is based on diagnostic and other indicators of the member’s level of need. If the MH/DD/SAS system does not serve these individuals, there is no other system that will serve them. The MH/DD/SAS system is the public safety net and its resources will be focused on those most in need.

Please see the most current version of the NC DMHDDSAS Benefit Plan Eligibility Criteria
Go to the link on the NC DHHS webpage:
https://www.ncdhhs.gov/providers/provider-info/health-care/nctracks/fy2020documents
<table>
<thead>
<tr>
<th>Adult MH Priority Populations</th>
<th>Child MH Priority Populations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual at risk of harming self or others</td>
<td>Individuals at risk of harming self or others</td>
</tr>
<tr>
<td>High Risk individuals (&gt;3 crisis and/or inpatient events in 12 months)</td>
<td>High Risk individuals (&gt;2 crisis, inpatient events in 12 months)</td>
</tr>
<tr>
<td>Individuals with Severe and Persistent Mental Illness, not stable</td>
<td>Youth who experience first episode psychosis</td>
</tr>
<tr>
<td>Individuals with co-occurring MI/SU or MI/DD</td>
<td>Individuals with co-occurring MI/SU or MI/DD</td>
</tr>
<tr>
<td>Homeless or at risk of homelessness</td>
<td>Homeless or at risk of homelessness</td>
</tr>
<tr>
<td>Individuals with TBI</td>
<td>Individuals with TBI</td>
</tr>
<tr>
<td>Criminal or justice system involved</td>
<td>Criminal or juvenile justice system involved</td>
</tr>
<tr>
<td>Deaf and hard of hearing</td>
<td>Deaf and hard of hearing</td>
</tr>
<tr>
<td>Veterans</td>
<td>Dept. of Social Services involved</td>
</tr>
<tr>
<td>Individuals with complex medical disorders</td>
<td>Individuals with complex medical disorders</td>
</tr>
<tr>
<td>DOJ settlement agreement involvement</td>
<td>Individuals living with an adult with MI or SUD</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SUD Priority Populations (Adult &amp; Child)</th>
<th>IDD Priority Populations (Adult &amp; Child)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pregnant women who inject drugs</td>
<td>Homeless or at risk of homelessness</td>
</tr>
<tr>
<td>Pregnant women who use alcohol and/or other drugs</td>
<td>Individuals at risk of abuse, neglect or exploitation</td>
</tr>
<tr>
<td>Individuals who inject drugs</td>
<td>Individuals transitioning from institutions &amp; residential placements</td>
</tr>
<tr>
<td>Dept. of Social Services involved (1)</td>
<td>Deaf and hard of hearing</td>
</tr>
<tr>
<td>Opioid Use</td>
<td>Individuals transitioning from school</td>
</tr>
<tr>
<td>Communicable Disease Risk/HIV</td>
<td>Individuals with complex medical disorders</td>
</tr>
<tr>
<td>Criminal or juvenile justice involved</td>
<td></td>
</tr>
<tr>
<td>Deaf and hard of hearing</td>
<td></td>
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<tr>
<td>Veterans</td>
<td></td>
</tr>
<tr>
<td>Individuals with complex medical disorders</td>
<td></td>
</tr>
</tbody>
</table>

(1) DSS involved adults include individuals receiving Work First cash assistance, individuals who are involved with Child Protective services or individuals who have been convicted of a Class H or I controlled substance felony in NC and who are applicants for or recipients of Food Stamps.

**Benefit Plan List**

- ADSN Adult with Developmental Disability
- AMI Adult with Mental Illness
- AMTCL Adult Transitions to Community Living
- AMVET All Military Veterans and Family Members
- ASCDR Adult Substance Abuse Injecting Drug User/Communicable Disease
- ASOUD Adult Substance Opioid Disorder
- ASTER Adult Substance Abuse Treatment & Engagement
- ASWOM Adult Substance Abuse Women
- CDSN Child with Developmental Disability
- CMSED Child with Serious Emotional Disturbance
- CSSAD Child with Substance Abuse Disorder
- GAP Generic Assessment Payment

**Please note that ALL Diagnoses must be ICD-10 Codes**
3. **Disenrollment of Members**

   When a member changes county of residence for Medicaid eligibility to a county other than SANDHILLS CENTER catchment area, the individual will continue to be enrolled in the NC MH/DD/SAS Health Plan until the disenrollment is processed by the Eligibility Information System at the state. Disenrollment due to a change of residence is effective at midnight on the last day of the month. A member will be automatically dis-enrolled from the NC MH/DD/SAS Health Plan if:

   a. The individual moves to a county other than the Sandhills Center catchment area.
   b. The individual is deceased.
   c. The individual is admitted to a correctional facility for more than thirty (30) days.
   d. The individual no longer qualifies for Medicaid or is enrolled in an eligibility group not included in the NC MH/DD/SAS Health Plan or NC Innovations 1915(b) (c) waivers.
   e. The individual is admitted to a facility that meets the definition of an IMD (Institution for Mental Disease) as set forth in 42 CFR 435.1010 as determined by DHB and is between the ages of 22 and 64.

   **F. Service Definitions**

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

   **G. Treatment Planning Case Management**

   Special Needs Populations are population groups defined by specific diagnostic, functional, demographic and/or service utilization patterns that are indicators of risk and need for assessment to determine need for further treatment. The goal of the Managed Care Waiver is to first identify these individuals and intervene in order to ensure that they receive both appropriate assessment and medically necessary services. Treatment Planning Case Coordination is a managed care tool that is designed to proactively intervene and ensure optimal care for Special Needs Populations. The Treatment Planning Case Coordination function is provided through the Sandhills Center Care Coordination Department.

   Sandhills Center Care Coordinators carry out this function in order to provide necessary support for individuals meeting the criteria defined below. The goal is to ensure that members are referred to and appropriately engaged with providers that can meet their needs, both in terms of MH/DD/SA services as well as medical care.

   **Intellectual and/or Developmental Disabilities:**

   Individuals who are functionally eligible for, but not enrolled in, the Innovations waiver, or who are not living in an ICF-IID facility OR Individuals with an intellectual or developmental disability diagnosis who are currently, or have been within the past 30 days, in a facility operated by the Department of Correction (DOC) or the Department of Juvenile Justice and Delinquency Prevention (DJJDP) for whom the LME/MCO has received notification of discharge.

   **Child Mental Health:**

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

Adults who have a diagnosis within the diagnostic ranges of:
295-295.99 296-296.99 298.9 309.81 AND A Current LOCUS Level of VI

Substance Dependent:

Individuals with a substance dependence diagnosis AND current ASAM PPC Level of III.7 or II.2-D or higher.

Opioid Dependent:

Individuals with an opioid dependence diagnosis AND who have reported to have used drugs by injection within the past 30 days.

Co-Occurring Diagnoses:

a. Individuals with both a mental illness diagnosis and a substance abuse diagnosis AND a current LOCUS/CALOCUS of V or higher, OR Current ASAM PPC Level of III.5 or higher;
b. Individuals with both a mental illness diagnosis and an intellectual or developmental disability diagnosis AND Current LOCUS/CALOCUS of IV or higher;
c. Individuals with both an intellectual or developmental disability diagnosis and a substance abuse diagnosis AND Current ASAM PPC Level of III.3 or higher.

H. Service Array

For a listing of services, please refer to the most current version of the service arrays by benefit level and disability. For Mental Health, Substance Abuse and Developmental Disabilities, further detail can be found in the North Carolina Mental Health/Developmental Disabilities/Substance Abuse Services Health Plan Operations Manual. For the NC Innovations Waiver, further detail can be found in the NC Innovations Technical Guide.

I. Hospital Admissions

DHB is responsible for payment of inpatient hospital services provided to members who are inpatient prior to the effective date of their enrollment in the Medicaid waiver operated by Sandhills Center and until the member is discharged from the hospital. For members hospitalized on or after the effective date of enrollment in the waiver operated by Sandhills Center, Sandhills Center will provide authorization for all covered services, including inpatient and related inpatient services, according to Medical Necessity requirements. Sandhills Center shall provide authorization for all inpatient hospital services to members who are hospitalized on the effective date of disenrollment (whether voluntary or involuntary) until such member is discharged from the hospital.
J. Support Services

1. Interpreter Services

Sandhills Center evaluates the provider network in regards to access and availability of its providers not only for geographic location and distance/travel time, but also for cultural and language needs of members. Network Providers must be able to communicate with limited English proficiency members in their preferred, respective languages.

Language interpretation services must be made available by telephone and/or in person enabling Medicaid members to effectively communicate with Sandhills Center and providers at no cost to the member. TDD (telecommunication devices for the deaf) must also be made available for persons who have impaired hearing or a communication disorder.

For Deaf and Hard of Hearing:

Language Line Language Solutions – Interpreting & translating services -
https://www.languageline.com/fluent_language_solutions

National Association of the Deaf - https://www.nad.org/ has resources for American Sign Language, Civil Rights Laws, Education, Emergency Preparedness, Health Care and Mental Health Services, Senior Resources, telephone relay services, video relay services and many more.

For the Blind:


You can also use our Cultural Competency Resource Booklet located at our website.
https://www.sandhillscenter.org/for-providers/resources/; also in Spanish, just click the link for “Cultural Competency Resource Booklet”.

2. Transportation Services

Transportation services are among the greatest needs identified to assist members in accessing care. It is Sandhills Center’s goal to assist members in accessing generic public transportation. Providers are requested to assist in meeting this need whenever possible. The Department of Social Services in each county has access to Medicaid approved transportation. Transportation is for medical appointments or getting prescriptions at the drug store. Riders have to call two (2) to four (4) days ahead to arrange a ride. There is no fee for members who are enrolled in Medicaid. For those who are not enrolled in Medicaid, transportation depends on available space, and there is a fee.

Assistance with arrangement for transportation to medically necessary treatment services through public and private means must be made available and communicated to Medicaid members.
Listed below are Sandhills Center’s counties for transportation services information. Please be sure to visit the county website or contact the individual county office for specific instructions regarding eligibility, scheduling, confirmations of pick up times, cancellations, hours of operation and more. Some counties have brochures that can be printed.

**Anson**
Phone: 800 735-8262 or (704) 694-2596
TDD/TTY: 800 735-2962
ACTS (Anson County Transportation System)
See brochure: [http://www.co.anson.nc.us/199/Transportation](http://www.co.anson.nc.us/199/Transportation)

**Guilford**
Phone: (336) 641-4848

**Harnett**
Phone: (910) 814-4019
TDD/TTY: 800 799-4889 or 711
HARTS (Harnett Area Rural Transit System)
See Brochure: [http://www.harnett.org/harts/](http://www.harnett.org/harts/)

**Hoke**
Phone: (910) 875-8696
TDD/TTY: 800 735-2962
HATS (Hoke Area Transit Service)

**Lee**
Phone: (919) 776-7201
TDD/TTY 800 735-2962
COLTS (County of Lee Transit System)
See [https://leecountync.gov/Departments/COLTS-Public-Transportation](https://leecountync.gov/Departments/COLTS-Public-Transportation)

**Montgomery**
Phone: (910) 572-3430 or 866 580-8726
TTY: 877 735-8200 or 711
RCATS (Regional Coordinated Area Transportation System)
See Brochure: [http://www.senioradults.org/Transportation.html](http://www.senioradults.org/Transportation.html)

**Moore**
Phone: (910) 947-3389
TTY: 800 735-2962
MCTS (Moore County Transportation Services)
See website & brochure: [https://www.moorecountync.gov/planning-and-transportation/transportation](https://www.moorecountync.gov/planning-and-transportation/transportation)

**Randolph**
Phone: (336) 629-7433 or 866 580-8726
TTY: 877 735-8200 or 711
RCATS (Regional Coordinated Area Transportation System)
See Brochure: [http://www.senioradults.org/Transportation.html](http://www.senioradults.org/Transportation.html)

**Richmond**
Phone: (910) 895-1313
SECTION 7: ACCESS, ENROLLMENT AND AUTHORIZATION OF SERVICES

A. Customer Services Department Description
   1. Clinical Triage & Referral
      a) Access to Services
         1. Routine Services
         2. Urgent Services
         3. Emergent Services

B. Registry of Unmet Needs
C. Eligibility & Enrollment
D. Care/Utilization Management Department Description
E. Prior Authorization for Acute Services
   1. Initial Reviewers
   2. Peer Reviewers
   3. Appeal Reviewers

F. Initial Assessment
   1. Services Authorizations Request Forms (SARs)

G. Initial Authorization
   1. Initial Authorization of Basic Augmented Services
   2. Initial Authorization of Enhanced Services

H. Continued Authorization of Services
   1. Continued Authorization of Basic Augmented Services
   2. Continued Authorization of Enhanced Services

I. Requesting Non-Covered Services
J. Reconsiderations/Appeal Process
K. Discharge Review
L. Utilization Review
A. Customer Services Department Description

1. Health Call Center

The Sandhills Center Customer Services Department is the link for provider, public, and member access to the Sandhills Center System for information, screening, and referral services.

Sandhills maintains a 24-hour 7 days a week telephone access line (800) 256-2452. All incoming calls are answered by a live person within 30 seconds. Customer Service Representatives will screen the urgency of the call and, if appropriate, will refer the caller to a licensed clinician for clinical triage and referral. Customer Service Representatives collect important demographic information such as name, address and contact information to identify the caller and his/her current location in case the call becomes emergent.

Based on the member’s responses, the Customer Service Representative will address the following areas:

- Information about Community Resources;
- Linkage to a Clinician for screening and referral;
- Document grievances or, appeals,
- Transfer calls to the appropriate department for specialized questions;

a. Access to Services

1. Routine Services:

Members who present a clinical level of need at the routine level are given an appointment for services within fourteen (14) calendar days through the clinical triage and referral line. Members are offered a choice of three providers (when available) based on:

1) Availability of service;
2) Proximity to the member and
3) Member’s desired attribute in provider or provider specialty.

2. Urgent Services:

The following criteria are used to determine urgent level of need:

1) The member reports a potential substance use-related problem;
2) The member appears to be at risk for continued deterioration if not seen within 48 hours.

The member is offered a choice of three providers (when available). If no scheduled appointments are available within the mandated time frame, the member will be referred to a walk-in crisis provider. Health Call Center staff will follow up to assure that the member was seen by the provider.

3. Emergent Services:

Members who present a clinical level of need at the Emergent level are required to be seen within two (2) hours, or immediately for life-threatening emergencies. Calls deemed to be emergent are immediately transferred to the Clinical Triage and Referral department via a “warm” transfer process (the member is not put on hold).
Callers are determined to be Emergent if:

1) Real or potential danger to self or others as indicated by behavior, plan, or ideation.
2) The member is labile or unstable and demonstrates significant impairment in judgment, impulse control, and/or functioning

**Access:**

Sandhills Center maintains a telecommunications Clinical Triage and Referral system with a 24 hours per day, 7 days per week access to a licensed clinician. The clinicians provide information and screening, as well as arranging an appointment for the caller, if needed. Sandhills is responsible for timely response to the needs of members and for quick linkage to qualified providers through a 1-800 number and a secure electronic enrollment system. 1 (800) 256-2452.

The Customer Services 1-800 line is staffed by:

- Customer Service Representatives
- Licensed Clinicians
- Eligibility and Enrollment Specialists

**Customer Service Representatives**

These are specially trained staff members who answer the 1-800 line and gather important information including contact information and demographic information. Additionally, they perform a brief risk screening to determine if the caller needs to be immediately transferred to the Call Center licensed clinicians. The Customer Service Representatives can provide information about community resources, take initial grievance and appeal information, or transfer the call to the appropriate department.

**Eligibility and Enrollment Specialists**

The Enrollment and Eligibility Specialists primary responsibilities include verifying Medicaid eligibility, confirming that all enrollment data has been gathered, and processing enrollment of members in the correct benefit plan. A daily Medicaid file is used to update the Medicaid eligibility files.

**Call Center Licensed Clinicians**

The role of the Call Center Licensed Clinician in the Customer Service Department is one of engaging the caller, assessing risk, completing the Screening Triage and Referral (STR) form, scheduling the appointment, interacting with crisis service providers around meeting the member’s needs, and following up on members.

**B. Registry of Unmet Needs**

Registry of Unmet Needs (Not applicable to Medicaid-funded services except for NC Innovations funding):

Sandhills Center ensures a standardized practice of initiating, monitoring and managing a Registry of Unmet Needs for Intellectual/Developmental Disability (I/DD) services that reach capacity as a result of limitations of non-Medicaid funding sources and NC Innovations funding.
1. PROCESS:

a. A Registry of Unmet Needs for I/DD services may be necessary when the demand for services exceeds available resources or when service capacity is reached as evidenced by no available provider for the service needed (This applies to Non-Medicaid Funds and NC Innovation Waiver Funds Only).

b. Standardized monitoring reports are available from Sandhills Finance Department indicating level of funding available for services daily.

c. Reports are monitored by the Finance and the Clinical Operations Departments.

d. Should funding levels reach a predetermined percentage of obligated / projected, the Clinical Management Team is notified and a determination to begin a waitlist process.

e. The I/DD Care Coordination Department maintains a Registry of Unmet Needs for all I/DD services meeting the service capacity or funding limitation criteria listed above.

f. All referrals to the Registry of Unmet Needs for services can be made through the Customer Service Department 1 (800) 256-2452. Referrals will then be transferred to the IDD Care Coordination Department with all available enrollment information.

For additional information on the Registry of Unmet Needs, please call 1 (800) 256-2452. If a Medicaid funded service is needed by a Medicaid recipient, and there is no capacity within the network to provide this service or an alternative agreeable to the member, the service is then sought from an out-of-network provider.

C. Eligibility and Enrollment

Sandhills Center LME/MCO maintains member enrollment information, which includes member demographic data, payer and benefit plan information. The electronic member record keeps an up to date log concerning each member.

A member’s eligibility for enrollment is dependent on their status regarding the following:

1) Residency – For State funded services, the member must be a resident of a county in the Sandhills catchment area (Anson, Guilford, Harnett, Hoke, Lee, Montgomery, Moore, Randolph or Richmond counties).

2) For members who hold a current Medicaid card for a county within Sandhills Center catchment area these members are eligible for medically necessary services based on their Medicaid benefit level.

Enrollment: Please refer to Member Enrollment on the Sandhills Managed Care Software System by utilizing specific login information. If you do not have login information please contact providersupport@sandhillscenter.org and request the login information specific to your provider.

When a provider wishes to enroll a member into Sandhills Center LME/MCO, the following steps should be followed:
a. Utilize Patient Search to verify whether or not the member has a previously assigned record number and is already enrolled in the Sandhills Managed Care Software System.

b. If the member is enrolled, go to the Client Update tab, complete all necessary fields including Clinical Information and submit the Update electronically to Sandhills Center for review and approval if all fields are complete. If additional information is required, the Client Update will be returned to the provider. Once the additional information is completed on the form, the provider resubmits the form.

c. If the member is not enrolled, the provider needs to go to Enrollment and complete all the fields on the form including the Clinical Information and submit to Sandhills Center for review and approval if all fields are complete. If additional information is required, the Enrollment will be returned to the provider electronically. Once the additional information is completed on the form, the provider resubmits the form.

d. When all information is received, the provider will be able to complete the SAR (Service Authorization Request) and/or submit claims. If the provider has any questions, please contact ME&E at 1-800-256-2452.

D. Care/Utilization Management Department Description

The CM/UM Program is managed on a day-to-day basis by the CM/UM Department and is an integral part of the ongoing clinical operations of Sandhills Center. The Sandhills Center CM/UM Program is nationally accredited and all operations, policies, procedures and practice are designed and monitored to ensure the highest standards of performance and compliance to DHBS, accrediting body, federal and state regulations, and contractual obligations and to be reflective of the mission and vision of Sandhills Center.

CM/UM Department’s normal hours of operations are 8:30 a.m. to 5:00 p.m. EST Monday thru Friday. Outside of normal business hours, such as during weekends and scheduled state and federal holidays, CM/UM Department uses an on-call remote access system and staff respond to any authorization or appeals request 24/7/365 including telephonic requests for pre-screening admissions to acute services. CM/UM staff are available to receive and respond to inquiries regarding CM/UM issues during normal business hours via toll free and local telephone numbers that are published on Sandhills Center’s website, in the provider manual, in the member handbook, and in all CM/UM department correspondence.

The majority of contact between providers and CM/UM staff occurs through the electronic information system that is accessible 24/7/365 and is monitored on an ongoing basis during the initial and concurrent review and submission processes.

Specialized telephonic access to CM/UM staff for pre-admission screening for acute services outside of normal business hours is accessed through the Sandhills Center toll free Customer Services number. 1 (800) 256-2452.

CM/UM staff is available during normal business via toll-free telephone numbers. During normal business hours, the phone is answered live. Outside of normal business hours, an automated voice mail system with complete instructions regarding routine and emergency contact is available. It is the requirement and expectation that all CM/UM staff will return all voice mail messages by the next business day for non-emergency CM/UM calls.
CM/UM staff responds to general inquiries regarding CM/UM policies and procedures and decision making as needed and frequently asked and answered questions are available on Sandhills Center’s website under the “For Providers” tab. Upon request, printed documentation is also available.

Final approved policies, procedures and criteria are shared with network practitioners and providers through initial and ongoing orientation, training, updates, and postings as well as publication in the provider manual, on the Sandhills Center’s website and through assimilation by the Clinical Advisory Committee and the Network Leadership Council. Specific questions related to policies and procedures, clinical criteria and decision support tools are answered through the Provider Help Desk or by Care Management/Utilization Management staff. This includes requests received from practitioners and providers to receive the criteria by mail when they do not have fax, email, or internet access. Criteria are made available to practitioners and providers upon request.

The CM/UM Department has full time staff to include Sandhills Center Chief Medical Officer/Chief Clinical Officer, CM/UM Director, CM/UM Manager and Masters Level Independently Licensed Reviewers as well as delegated contracted staff staffed by PREST - a nationally accredited URAC external utilization review organization.

The Chief Medical Officer/Chief Clinical Officer has overall responsibility for the clinical oversight of the CM/UM Department and is available on a daily basis to provide consultation and direction to staff as well as to consult with providers as needed. The Chief Medical Officer/Chief Clinical Officer has responsibility to review and approve all CM/UM policies and procedures, protocols, criteria and decision support tools and provides formal weekly supervision to CM/UM staff.

The CM/UM Department contracts with a nationally renowned URAC accredited external peer review organization, PREST for some peer and most appeals reviews. PREST utilizes board certified North Carolina licensed physicians to perform peer review and appeals utilization management functions.

PREST performs these functions under a delegated contract that is reviewed on an ongoing basis for contractual compliance, performance and quality by the Sandhills Center Chief Clinical Office/Medical Director and is formally reviewed and approved annually by Sandhills Center Committees.

Numerous Sandhills Center Committees and sub committees support and oversee the functions and responsibilities of the CM/UM Department including the internal Clinical Leadership Team, the external Clinical Advisory Committee, the CM/UM Committee and the Quality Management Committee.

The role of these committees are to oversee and monitor the Care Management / Utilization Management structure, process and related activities to ensure members have prompt access to all relevant covered services according to member need, choice, medical necessity and established and emerging best practices. Through the review and analyses of single member, population specific and aggregate data, the CM/UM Committee monitors and evaluates to ensure all members receive culturally competent, relevant medically necessary services that are aligned with evidence-based and best practice guidelines.

CM/UM Department is an integral part of Sandhills Center clinical operations and as such interfaces with all core and support departments and programs.

CM/UM Department works in synchronization primarily with Care Coordination Department as well as the other accredited departments, Customer Services, Network Operations and Quality Management to ensure the fulfillment of Sandhills Center’s mission of effectively serving all members that are foremost in our culture.
Particular emphasis is levied to collaborate with the Care Coordination Department to ensure members are appropriately and promptly identified for care coordination services when needed. The CM/UM and Care Coordination Departments have developed sets of criteria to first identify and then communicate member need and multi-system involvement including collaboration with CCNCs and primary care providers. Care Coordination aids in the tracking of the use of evidence-based and best practice treatment for the improvement of the lives of the recipients of services.

Sandhills Center does not encourage barriers to care and service, and affirms the following:

1. Care Management/Utilization Management decision making is based only on appropriateness of care and services and existence of coverage.

2. Sandhills Center does specifically reward practitioners or other individuals for issuing denials of coverage or services.

3. Sandhills Center does not employ financial incentives for reimbursement or bonuses to CM/UM decision makers that encourage decisions resulting in underutilization.

E. Prior Authorization for Acute Services

Sandhills Center does not perform Prior Authorizations for Acute Services. The expectation is that, should a member present in a crisis at an acute care setting and the acute care provider determines it to be a medical necessity for an admission into the hospital for treatment, the provider should move with dispatch to admit the member and have up to 48 hours to electronically submit an authorization request to Sandhills Center’s CM/UM Department.

However, for members who are being hospitalized in a State Hospital, the assessing clinician at the Acute Care location (whether they be clinicians assigned to the Mobile Crisis Team or contracted clinicians who are on call to perform assessments at these Acute Care locations) are required to call Sandhills Center’s 24/7/365 Customer Services Access Line, 1 (800) 256-2452, to receive an administrative only Tracking/Authorization Number for that admission in the amount of seven (7) days for members who are enrolled with Sandhills Center or reside within Sandhills Center’s catchment area or provide one (1) day if they reside outside our catchment area.

Thereafter any requests for continued stay beyond the established criteria, the Service Authorization Request (SAR) must be electronically submitted to Sandhills Center’s CM/UM Department.

Concurrent Authorizations for Acute Services:

Concurrent authorizations for acute services are submitted electronically on the SAR. Concurrent reviews for acute services are reviewed on expedited time frames with a concurrent care decision being rendered within 24-72 hours within normal business hours.

1. Initial Reviewers

CM/UM initial reviewers are masters level independently licensed clinical care managers with generalized experience, expertise and training in the populations served and covered services array. During the initial review, the initial reviewers conduct a pre-screening review to determine member
eligibility, service eligibility, and completion of the Service Authorization Request (SAR) and the inclusion of all required documentation.

If there are problems at pre-screening review, the authorization is deemed “unable to process” and the provider will need to submit a new authorization request with all valid and required data to begin the initial review again.

If the authorization passes pre-screening review, CM/UM initial reviewers initiate the first or initial clinical review. The initial reviewer reviews the Service Authorization Request (SAR), the SAR data elements and all submitted documentation, and applies the appropriate criteria and clinical decision support tools to determine medical necessity. If medical necessity criteria are met, the request is authorized and information is communicated to the provider.

If there is evidence that medical necessity is not met, then the authorization is deemed “unable to authorize” and referred to peer reviewer for next clinical review. Detail of this decision and next steps are communicated to the provider.

2. Peer Reviewers

CM/UM peer reviewers are independently licensed behavioral health professionals -with a minimum of a master’s level degree and many with post-masters, doctorate (PhD, PsyD and/or EdD) or medical degrees (MD or DO) with advanced certification and board certification in specialties that are population and service specific. The peer reviewer must have expertise, experience and training in the population and service to be reviewed and have a licensure that is comparable or greater than that of the requesting provider. The peer reviewer is never the same individual that conducts the initial clinical review.

During the peer review, the peer reviewer reviews the initial reviewer’s documentation, the provider’s Service Authorization Request (SAR), originally submitted documentation (PCP, assessment and progress notes if included) as well as any additional information submitted by the provider or member. The peer review may also include a conversation with the requesting provider most often conducted telephonically. If medical necessity criteria are met, the peer reviewer authorizes the request and this is communicated to the provider.

If there is evidence that medical necessity is not met, then the authorization is given a “non-certification” care decision. If the peer reviewer was not a MD or DO, then the non-certification decision is reviewed by an MD prior to the issuance of a final denial decision. The final peer review decision is communicated to the provider. Written notification of a denial is sent to the member along with instructions on the filing of an appeal.

3. Appeal Reviewers

CM/UM appeals reviewers are independently licensed behavioral health professionals with medical degrees and advanced certification and board certification in specialties that are population and service specific. The appeal reviewer must have expertise, experience and training in the population and service to be reviewed and have a licensure that is comparable or greater than that of the requesting provider. The appeal reviewer is never the same individual that conducts the peer review and is not a subordinate of the peer reviewer.
Sandhills Center CM/UM Department contracts with a nationally renowned URAC accredited external peer review organization, PREST, to conduct its appeals. PREST utilizes board-certified North Carolina licensed physicians to perform appeals review. PREST performs these functions under a delegated contract that is reviewed on an ongoing basis for contractual compliance, performance and quality.

The appeals process can be completed on an expedited or standard time frame.

**F. Initial Assessment**

1. **Service Authorization Request Forms:**

Sandhills Center has formulated a Service Authorization Request form (SAR) that captures both demographic and clinical information. When this form is completed thoroughly, the CM/UM Care Manager will be able to use this form to make the clinical determination required to meet the member’s needs. If the form is not completed including all clinical information required, the SAR will be labeled as “Unable to Process” and the Provider notified that they need to submit a complete request.

An instruction manual on how to electronically submit a SAR and additional information is available for review by going to Sandhills Center website and clicking on the following link [https://www.sandhillscenter.org/for-providers/trainings-events/provider-orientation/](https://www.sandhillscenter.org/for-providers/trainings-events/provider-orientation/), then go to “Alpha Provider University”. Any provider can request specific technical assistance on SAR submission by contacting the Sandhills Center Provider Help Desk at 1 (855) 777-4652.

**G. Initial Authorization**

Sandhills Center is prohibited from implementing utilization management procedures that provide incentives for the individual or entity conducting utilization reviews to deny (reduce, terminate, or suspend), limit, or discontinue medically necessary services to any member. Utilization management decision making is based only on appropriateness of care and the existence of coverage. Sandhills Center does not specifically reward practitioners or other individuals for issuing denials of coverage or services. Financial incentives for utilization management decision makers do not encourage decisions that result in under-utilization.

The purpose of this process is to identify the steps required in performing prior authorization of services. Prior authorization of services is the responsibility of Sandhills Center’s CM/UM Department. Requesting the prior authorization is the responsibility of the provider.

**NOTE:** For a full listing of all State Medicaid Plan Service Definitions and Clinical Coverage Criteria, follow the link [https://medicaid.ncdhhs.gov/providers/clinical-coverage-policies/behavioral-health-clinical-coverage-policies](https://medicaid.ncdhhs.gov/providers/clinical-coverage-policies/behavioral-health-clinical-coverage-policies)

**Process for Prior Authorization of Services:**

To remain consistent with the Division of Health Benefits (DHB) guidelines, the Sandhills Center CM/UM Department is only able to make formal decisions (approval, denial, or extensions when appropriate) when a complete request is received. For a request to be considered “complete”, it must contain the following elements:

1. Completed SAR which constitutes a service request and starts the timeline for review;
2. Individualized Service Plan/Person Centered Plan (if applicable). This document alone does not initiate a request for service. If a SAR is received and request a service or frequency that is different from the ISP/PCP, the Sandhills Center CM/UM Department will deem the SAR as an incomplete request, label as “Unable to Process” and the Provider notified. If a SAR is received that requires a corresponding ISP/PCP and one is not submitted, this will also be deemed as an incomplete request, labeled as “Unable to Process” and the Provider notified.

3. Level of Care form (I/DD services) Note: Request an original carbon copy document from Sandhills Center;

4. North Carolina Support Needs Assessment Profile (NCSNAP) / Supports Intensity Scale (SIS) (I/DD services);

5. Service Order (when necessary);

6. Certificate of Need (CON) (when necessary);

7. Other documentation as requested.

1. Initial Authorization of Basic Augmented Services

a. For those members whose needs require more than the automatically authorized sessions to maintain or improve his/her level of functioning, the provider is required to submit a request for prior authorization before the use of any unauthorized service date (e.g., outpatient services: this would be prior to the 24th visit for adults twenty-one (21) and older / prior to the 24th visit for children under twenty-one (21)).

b. Prior authorization for all Basic Augmented services may be requested through submission of the Service Authorization Request (SAR) form through the Sandhills Managed Care Software System.

c. Appropriate documentation will need to be included in this request to include (but not be limited to) Person Centered Plan (PCP)/Individualized Support Plan (ISP), Service Order, etc.

d. The CM/UM Department staff will review the request and make a care determination.

e. Any denial of service will follow the Medicaid Appeals process for Medicaid services.

f. All determinations and related actions will be recorded in the Sandhills Managed Care Software System.

2. Initial Authorization of Enhanced Services

NOTE: Enhanced services will be authorized through the review of the SAR and approved Person Centered Plan as submitted by the provider. Services will be identified through the Person Centered planning process in a coordinated effort between (at a minimum) the member, the Member’s family and Provider.

a. Enhanced level services needing immediate authorization should be submitted to the Sandhills Center CM/UM Department electronically as a Service Authorization Request (SAR). Additional documentation should also be submitted as deemed necessary on the CM/UM Master Grid that is located on the Sandhills Center website at https://www.sandhillscenter.org/for-providers/provider-forms/ and click on “Sandhills Center UM Services Grid” under Care/Utilization Management.

b. CM/UM Department staff will review the submitted request for completion and medical necessity.

c. All CM/UM actions are documented in Sandhills Managed Care Software System.
d. If the PCP/ISP and SAR is not complete, the request will be labeled as “Unable to Process” and the provider notified of the reason for not processing the request.

e. The provider will update/complete a new SAR and submit for approval.

f. All versions of the document will be maintained in the Sandhills Managed Care Software System.

g. If the initial request for authorization of services is approved, the provider will be notified in Sandhills Managed Care Software System.

h. If the initial request for authorization of services is not authorized, the peer review process will be utilized and the provider will be notified in Sandhills Managed Care Software System. For acute/urgent service requests, the provider will also be notified by telephone.

i. Any denial of service will follow the Medicaid Appeals process for Medicaid services.

**H. Continued Authorization of Services**

1. Continued Authorization of Basic Augmented Services

a. The anticipated next review date is indicated in Sandhills Managed Care Software System. It is the provider’s responsibility to submit a request for continued stay/concurrent authorization to Sandhills Center’s CM/UM Department prior to the expiration of the current authorization.

b. The request for additional services must be made no earlier than thirty (30) calendar days and no later than fifteen (15) calendar days before the current service authorization expires. In acute situations, it is recommended that, the concurrent review should be conducted at least forty-eight (48) hours prior to the expiration of the current authorization. CM/UM Care Manager refers to the Authorization Guidelines to determine when concurrent reviews should be conducted for each level of care.

c. If the provider indicates that the member requires additional care at that level, the CM/UM Care Manager will conduct a clinical review and possibly additional information (i.e., updated ISP/PCP, clinical notes, etc.). When it is received, the CM/UM Care Manager will review the information.

d. Based on a review of the information provided, the CM/UM Care Manager will make a care decision according to the following:

   i. If the member's condition continues to meet concurrent/continued stay clinical criteria for the current level of care, the CM/UM Care Manager will authorize the care within the guidelines applicable to the requested level of care and generate an authorization.

   ii. If the member's condition no longer meets the concurrent/continued stay clinical criteria for the current level of care, the CM/UM Care Manager advises the provider and the peer clinical review process will be initiated.

e. Any denial of service will follow the Medicaid Appeals process for Medicaid services.

f. All determinations and related actions will be recorded in Sandhills Managed Care Software System.
2. Continued Authorization of an Enhanced Service:

a. The anticipated next review date is indicated in Sandhills Managed Care Software System. It is the provider’s responsibility to submit a request for continued stay/concurrent authorization to Sandhills Center’s CM/UM Department prior to the expiration of the current authorization.

b. The request for additional services must be made no earlier than thirty (30) days and no later than fifteen (15) days before the current service authorization expires. In acute situations, it is recommended that the concurrent review should be conducted at least forty-eight (48) hours prior to the expiration of the current authorization. The CM/UM Care Manager refers to the Authorization Guidelines to determine when concurrent reviews should be conducted for each level of care.

c. If the provider indicates that the member requires additional care at that level, the CM/UM Care Manager will conduct a clinical review and possibly additional information (i.e., updated ISP/PCP, clinical notes, etc.). When it is received, the CM/UM Care Manager will review the information.

d. Based on a review of the information provided, the CM/UM Care Manager will make a care decision according to the following:

i. If the member's condition continues to meet concurrent/continued stay clinical criteria for the current level of care, the CM/UM Care Manager will authorize the care within the guidelines applicable to the requested level of care and generate an authorization.

ii. If the member's condition no longer meets the concurrent/continued stay clinical criteria for the current level of care, the CM/UM Care Manager advises the provider and the peer clinical review process will be initiated.

e. Any denial of service will follow the Medicaid Appeals process for Medicaid services.

f. All determinations and related actions will be recorded in the Sandhills Managed Care Software System.

I. Requesting Non-Covered Services (Medicaid Only)

Requests for new services that have not previously been approved are reviewed with Sandhills Center Clinical Leadership Team and the Medical Director. The Medical Director makes a recommendation to the LME/MCO Director regarding service provision. Members or providers can submit the Non-Covered Services Request Form provided on our website for consideration of new services or technologies. See Sandhills Center link: https://www.sandhillscenter.org/for-providers/provider-forms/.

J. Reconsiderations/Appeals Process (Medicaid Only)

Under The NC MH/DD/SAS Health Plan (1915(b) waiver) and the NC Innovations (Home & Community Based) Waiver (1915(c) waiver), all persons who do not agree with Sandhills Center’s Notice of Decision on a request for Medicaid services are entitled to a Reconsideration Review through the Sandhills Center Reconsideration Review process.

To request a Reconsideration Review, the member/member’s legal representative must complete and return the Reconsideration Request Form by fax, mail, verbally over the phone, or by bringing the form to Sandhills Center in person. The member/member’s legal representative has sixty (60) days from the date of notification.
to request a Reconsideration Review. During a Reconsideration Review, member/member’s legal representative and anyone they choose may represent them. Sandhills Center may request that a release of information be completed. Member/member’s legal representative has the right to review any information that was utilized as part of the Reconsideration process. They may also submit any additional information they feel supports the level of service(s) being requested.

**Exception:** For decisions involving a reduction, termination or suspension of authorized services, a member/member’s legal representative may be able to have his or her services continue during the appeal. This process is called “Continuation of Benefits”. It does not apply if Sandhills Center’s decision is a denial of an initial request or a concurrent request that has had a break in service of more than (one) 1 calendar day. In order to continue with existing services during the appeal process, the member/member’s legal representative must request a Reconsideration Review within ten (10) days of the date of the Notification letter and indicate that he or she wants his or her services to continue. The services may then be able continue until the end of the original authorization period as long as the member remains Medicaid eligible. The Notice of Decision letter sent to the member will explain how this “Maintenance of Service” may be able to occur. This right to receive services applies even if the member changes providers. The services may be provided at the same level the Member was receiving the day before the decision or the level requested by the member’s provider, whichever is less. The services that continue must be based on the member’s current condition and must be provided in accordance with all applicable state and federal statutes, rules, and regulations.

If the final resolution of the Appeal is not decided in the member’s favor (that is, Sandhills Center’s or DHHS’s action was upheld), Sandhills Center may recover the cost of the services furnished to the member while the Appeal was pending. **This does not apply for the denial of an initial service request.**

A Sandhills Center Reconsideration Review is a local impartial review of Sandhills Center’s decision to reduce, suspend, terminate or deny Medicaid services. The Reconsideration Review Decision is determined by a health care professional who has appropriate clinical expertise in treating the member’s condition or disorder and was not previously involved in the Sandhills Center initial, adverse decision.

The Reconsideration Review will be completed within thirty (30) days, with a possible extension of up to an additional fourteen (14) days, after Sandhills Center receives a request for a Reconsideration Review. This Reconsideration Review process must be completed before the member can request a hearing with DHHS and OAH.

**a. Steps to file a Reconsideration Review Request.**

To request a Sandhills Center Reconsideration Review, the member/member’s legal representative must complete and return the Sandhills Center Reconsideration Review Request Form by one of the following methods:

- Fax 1 (336) 389-6543
- Mail or in person (Sandhills Center Medicaid Appeals Coordinator at P.O. Box 9; West End, NC 27376); or
- Verbally by Phone 1 (800) 241-1073

Upon completion of the Reconsideration Review decision, if the member/member’s legal representative disagrees with the decision, the member/member’s legal representative can then Appeal the decision to both DHHS and the Office of Administrative Hearing (OAH) by filing a Request for a State Fair Hearing.
Notification of this process will be mailed out to the member along with the Reconsideration Review determination.

b. Expedited Reconsideration Review Process

An Expedited Reconsideration Review may be requested by the member/member’s legal representative, if it is indicated that taking the time for a standard Reconsideration Review could seriously jeopardize the member’s life, health, or ability to attain, maintain, or regain maximum function. A Reconsideration Review will be completed within seventy-two (72) hours and the member will be notified of the decision. If the member/member’s legal representative disagrees with the Reconsideration Review determination, the member/member’s legal representative can then Appeal the decision to DHHS and the Office of Administrative Hearing (OAH) by filing a Request for a State Fair Hearing. Notification of this process will be mailed out to the member along with the Reconsideration Review determination.

c. Mediation

Once the Appeal form is processed, the Mediation Network of North Carolina will contact the member/member’s legal representative to offer an opportunity to mediate the disputed issues in an effort to informally resolve the pending Appeal. Mediation should be completed within twenty-five (25) days of the request. If the issues are resolved at mediation, the appeal will not continue, and Sandhills Center and the member must honor the terms of the Mediation Agreement. If member/member’s legal representative does not accept the offer of mediation or the results of mediation, the case will proceed to a hearing and will be heard by an Administrative Law Judge with the Office of Administrative Hearings.

d. State Fair Hearing Process

If the Reconsideration Reviewer upholds Sandhills Center’s original care decision, the member/member’s legal representative may file a request for a State Fair Hearing as the next step of the appeal. The member/member’s legal representative must file their appeal with the North Carolina Office of Administrative Hearings (OAH), Department of Health and Human Services and Sandhills Center within one hundred twenty (120) days from the date of the Reconsideration Review decision to the addresses listed on the form.

This state level hearing is conducted by an Administrative Law Judge (ALJ) at the Office of Administrative Hearings (OAH). The hearing is scheduled to occur by telephone unless member/member’s legal representative requests to attend in person. The member/member’s legal representative will receive notice of the date, time and location of the hearing. The hearing will be scheduled at the member/member’s legal representative convenience in a location close to the member/member’s legal representative. The member/member’s legal representative may represent themselves in this process, ask a relative, friend or spokesperson to speak for them, or may hire an attorney to represent them during the Appeal process. The member/member’s legal representative has a right to receive a copy of all documents relevant to the Appeal. An Administrative Law Judge will issue a decision regarding the Member’s/Member’s Legal Representative’s case. If the member/member’s legal representative disagrees with this decision, they may then ask for a judicial review in Superior Court.
Member’s Responsibility for services furnished while the Appeal is pending:

If the final resolution of the Appeal is not decided in the members’ favor (that is, Sandhills Center’s or DHHS’s action was upheld), Sandhills Center may recover the cost of the services furnished to the member while the appeal was pending.

K. Reconsiderations – State Funds

Non-Medicaid Service Appeal Process

Non-Medicaid Service Decisions due to termination, reduction, suspension or denial of Non-Medicaid services are handled within the Utilization Management Department, rather than Customer Services or Quality Management.

If member/guardian disagrees with the Non-Medicaid Service Decision, he/she may request an appeal of the decision by completing the Appeal Request Form. This form will need to be completed and sent back to the Sandhills Center Utilization Management Department along with a copy of the Non-Medicaid Decision within fifteen (15) days from the decision date. The Appeals Coordinator will send out an acknowledgement of receipt of the appeal request.

The member will receive an Appeal Decision conducted by a health care professional that has appropriate clinical expertise in treating the member’s condition or disorder.

Following receipt of the request for a “standard” appeal, the Utilization Management Program has thirty (30) calendar days to conduct a review of an appeal and issue a written notification of the appeal determination. State regulations stipulate the appeal request must be in writing, by the member or the member’s legal representative. The Utilization Management Program may assist members in filing a written appeal. Instructions for requesting a written appeal, including where and to whom to send the appeal are included in the peer review notification of non-certification. Notification also includes the time frames in which a member has to request an appeal. The appeal time frame starts when the Utilization Management Program or the Sandhills Center organization receives the written request by the member and/or the member’s legal representative.

Members may appeal upheld denials externally to the State Division of Mental Health, Developmental Disabilities and Substance Abuse Services Non-Medicaid Appeals Panel. (10A NCAC 27I.0601 and G.S. 143B-147(a) (9). A panel of individuals designated by the NC MH/DD/SAS reviews the Non-Medicaid Appeal Request to DHHS. The panel will issue their recommendations to both the member / guardian and Sandhills Center CEO. Sandhills Center will then issue the Final Decision in writing within ten (10) days from the receipt of the panel’s recommendations. This decision is final and there are no further appeal rights as set forth in N.C. G.S. 143B-147(a) (9).

A member in the NC MH/DD/SAS Health Plan or guardian may submit additional information that he/she feels supports the request. All information should be faxed or mailed to the Sandhills Center Utilization Management Department with the Appeal Request form. A member / guardian may speak for him / herself or be represented by an attorney, representative or other spokesperson.

Note: Non-Medicaid services are not an entitlement.
**Expedited Appeal Process**

An Expedited appeal may be requested by the member / guardian or legal representative on the member’s behalf, if it is indicated that taking the time for a standard resolution could seriously jeopardize the member’s life or health or ability to attain, maintain, or regain maximum function.

Expedited appeals provide members with a disposition within seventy-two (72) hours for a final decision and verbal notification and three (3) calendar days for written notification. The written notification includes the appeal decision. If the decision is to uphold non-certification, the principle reason(s) for the upheld denial is / are included, as is information regarding the securing of additional clinical rationale as well as instructions regarding further appeals rights.

Members may appeal upheld denials externally to the State Division of Mental Health, Developmental Disabilities and Substance Abuse Services Non-Medicaid Appeals Panel (10A NCAC 27I.0601 and G.S. 143B-147(a) (9).

**RECEIVING SERVICES DURING THE NON-MEDICAID APPEAL PROCESS:**

Sandhills Center has the option of authorizing other Non-Medicaid Services that are appropriate. The duration of the authorization will be noted in the Sandhills Center Software Management System. Services may be authorized for the duration of the Appeal process at the discretion of Sandhills Center. Other community resources may also be referred to the member for support.

Note: When a member/guardian requests an appeal for the denial of a new service, Sandhills Center is under no obligation to provide the requested service during the Appeal process.

**Disability Rights North Carolina's (toll free 877-235-4210)**

**Grievances**

The provider must have a Grievance process to address any concerns of the member and the member’s family related to the services provided. The provider must keep documentation on all grievances received including date received, points of grievances, and resolution information. Any unresolved concerns or grievances should be referred to Sandhills Center.

The provider’s Grievance process must be provided to all members and families of members upon admission and upon request. The provider must advise members and families that they may contact Sandhills Center directly about any concerns or grievances.

Sandhills Center’s Customer Services Line (800) 256-2452 must be published and made available to the member and family members along with the Governor Advocacy Council’s Telephone number.

Sandhills Center may also receive grievances directly about a provider’s services or staff. Based on the nature of the grievances, Sandhills Center may choose to investigate the grievance in order to determine its validity. Investigations may be announced or unannounced. It is very important that the provider cooperate fully with all investigative requests.

Refusal to comply with any grievance follow-up or investigation is a breach of contract. It is important to understand that this is a serious responsibility that is invested in Sandhills Center, and that we must take all grievances very seriously until we are able to resolve them. Sandhills Center management of grievances
is carefully monitored by DHB/DHHS and Sandhills Center maintains a database where all grievances and resolutions are recorded.

Sandhills Center maintains documentation on all follow up and findings of any grievance investigation and a written summary will be provided to the provider. If problems are identified, the provider may be required to complete a plan of correction.

L. Discharge Review

Discharge planning begins at the time of the initial assessment and is an integral part of every member’s treatment plan regardless of the level of care being delivered. The discharge planning process includes use of the member’s strengths and support system, the provision of treatment in the least restrictive environment possible, the planned use of treatment at varying levels of intensity, and the selected use of community services and support when appropriate to assist the member with functioning in the community.

Involvement of family members and other identified supports, including members of the medical community, requires the member’s written consent. The purpose of this process is to identify the steps to be taken by the Care Management/Utilization Management Care Manager in assisting with Discharge Planning Efforts.

PROCESS:

1. The Care Management/Utilization Management Care Manager reviews the status of the discharge plan at each review to assure that:
   - A discharge plan exists;
   - The plan is realistic, comprehensive, timely and concrete
   - Transition from one level of care to another is coordinated;
   - The discharge plan incorporates actions to assure continuity of existing therapeutic relationships;
   - The member understands the status of the discharge plan;

2. When the discharge plan is lacking in any respect, the Care Management/Utilization Management Care Manager addresses the relevant issues with the provider.

M. Utilization Review

The primary function of the CM/UM Department is to monitor the utilization of services and review utilization data to evaluate and ensure:

i. Services are being provided appropriately within established benchmarks and clinical guidelines;
ii. Services are consistent with the authorization and approved PCP/ISP; and
iii. Established penetration goals are maintained.

Utilization review is an audit process that involves a review of a sample of services that have been provided. Information from the member’s record (assessment information, treatment plan and progress notes) is evaluated against medical necessity criteria. This is done initially (during prior authorization), concurrently (during re-authorization) and retrospectively (after the service has been provided). The outcome of this review can indicate areas where provider training is needed, services that were provided that did not meet medical necessity, and situations where the member did not receive appropriate services or care that was
needed. Indicators will be identified to select cases for review, such as high utilization of service, frequent hospital admissions, etc., as well as random sampling of other events. Sandhills Center utilizes both Focused Utilization Review and a sampling process across Network Providers in its utilization review methodologies.

a. **Focused Reviews** will be based on the results of Monitoring Reports that identify outliers as compared to expected/established service levels or through specific cases identified in the Sandhills Center clinical staffing process to be found outside the norm. Focused samples may include:

i. **High-Risk Members** - Examples may include, but are not limited to, members who have been hospitalized more than one time in a 30-day period; developmentally disabled members as identified in the North Carolina Support Needs Assessment Profile (NCSNAP); children and youth with multiple-agency involvement; or active substance use by a pregnant female.

ii. **Under-Utilization of Services** – Examples may include, but are not limited to, members who utilize less than 70% of an authorized service or members who have multiple failed appointments.

iii. **Over-Utilization of Services** – Example: members who continue to access crisis services with no engagement in other services.

iv. **Services infrequently utilized** – Example: an available practice that is not being used.

v. **High-Cost Treatment** – Members in the top 10% of claims for a particular service.

b. **Routine Utilization Review** will focus on the efficacy of the clinical processes in cases as they relate to reaching the goals in the member’s ISP/PCP. Sandhills Center will also review the appropriateness and accuracy of the service provision in relation to the authorizations. All providers contracted with Sandhills Center who currently serve Sandhills Center members are subject to utilization reviews to ensure that clinical standards of care and medical necessity are being met. A routine utilization review will be inclusive of, but not limited to, evaluations of services across the delivery spectrum; evaluations of members by diagnostic category or complexity level; evaluations of providers by capacity, service delivery, and best-practice guidelines and evaluations of utilization trends.

The criteria used in the utilization review processes will be based on the most current approved guidelines and service manuals utilized under the NC MH/DD/SAS Health Plan and NC Innovations Waiver and processes for NC State services. These documents include, but are not limited to, the current NC State Plan service definitions with Admission, Continuation, and Discharge criteria; the Sandhills Center approved Clinical Guidelines; the current approved NC MH/DD/SAS service rules; and the current approved NC DHB Clinical Coverage policy.
SECTION 8: SERVICE DEFINITIONS AND CRITERIA

A. Covered Services – Service Definitions

Covered Benefit Package

The following links are to covered services under the DHB Clinical Coverage Policies.
https://medicaid.ncdhhs.gov/providers/clinical-coverage-policies behavioirthal-health-clinical-coverage-policies

8A Enhanced Mental Health and Substance Abuse Services
8A-1 Assertive Community Treatment (ACT) Program
8A-2 Facility-Based Crisis Service for Children and Adolescents
8A-5 Diagnostic Assessment
8A-6 Community Support Team
8B Inpatient Behavioral Health Services
8C Outpatient Behavioral Health Services Provided by Direct-Enrolled Providers
8D-1 Psychiatric Residential Treatment Facilities for Children under the Age of 21
8D-2 Residential Treatment Services
8E Intermediate Care Facilities for Individuals with Intellectual Disabilities
8F Research-Based Behavioral Health Treatment (RB-BHT) for Autism Spectrum Disorder
8G-1 Peer Support Services (PSS)
8I Psychological Services in Health Departments and School Based Health Centers Sponsored by Health Departments to the under 21
8J Children’s Developmental Service Agencies (CDSAs)
8L Mental Health/Substance Abuse Targeted Case Management
8N NC Health Choice – Intellectual and Developmental Disabilities Targeted Case Management
8O Services for Individuals with Intellectual & Developmental Disabilities & Mental Health or Substance Abuse Co-Occurring
8P North Carolina Innovations 1915 (c) Waiver

All CPT Codes provided by Psychiatrists
https://www.sandhillscenter.org/for-providers/provider-forms/financeclaims-forms/

Hospital Emergency Department (ED) services: Each LME/MCO will be responsible for all facility, professional, and ancillary charges for services delivered in the emergency department to individuals with a discharge diagnosis ranging from 290 to 319.

Outpatient Hospital Clinical Services for individuals with a primary diagnosis ranging from 290-319.

SECTION 9: RESOURCES FOR PROVIDERS

A. Training and Technical Assistance
B. Advocacy
C. Behavioral Healthcare Resource
D. Member and Family Resources
E. Cultural Competency Resource Booklet
F. Intellectual/Developmental Disabilities
G. Federal and State Government
H. North Carolina State Links (DMH/DD/SAS, DHB, DHSR)
Contracted providers must keep abreast of rule changes at the State level, attend workshops and trainings to maintain clinical skills, and/or licensure, be knowledgeable on evidenced-based or emerging practices and be current on coding and reimbursement. Sandhills Center will provide the following resources to assist the provider in meeting this requirement:

**A. Training and Technical Assistance**

In addition to assistance provided by Sandhills Center staff, information and resources are also available on the Sandhills Center website located at the following link: [https://www.sandhillscenter.org/for-providers/trainings-events/](https://www.sandhillscenter.org/for-providers/trainings-events/). Sandhills Center sends out information about training events and activities when received by the State or the NC Council of Community Programs.

**B. Advocacy**

Refer to Member Handbook for a list of Advocacy Organizations at [https://www.sandhillscenter.org/for-consumers/member-handbook](https://www.sandhillscenter.org/for-consumers/member-handbook)

**C. Behavioral Healthcare Resources**

Healthy Minds Network: [https://healthymindsnetwork.org/](https://healthymindsnetwork.org/)

Wellness Recovery Action Plan (WRAP): [https://mentalhealthrecovery.com/](https://mentalhealthrecovery.com/)

Brain Injury Family Help Line: 1 (800) 377-1464 or [http://www.bianc.net/](http://www.bianc.net/) (regarding TBI Services)

The Arc: [https://thearc.org/](https://thearc.org/)

**D. Member and Family Resources**

Alcohol/Drug Council of NC: (800) 688-4232

Association for Person in Supported Employment (APSE): [https://apse.org/](https://apse.org/)

Association of Self-Advocates of NC: [http://www.self-advocate.org/aboutUs/](http://www.self-advocate.org/aboutUs/)

Autism Society of North Carolina: [https://www.autismsociety-nc.org/](https://www.autismsociety-nc.org/)

Children and Adults with Attention-Deficit/Hyperactivity Disorder: [https://chadd.org/](https://chadd.org/)

Disability Rights North Carolina Persons with Disabilities: [https://disabilityrightsnc.org/](https://disabilityrightsnc.org/)

Federation of Families for Children’s Mental Health: [https://www.ffcmh.org/](https://www.ffcmh.org/)

National Alliance for Mental Illness (NAMI): [https://naminc.org/](https://naminc.org/)

National Empowerment Center: [https://power2u.org/](https://power2u.org/)

National Mental Health Consumers” Self-Help Clearinghouse: [https://www.mhselfhelp.org/](https://www.mhselfhelp.org/)
Relay North Carolina: http://www.relaync.com/
North Carolina Families United: https://www.ncfamiliesunited.org/
Sandhills Center CFAC: Toll Free at 1 (800) 256-2452
The Arc: https://thearc.org/
The Arc of North Carolina: https://www.arcnc.org/
Veterans Services: https://www.milvets.nc.gov/homepage

Accrediting Bodies
Commission on Accreditation of Rehabilitation Facilities (CARF): http://www.carf.org/home/
Council on Accreditation (COA): http://coanet.org/home/
Council on Quality and Leadership (CQL): https://c-q-l.org/
Joint Commission (JCAHO): https://www.jointcommission.org/

E. Cultural Competency Resource Booklet (see Sandhills Center website)
   https://www.sandhillscenter.org/for-providers/resources/

F. Intellectual/Developmental Disabilities
Autism Speaks Family Services: (General Information) https://www.autismspeaks.org/
Autism Society of North Carolina: https://www.autismsociety-nc.org/
Brain Injury Association of North Carolina: http://www.bianc.net
Autism Research Institute: https://www.autism.org/
First Resource Center: https://firstwnc.org/
Family Support Network: https://missionhealth.org/member-hospitals/childrens/
Exceptional Children’s Assistance Center: https://www.ecac-parentcenter.org/
National Association for Developmental Disabilities: http://thenadd.org/
National Down Syndrome Society: https://www.ndss.org/


North Carolina Council on Developmental Disabilities: https://nccdd.org/


North Carolina Special Olympics: https://sonc.net/

TEACCH Autism Program: https://teach.com

The National Inclusion Project: https://www.inclusionproject.org/

The Autism Society of NC: https://www.autismsociety-nc.org

The Arc of the United States: https://www.thearc.org/

For All Disabilities:

Disability Partners: http://disabilitypartners.org/

Exceptional Children Assistance Center: https://www.ecac-parentcenter.org/

NC Council on Developmental Disabilities: https://nccdd.org/

North Carolina Families United https://www.ncfamiliesunited.org/

The Council for Exceptional Children: https://www.cec.sped.org/

The North Carolina Office on Disability: https://fpg.unc.edu/node/2884

G. Federal and State Government

Comprehensive List of Federal and State Requirements for Sandhills Center and Providers

STATE REGULATIONS

APSM 10-5 Records Retention & Disposition Schedule for DMH/DD/SAS Provider Agency
https://www.ncdhhs.gov/providers/provider-info/mental-health/records-management

APSM 10-6 Records Retention & Disposition Schedule for DMH/DD/SAS for LMEs
https://www.ncdhhs.gov/providers/provider-info/mental-health/records-management
General Records Schedule for Local Government Agencies

APSM 30-1 Rules for MH/DD/SA Facilities and Services - Core rules for services and also includes Administrative Rules for Substance Abuse Services – DWI Offenders

APSM 45-1 Confidentiality Rules https://www.ncdhhs.gov/apsm-45-1-confidentiality-rules


45 CFR Part 160 & 164 HIPAA Standards for Privacy and Security of Health Information
https://www.hhs.gov/hipaa/for-professionals/privacy/index.html

NC General Statutes 122-C -Mental Health, Developmental Disabilities and Substance Abuse
https://www.ncleg.gov/Laws/GeneralStatuteSections/Chapter122C

Innovations Waiver
https://www.ncdhhs.gov/providers/provider-info/mental-health/idd-systems-of-services

Monitoring of Providers https://www.ncdhhs.gov/providers/provider-info/mental-health/provider-monitoring

DHHS Disaster Preparedness, Response and Recovery Plan

Reporting Requirements
https://www.ncdhhs.gov/providers/provider-info/mental-health/reporting-requirements

GAPS Analysis Report https://www.sandhillscenter.org/about/performance-measures/

NC Division of Mental Health, Developmental Disabilities, Substance Abuse Services - Service Definitions
https://www.ncdhhs.gov/divisions/mhddsas/servicedefinitions

NC Division of Health Benefits – Service Definitions
https://medicaid.ncdhhs.gov/providers/clinical-coverage-policies/behavioral-health-clinical-coverage-policies
FEDERAL REGULATIONS

U.S. Department of Labor Laws include:
Fair Labor Standards Act (FLSA)
Employee Retirement Income Security Act (ERISA)
Occupational Safety and Health (OSH) Act
Family and Medical Leave Act (FMLA)
Office of Workers’ Compensation Programs
Drug-Free Workplace Act of 1998
The Rehabilitation Act of 1973, Section 503
Title VII of the Civil Rights Act of 1964
Sarbanes-Oxley Act of 2002

All Federal Department of Labor regulations are located at: https://www.dol.gov/

NC Dept. of Labor located at: https://www.labor.nc.gov/
https://www.labor.nc.gov/safety-and-health/publications

Deficit Reduction Act (DRA) of 2005

42 CFR Part 2 Confidentiality Regulations
https://www.ecfr.gov/cgi-bin/searchECFR?ob=r&idno=42&q1=&r=&SID=29d22b88e8d1fb8c6f6883884397940e&mc=true

45 CFR Part 160 & 164 HIPAA Standards for Privacy of Health Information
Federal Regulations search:

45 CFR Public Welfare Administrative Data Standards & Related Requirements Part 160
https://www.ecfr.gov/cgi-bin/text-idx?SID=49b6db4cb44e33608c37329208393f65&mc=true&tpl=/ecfrbrowse/Title45/45cfr160_main_02.tpl

45 CFR Public Welfare Security and Privacy Part 164
https://www.ecfr.gov/cgi-bin/text-idx?SID=49b6db4cb44e33608c37329208393f65&mc=true&node=pt45.1.164&rgn=div5

Title VI of the Civil Rights Act of 1964
Executive Order 13166, "Improving Access to Services for Persons with Limited English Proficiency":
https://www.lep.gov/

42 CFR 438 – Public Health, CMS – DHHS, Medical Assistance Programs, Managed Care
https://www.ecfr.gov/cgi-bin/text-idx?SID=49b6db4cb44e33608c37329208393f65&mc=true&node=pt42.4.438&rgn=div5

42 CFR 456 - Public Health, CMS – DHHS, Medical Assistance Programs, Utilization Control
https://www.ecfr.gov/cgi-bin/text-idx?SID=49b6db4cb44e33608c37329208393f65&mc=true&node=pt42.4.456&rgn=div5
LOCAL/OTHER REGULATIONS

URAC Accreditation Standards    NCQA Accreditation Standards
https://www.urac.org/            https://www.ncqa.org/

H. North Carolina State Links (DMH/DD/SAS/DHB, DHSR)

Division of Health Service Regulation: https://www.nc.gov/health-service-regulation-division

Division of Mental Health/Developmental Disabilities/Substance Abuse Services:
https://www.ncdhhs.gov/divisions/mhddssas or https://www.ncdhhs.gov/providers/provider-info

Division of Health Benefits: https://medicaid.ncdhhs.gov/providers

North Carolina Department of Health and Human Services: https://www.ncdhhs.gov/

North Carolina Coalition to End Homelessness: https://www.nceeh.org/

North Carolina Division of Health Benefits (DHB): https://medicaid.ncdhhs.gov/providers

North Carolina Division of Health Benefits Publications: https://medicaid.ncdhhs.gov/documents

NC Division of Health Service Regulation: https://www.ncdhhs.gov/divisions/dhsr

North Carolina Housing Coalition: http://nchousing.org/

North Carolina Housing Finance Agency: https://www.nchfa.com/

North Carolina Health Information Exchange Authority: https://hiea.nc.gov/

Visit the HIEA website to learn more information – see table below.

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NCMMIS Provider Claims and Billing Assistance Guide available at https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html

Medicaid Bulletins: General and specific available at https://medicaid.ncdhhs.gov/providers/medicaid-bulletin

See NEW “Medicaid Bulletin Digests”. The Medicaid Bulletin process was updated on October 15th, 2019 to weekly online posts and a monthly digest posted the last day of each month per the NC Medicaid Bulletin website. The Medicaid Monthly Digest is a compilation of online posts of all articles distributed in the Medicaid Monthly Bulletin and Special Medicaid Bulletins. The Digests contains titles of all articles for that month, and a brief summary of what the article is about, with a link to the full article. There will no longer be a PDF containing all monthly articles in full.

Joint DHB-DMH Communication Bulletins available at https://www.ncdhhs.gov/divisions/mhddsas/joint-communication-bulletins

NCDHHS Mental Health, Developmental Disabilities, and Substance Abuse including NC CFACs Councils and Commissions https://www.ncdhhs.gov/divisions/mhddsas/councils-commissions

Transportation Policy available at https://medicaid.ncdhhs.gov/providers/programs-services/medicaid-transportation


OTHER INFORMATION

Sandhills Center LME/MCO Local Business Plan:

https://www.sandhillscenter.org/about/regulatory-plans/
SECTION 10: GETTING PAID

A. Enrollment & Eligibility Process
   1. Eligibility Determination
   2. Key Data to Capture During Enrollment
   3. Effective Date of Enrollment
   4. Member ID

B. Authorizations Required for Payment
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C. Payment of Claims & Claims Inquiries
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   2. Process for Submission of Replacement & Voided Claims
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E. Standard Codes for Claims Submission
   1. CPT/HCPC/Revenue Codes
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   3. Place of Service Codes

F. Definition of Clean Claims

G. Coordination of Benefits
   1. Eligibility Determination Process by Provider
   2. Obligation to Collect
   3. Reporting of Third Party Payments

H. Fee Schedules
   1. Eligibility for Benefit Determination
   2. Process to Modify

I. Response to Claims
   1. Remittance Advice
   2. Electronic Remittance Advice (835) for 837 Providers
   3. Management of Accounts Receivable – Provider Responsibility

J. Claims Investigations – Fraud & Abuse
   1. Trends of Abuse & Potential Fraud
   2. Audit Process
   3. Role of Finance Department
   4. Voluntary Repayment of Claims
   5. Reporting to State & Federal Authorities

K. Repayment Process/Paybacks
A. Enrollment and Eligibility Process

1. Eligibility Determination

Members who have their services paid for in whole or in part by Sandhills Center must be enrolled in the Sandhills Center system. If you have any questions about a member’s eligibility, please call Customer Services at (800) 256-2452. Assistance can be found on Sandhills Managed Care Software System using the current version of Sandhills Center's Enrollment documentation. Individuals who are at 100% ability to pay according to Sandhills Center’s sliding fee schedule or who have insurance coverage that pays 100% of their services, must not be enrolled into the Sandhills Center system. However, the person may still receive and pay for services from a provider independent of Sandhills Center involvement.

It is the responsibility of each provider to make a complete and thorough investigation of a member’s ability to pay prior to requesting to enroll that person into the Sandhills Center system. This would require that the provider check for the following:

- Determine if the member has Medicaid or whether the member may be eligible for Medicaid.
- Determine if the member has Medicare or any other third party insurance coverage.
- Determine if there is any other payer involved – worker's compensation, EAP (Employee Assistance Program), court ordered services paid for by the court, etc.
- Determine if the member meets Sandhills Center criteria for use of Local or State Funds to pay for services. The criteria will be the lack of Medicaid or other third party insurance and the inability of the individual or family to pay for a portion of healthcare services based on the Sandhills Center published Sliding Fee Schedule. Sandhills Center publishes a Sliding Fee Schedule that providers must use to determine member’s ability to pay for non-Medicaid members and/or non-Medicaid reimbursable services being provided to Medicaid members.
- Determine if the member has already been enrolled in the Sandhills Center system.

If the member has Medicaid or has already been enrolled in the Sandhills Center system, they are financially eligible for Medicaid reimbursable services from Sandhills Center. If they are not yet enrolled, then the provider must provide the data necessary to enroll the member. Member enrollment can be performed by completing a Consumer Admission Form on the Sandhills Center website or through the provider by contacting the Customer Services Department at (800) 256-2452 with questions. Assistance can be found on Sandhills Managed Care Software System using the current version of Sandhills Center Enrollment documentation.

Providers should assist members that may be eligible for Medicaid funding in applying for Medicaid through the county Department of Social Services.

1. Member Confidentiality

Each member who requests services will receive a copy of the Privacy Notice from Sandhills Center, making them aware of their rights and the use of their Protected Health Information (PHI) to obtain payment for their services.
2. **Key Data to Capture during Enrollment**

All providers are required to ensure member enrollment data is up to date based on the most current Sandhills Center Enrollment Procedures and training. These documents can be found in Sandhills Center Provider Manual and on the Sandhills Center’s website at [https://www.sandhillscenter.org/providers/trainings-events/provider-orientation/](https://www.sandhillscenter.org/providers/trainings-events/provider-orientation/) - see “Alpha Provider University” under Finance.

Training documentation is found by logging into Sandhills Managed Care Software System and clicking on the Training Materials link.

If enrollment data is not complete prior to service provision, authorizations and claims will be affected. This would include denials of authorizations and claims.

The Medicaid information must be provided to Customer Services when requesting an enrollment. If the member has any other third party insurance, including Medicare, this information must also be included in the enrollment request. Members whose services are paid in part by third party insurance can be enrolled if Sandhills Center is to be a secondary payer.

3. **Effective Date of Enrollment**

Enrollment into the Sandhills Center system must be done prior to providing services except in emergency situations. It is the provider's responsibility to complete the eligibility determination process, including verification of previous enrollment in the Sandhills Center system and to complete the enrollment process prior to providing services. Crisis services provided in an emergency situation are an exception to this rule. In these cases, the provider must enroll the member within seven (7) days and indicate the date of enrollment as the date that the emergency services were provided.

**Services with service dates prior to an enrollment date will be denied.**

4. **Member ID**

The Member ID Number identifies the specific member receiving the service and is assigned by the Sandhills Center Software Management System. The member must be enrolled in the Sandhills Center system in order for a claim to be accepted. In order for the provider to obtain this number, the member must have been successfully enrolled into the Sandhills Center Software Management System. All claims submitted with incorrect Member ID numbers, or for members whose enrollment is no longer active, will be denied.

**B. Authorizations Required for Payment**

1. **System Edits**

Sandhills Center’s Software Management System is specifically designed to look for authorization data prior to paying claims. The information system has edits that are verified, so the provider must be very attentive to what has been authorized to ensure maximum reimbursement.

2. **Authorization Number and Effective Dates**

Each authorization will have a unique number, a start date and an end date. Only services with dates of service within these specific time frames will be paid. Dates and/or units outside these parameters will be denied.
3. Service Categories or Specific Services

Each authorization will indicate specific categories of services or in some cases very specific services that have been authorized. Each service will be validated against the authorization to make sure that the service matches the authorization. Services that are outside of these parameters will be denied.

4. Units of Service

Each authorization will indicate the maximum number of units of service that are being authorized. As each claim is being processed, the system will check to make sure that the units being claimed fall within the units of services authorized. The system will deny any claims that exceed the limits. Providers need to establish internal procedures to monitor units of service against authorizations to avoid having claims denied due to exceeding units of service.

5. Exceptions to Authorization Rule

There are certain services that will be paid without an authorization. These services are limited in scope and are limited in total number to a member, not to a Provider. Once the annual limit has been reached for a member, then all services without an authorization, regardless of the Provider of the service, will be denied. Providers must be constantly aware of this issue in order to avoid denied claims.

C. Payment of Claims and Claims Inquiries

Providers must submit claims through Sandhills Managed Care Software Systems or an 837 file unless their contract specifically states an alternative method. Providers are encouraged to produce routine billings on a weekly or bi-monthly schedule.

1. Timeframes for Submission of Claims

All claims must be submitted within 90 days of the date of service to ensure payment, unless otherwise specified in the provider's contract. Claims submitted outside of the allowable billing days will be denied. Providers must notify Sandhills Center Finance Department in writing if they anticipate not being able to meet this guideline.

Process for Submission of Claim Corrections

Providers may submit claim corrections for originally paid claims within 90 days from the service date. Claim corrections submitted past 90 days from the service date will be denied for exceeding billing days and cannot be resubmitted.

If a claim was billed incorrectly and the provider has been reimbursed, a Claims Inquiry/Resolution Form will need to be completed and sent to the Sandhills Center Finance Department with the appropriate Remittance Advice attached. This form is posted on the Sandhills Center website at https://www.sandhillscenter.org/for-providers/provider-forms/financeclaims-forms/, in the provider section under Finance/Claim forms. Do not send a corrected claim. Once the request has been processed, the Claim Specialist will contact you and advise you if a corrected claim needs to be submitted.
If a claim was billed incorrectly and the provider has not been reimbursed, a Claim Inquiry/Resolution Form will need to be completed and sent to the Sandhills Center Finance Department.

2. Process for Submission of Replacement and Voided Claims

Providers may submit replacement or voided claims for originally paid claims within 90 days from the service date. Claims submitted past 90 days from the service date will be denied for exceeding billing days and cannot be resubmitted.

Instructions for replacement claims submitted via an 837 transaction set

- In Loop 2300 – Claim segment/5th element (CLM05-03), 7 (code for resubmission) should be submitted along with a REF segment with "F8" as reference code identifier and the claim number found on the RA as the reference number. Here is an example:
  CLM*01319300001*500***11::7*Y*A*Y*Y***02******N–REF*F8*111111–

Once the replacement claim has been received, your original claim will deny and the replacement claim will be processed according to all Sandhills Center billing guidelines.

Voided claims will be reverted from our system and the original claim payment will be recouped.

Instructions for voided claims submitted via an 837 transaction set

- In Loop 2300 – Claim segment/5th element (CLM05-03), 8 (code for reversal) should be submitted along with a REF segment with "F8" as reference code identifier & the claim number found on the RA as the reference number. Here is an example:
  CLM*01319300001*500***11::8*Y*A*Y*Y***02******N–REF*F8*111111

Voided claims will be reverted from our system and the original claim payment will be recouped.

3. Sandhills Managed Care Software System Claims Submission

Providers are contractually required to submit billing electronically. Sandhills Managed Care Software System is a web-based system available to Sandhills Center Providers upon completion of a Trading Partner Agreement (TPA). Direct data entry of billing information is entered and submitted to Sandhills Center for reimbursement.

The SANDHILLS CENTER’s Software Management Systems gives very specific instructions on what is needed to submit billing. The TPA and the SANDHILLS CENTER’s Software Management System may be accessed via the Sandhills Center website, www.sandhillscenter.org.

4. 837 Claims Submission

Detailed instructions are provided in the Companion Guides. The Companion Guides (a user manual for electronic 837 submissions) gives very specific instructions on what is required to submit claims electronically to Sandhills Center. The entire testing and approval process is covered in this document. The HIPAA-compliant ANSI transactions are standardized; however, each payer has the ability to exercise certain options and to insist on use of specific loops or segments. The purpose of the Companion Guide is to clarify those choices and requirements so that providers can submit accurate
HIPAA transactions. Sandhills Center will accept only HIPAA compliant transactions as required by law. Sandhills Center provides the following HIPAA transaction files back to providers: 999 (an acknowledgment receipt) and 835 (an electronic version of the remittance advice).

Due to copyright laws, detailed companion guides are not permitted. The companion guides are meant to provide information specific to the IPRS payer. Otherwise, the ASC X12 Implementation Guides are to be referenced.

Other general rules to follow include:

a. Formats

Innovations Services, Out-Patient Therapy, Residential (state funded) and other daily and periodic services must be submitted using the ANSI 837P (Professional) format or through the Sandhills Managed Care Software System. Inpatient, Therapeutic Leave, Residential Services (Medicaid payable), Out-Patient Revenue Codes and ICF Services must be submitted using the ANSI 837I (Institutional) format or Sandhills Managed Care Software System.

b. Authorization Number

As described in the authorization section of this manual, authorizations are for specific members, providers, types of services, date ranges, and for a set number of units. Providers are responsible for maintaining internal controls within their information systems to avoid a denial due to not being consistent with the authorization.

c. NPI (National Provider Identifier)

Providers are required to obtain an NPI number to submit billing on the electronic 837. The NPI number and taxonomy code(s) are required for claims to be accepted and processed. Failure to comply with these guidelines will result in denied billing.

d. Verification and Notification

Sandhills Center provides the following responses via electronic means to ensure that electronic 837 billing is accepted into the Sandhills Managed Care Software System for processing and payment:

- 999 File - This file acknowledges receipt of the 837 billing file.
- 837 File has been accepted or rejected. If the line item has been rejected, a detailed explanation will be provided.

It is the provider's responsibility to review these responses to verify billing has been accepted into the Sandhills Managed Care Software System for processing so reimbursement is not interrupted due to file formatting issues.

Due to copyright laws, detailed companion guides are not permitted. The companion guides are meant to provide information specific to the IPRS payer. Otherwise, the ASC X12 Implementation Guides are to be referenced. Summarized companion guides are available at: https://www.sandhillscenter.org/for-providers/provider-forms/financeclaims-forms/.
5. Providers Who Submit Paper Claims

Providers who continue to submit paper claims until they can transition to electronic claims processing will be required to submit an accurate CMS 1500 or UB04 billing form with the correct data elements.

A remittance advice will be available via mail and/or fax until arrangements are made to receive electronically. The remittance advice will report whether billed services have been approved for payment or denied.

D. Service Codes and Rates

Contract Provisions

Provider contracts include a listing of services, which they are eligible to provide. All providers are reimbursed according to contract. Providers must only use the service codes in their contract or reimbursement will be denied as non-contracted services. Providers can submit claims for more than the published rates via 837 or paper, but only the contracted rate will be paid. It is the Provider's responsibility to review their contract and to make the necessary changes to their billing systems.

1. Publishing of Rates - Refer to Sandhills Center website

https://www.sandhillscenter.org/for-providers/provider-forms/financeclaims-forms

E. Standard Codes for Claims Submission

1. CPT/HCPC/Revenue Codes
   See Sandhills Center website
   https://www.sandhillscenter.org/for-providers/provider-forms/financeclaims-forms/

2. Diagnosis Codes - Use diagnosis codes from the ICD10 Code Manual.
   See Sandhills Center web page http://www.sandhillscenter.org/icd-10/

3. Place of Service Codes
   See Sandhills Center website https://www.sandhillscenter.org/for-providers/provider-forms/

F. Definition of Clean Claims

Means as defined in 42 CFR § 447.45(b). A clean claim means one that can be processed without obtaining additional information from the provider of the service or from a third party. It includes a claim with errors originating in a State’s claims system. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity.
G. Coordination of Benefits

Sandhills Center is the payer of last resort. Providers are required to collect all first and third party funds prior to submitting claims to Sandhills Center for reimbursement. First party payers are the members or their guarantors. Services paid for with Local or State funds are subject to the Sliding Fee Schedule.

Third party payers are any other funding sources than can be billed to pay for the services provided to the member. This can include worker's compensation, disability insurance or other health insurance coverage.

All claims must identify the amounts collected from both first and third parties and only request payment for any remaining amount.

1. Eligibility Determination Process by Provider

Providers should conduct a comprehensive eligibility determination process whenever a member enters the delivery system. Periodically (no less than quarterly), the provider should update its eligibility information to determine if there are any first or third party liabilities for this member. It is the provider's responsibility to monitor this information and to adjust billing accordingly. First or third party insurances should be reported to the Sandhills Center.

2. Obligation to Collect

Providers must make good faith efforts to collect all first and third party funds prior to billing Sandhills Center. First party charges must be shown on the claim whether they were collected or not.

3. Reporting of Third Party Payments

Providers are required to record on the claim either the payment or denial information from a third party payer. Copies of the ERA or EOB from the insurance company should be retained by the provider if they submit electronic billing. If paper claims are submitted to Sandhills Center, the provider is required to submit copies of the ERA or EOB with the claim form to Sandhills Center.

Providers must bill any third party insurance coverage. This includes worker's compensation, Medicare, EAP programs, etc. Providers must wait a reasonable amount of time in order to obtain a response from the insurance company. However, it is important that providers not exceed the 90-day rule before submitting claims. If an insurance company pays after a claim has been submitted to Sandhills Center, the provider must notify Sandhills Center and reimburse Sandhills Center.

H. Fee Schedules

1. Eligibility for Benefit Determination

Each member enrolled in the Sandhills Center system must complete the financial eligibility process to establish any third party coverage and to establish the ability to pay for services.

Medicaid members are not subject to Sliding Fee Schedules for services paid for by Medicaid.
If a member does not qualify for the Sliding Fee Schedule, they should pay 100% of the services being provided. In this case, the member should not be enrolled in the Sandhills Center system and claims should not be submitted to Sandhills Center for reimbursement.

2. Process to Modify

If there are known changes to the member’s income or family status, the provider should update their records and adjust the payment amount based on the Sliding Fee Schedule. Members who become Medicaid eligible are not subject to Sliding Fee Schedules for Medicaid covered services and payments should be adjusted immediately when this is determined.

The Sliding Fee Schedules are managed by providers and first party liability must be reported on claims. This compliance issue will be audited.

I. Response to Claims

1. Remittance Advice

The Remittance Advice is Sandhills Center’s way of communicating back to the provider community exactly how each and every service has been adjudicated. Sandhills Center provides the Remittance Advice in a downloadable file and can be accessed through the providers’ Share Point FTP site assigned by Sandhills IT Department.

2. Electronic Remittance Advice (835) for 837 Providers

HIPAA regulations require payers to supply providers with an electronic Remittance Advice known as the 835. The 835 will report electronically the claims status and payment information.

This file is used by the provider's information system staff or vendor to automatically post payments and adjustment activity to their member accounts. This allows providers the ability to manage and monitor their accounts receivables.

3. Management of Accounts Receivable – Provider Responsibility

Providers must take full responsibility for the management of their member accounts receivable. Sandhills Center produces Remittance Advices based on the current check write schedule each week.

J. Claims Investigations - Fraud and Abuse

1. Trends of Abuse and Potential Fraud

One of the primary responsibilities of Sandhills Center will be to monitor the Provider Network for fraud and abuse. Both the Medicaid and State contracts make Sandhills Center responsible for monitoring and conducting periodic audits to ensure compliance with all Federal and State laws and in particular the Medicare/Medicaid fraud and abuse laws.

Specifically, Sandhills Center will need to validate the presence of material information to support billing of services consistent with Medicaid and State regulations. Sandhills Center will systematically monitor the paid claims data to look for trends or patterns of abuse.
2. Audit Process

Sandhills Center has the responsibility to ensure that funds are being used for the appropriate level and intensity of services as well as in compliance with Federal, State, and general accounting rules.

The Finance Department is primarily responsible to collect any paybacks that result from a QM or Financial Audit. The Finance Department will work with the QM audit team, the Network Manager and provider in the collection of any determined paybacks.

3. Role of Finance Department

The Finance Department will assist the QM Audit Team and Network Manager with the review of financial reports, financial statements, and accounting procedures.

4. Voluntary Repayment of Claims

It is the provider's responsibility to notify Sandhills Center in writing of any claims billed in error that will require repayment. Providers are required to complete a Claims Inquiry/Resolution Form. This form is posted on the Sandhills Center website at https://www.sandhillscenter.org/for-providers/provider-forms/financeclaims-forms/, in the provider section under Finance Claim Forms. Sandhills Center will make adjustments in the system and those adjustments will appear on the next Remittance Advice.

5. Reporting to State and Federal Authorities

For each case of reasonably substantiated suspected provider fraud and abuse, Sandhills Center is obligated to provide DHB with the provider's name and number, the source of the grievance, the type of provider, the nature of the grievance, the approximate range of dollars involved and the legal and administrative disposition of the case.

K. Repayment Process/Paybacks

The Finance Department is responsible for the recovery of funds based on any audit findings. If Sandhills Center determines a provider has failed to comply with State, Federal, Medicaid or any other revenue source requirements, Sandhills Center will recoup the amount owed from current and/or future claims. If payback amount exceeds outstanding provider claims, Sandhills Center will invoice the provider the amount owed.

Providers shall have thirty (30) calendar days from the invoice date to pay back the total amount owed. If a provider fails to repay funds identified, Sandhills Center reserves the right to take action to collect the outstanding balance from the provider.

If Sandhills Center or a provider determines they have received revenues as a result of an error or omission, Sandhills Center will consult with the provider on the method of repayment. If the provider fails to repay Sandhills Center within the specified period, Sandhills Center will recoup the amount owed from current and/or future claims.

If Sandhills Center, through an audit or review, determines a provider has been paid for a service or a portion of a service that should have been disallowed, Sandhills Center will recoup the amount owed from current
claims. If payback amount exceeds outstanding provider claims, Sandhills Center will invoice the provider the amount owed.

Providers shall have thirty (30) calendar days from the invoice date to pay back the total amount owed. If a provider fails to repay funds identified, Sandhills Center reserves the right to take action to collect the outstanding balance from the provider.

Sandhills Center may establish a payment plan with the provider for repayment of funds.

If Sandhills Center, through an audit or review, determines a Provider has been paid for a claim that was fraudulently billed, Sandhills Center will recoup the amount owed from current claims. If payback amount exceeds outstanding provider claims, Sandhills Center will invoice the provider the amount owed.

The provider shall have thirty (30) calendar days from the invoice date to pay back the total amount owed. Fraudulent billing may include, but is not limited to, unbundling services, billing for services by non-credentialed or non-licensed staff, or billing for a service that the provider never rendered or for which documentation is absent or inadequate.
SECTION 11: STANDARDS AND CORPORATE COMPLIANCE

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A. Introduction

Sandhills Center is committed to working in collaboration with the Network of Community Providers to achieve the highest standards of quality in service delivery.

B. Quality Improvement

To assure services are appropriately monitored and continuously improved, Sandhills Center has developed and implemented a comprehensive Quality Management program that systematically monitors the quality and effectiveness of its internal systems, as well as ensuring the provision of high quality services delivered by its provider network. It is designed to comply with URAC standards, DMH/DD/SAS Rules, 42 CFR 438.240 and with the utilization control program required by CMS for DHB’s overall Medicaid program described in 42 CFR 456. The QM Program of Sandhills Center follows the CMS Quality Framework.

Functions of this framework include:

- Design – designing quality assurance and improvement strategies.
- Discovery – collecting data and direct participant experience in order to assess the ongoing implementation of the program while identifying strengths.
- Remediation – taking action to remedy specific concerns that arise.
- Continuous Improvement – utilizing data and quality information to engage in actions that lead to continuous improvement.

The purpose of the QM Program is to ensure the continual assessment and improvement of Sandhills Center service management system and its operations with an emphasis on open communication, interdepartmental, structured communication and teamwork. Sandhills Center maintains a strong commitment to continual improvement of its services and those services provided directly to members. A focus on quality requires basic principles, which include:

- Commitment to the involvement of the members in all areas and levels of the service system in regards to analysis, planning, implementing changes, and assessing quality and outcomes.
- Commitment to strengthen systems and processes - By viewing the system as a collection of interdependent processes we can understand how problems occur and can strengthen the system as a whole.
- Encouraging participation and teamwork – Every member of the system can help assure quality if they are included in processes and are empowered to solve problems and recommend improvements.
- Decisions are based on reliable information – By collecting and analyzing accurate, timely and object data we can diagnose and solve system problems and measure progress.
- Improvement in communication and coordination – Different members of the system can work together to improve quality if they share information freely and coordinate their activities.

Sandhills Center maintains an established quality structure that ensures the participation of all persons and agencies involved in the service system.
Committees include:

- Sandhills Center Quality Management Committee
- Global CQI Committee
- Health Network Committee
- Network Leadership Council
- Clinical Advisory Committee
- Credentialing Committee
- Care Management/UM Committee
- Customer Services Committee
- Client Rights Committee
- Corporate Compliance & Internal Audit Committee
- Consumer and Family Advisory Committee
- Clinical Leadership Team

The continual self-assessment of services and operations and the development and implementation of plans to improve outcomes to members is a value and expectation that Sandhills Center extends to its community of network providers and practitioners. Network providers and practitioners are required to be in compliance with all Quality Assurance and Improvement standards outlined in North Carolina Administrative Code as well as the Sandhills Center Contract.

These items include:

- The establishment of a formal Quality Committee to evaluate services, plans for improvements and assess progress made towards goals.
- The assessment of need as well as the determination of areas for improvement should be based on accurate, timely, valid data. The provider’s improvement system, as well as systems used to assess services, plans for improvement and their effectiveness will be evaluated by Sandhills Center at the provider’s triennial qualifying review.

C. Performance Measurements

1. Data Collection and Verification

Sandhills Center is required to measure outlined performance indicators in the following domains: Access & Availability, Effectiveness of Care, Use of Services, Network Capacity, Quality of Care, Quality of Services, Appropriateness of Services, Health & Safety, System Performance, and Satisfaction, in order to assure compliance with DMH & DHB contract requirements.

2. Performance Improvement

Sandhills Center will complete Performance Improvement Projects (PIPs) as indicated in DMH & DHB contracts and URAC Standards. These Performance Improvement Projects will consist of both clinical and non-clinical studies and may require provider participation.
3. Provider Performance Reviews

Providers come into the system on a routine status and have a routine review and a post payment review at least once every two years. Additionally, they may be reviewed as a result of a grievance or incident report or quality of care.

D. Performance Monitoring

An important part of Sandhills Center’s role as a LME/MCO is to monitor the performance of providers in its network. Sandhills Center maintains the following systems to assist in monitoring the health and safety of members, rights protections, and quality of care:

1. Monitoring of Incidents

An incident as defined in 10A NCAC 27G.0103(b)(32), is “any happening which is not consistent with the routine operation of a facility or service or the routine care of a member and that is likely to lead to adverse effects upon a member.” Incidents are classified into three categories according to the severity of the incident.

- **Level I** – Events that, in isolated numbers, do not significantly threaten the health or safety of an individual, but could indicate systematic problems if they occur frequently.
- **Level II** – Incidents that involve a member death due to natural causes or terminal illness or result in a threat to a member’s health or safety or a threat to the health or safety of others due to member behavior.
- **Level III** – Any incident that results in (1) a death, sexual assault or permanent physical or psychological impairment to a member, (2) a substantial risk of death or permanent physical or psychological impairment to a member (3) a death, sexual assault or permanent physical or psychological impairment caused by a member (4) a substantial risk of death or permanent physical or psychological impairment caused by a member or (5) a threat caused by a member to a person’s safety.

Providers are required to develop and maintain a system to collect documentation on any incident that occurs in relation to a member. This includes all state reporting regulations in relation to the documentation and reporting of critical incidents.

In addition, providers must submit all Level II and Level III incident reports in the Incident Reporting and Improvement System (IRIS). Sandhills Center will make a request to DMH/DD/SAS to waive Subsection C of Rule 10A NCAC 27G. 0604 Incident Reporting Requirements for Categories A and B on behalf of our provider network. Providers will no longer receive a letter indicating permission to waive the quarterly incident report of all Level I incidents. As part of its quality management process, it is important for the provider to implement procedures that ensure the review, investigation and follow-up for each incident that occurs through its own internal quality management process.

This includes:

- A review of all incidents on an ongoing basis to monitor for trends and patterns;
- Strategies aimed at the reduction/elimination of trends/patterns;
- Documentation of the efforts at improvement as well as an evaluation of ongoing progress;
- Mandatory reporting requirements are followed; and
• Enter level II and III incidents into IRIS.

There are specific state laws governing the reporting of abuse, neglect or exploitation of members. It is important that the provider’s procedures include all of these requirements.

If a report alleges the involvement of a provider’s staff in an incident of abuse, neglect or exploitation, the provider must ensure that members are protected from involvement with that staff person until the allegation is proved or disproved. The agency must take action to correct the situation if the report of abuse, neglect or exploitation is substantiated.

2. Incident Review Process

Sandhills Center is required, under North Carolina Administrative Code, to monitor certain types of incidents that occur with providers in its network, as well as, providers who while not in the Sandhills Center network, operate services in Sandhills Center catchment area.

Regulations regarding the classification of incidents (Level I, II, or III) as well as requirements related to the submission of incident reports to home and host LME/MCOs and state agencies can be located in North Carolina Administrative Code 27G.0600. Sandhills Center is required to monitor the IRIS system. For more information regarding these classifications, please see the following websites:

- [https://iris.dhhs.state.nc.us/](https://iris.dhhs.state.nc.us/)

Sandhills Center Critical Incident Support Specialists shall review all incidents when received by Sandhills Center for completeness, appropriateness of interventions, achievement of short and long term follow-up both for the individual member, as well as the provider’s service system. If questions/concerns are noted when reviewing the incident report, the Critical Incident Support Specialist and Clinical Monitoring Manager will work with the provider to resolve these. If concerns are raised related to members care or services, or the provider’s response to an incident, the Customer Services Department may elect to refer to Network Monitoring to conduct an on-site review of the provider. If at all possible, the review will be coordinated with the provider and, if deficiencies are found, the Monitoring Manager will work with the provider on the implementation of a plan of correction.

A Critical Incident Committee (a subcommittee of QM) has been established to review all Level III incidents and any Level II incidents that are suicide attempts that need referral to Care Coordination or show provider trends. This committee meets monthly and is chaired by the Chief Medical Officer/Chief Clinical Officer.
3. Monitoring to Ensure Quality of Care

The Sandhills Center Network Operations Department is charged with conducting compliance reviews and audits of medical records, administrative files, the physical environment, and other areas of service, including cultural competency reviews.

The Network Monitoring department performs compliance safety reviews of facilities, monitors providers. Customer Service reviews critical incidents, death reports, and restrictive interventions as an important role in assuring the protection of rights and health and safety of members.

The Customer Services Department reviews incidents reported and determines whether any follow-up is needed. The Network Monitoring Department may conduct investigations of incidents reported directly by providers on Incident Reports, as well as reports provided by members, families and the community at the request of the Customer Services Department. The Customer Services Department also is responsible for reviewing grievances utilizing independent psychiatric review, as needed, for clinical concerns.

4. Grievances

Sandhills Center may receive grievances from providers, stakeholders, members, families, or legal guardians regarding Sandhills Center’s Provider Network, the LME/MCO and/or a specific provider’s services or staff. Any Sandhills Center staff can take a grievance.

All grievances are sent to a designated email address, monitored daily by the Grievances and Incidents Report Manager in the Customer Services Department. If an on-site visit is required, it is referred by the Grievances and Incidents Report Manager to Network Monitoring to conduct a review. If the grievance can be handled via a telephone call, the call is made by the Grievances and Incidents Report Manager. Within 5 business days of the receipt of the grievance, the grievant will receive in writing a letter indicating the receipt of the grievance and that it will be investigated by Sandhills Center or referred to an external agency for investigation. If investigated by Sandhills, within 30 days of receipt of the grievance, the grievant will be notified of the results of the investigation. Sandhills Center may extend this time frame up to 14 days if the member request an extension or Sandhills demonstrates to DHB that there is a need for additional information and the delay is in the best interest of the member.

It is very important that the provider cooperate fully with all investigative requests. It is important to understand that this is a serious responsibility that is invested in Sandhills Center, and that we must take all grievances very seriously until we are able to resolve them. Sandhills Center management of grievances is carefully monitored by DHB and Sandhills Center maintains a database where all grievances and resolutions are recorded.

Sandhills Center’s Customer Services Department maintains the documentation for all grievances. A written summary will be provided to the provider by the Grievances and Incidents Report Manager. If problems are identified with either formal or informal grievances, the provider involved may be required to complete a plan of correction.
5. Member Satisfaction Surveys

Sandhills Center values the satisfaction of members/family members/stakeholders with services provided in the Sandhills Center Network. Sandhills Center has various ways member satisfaction is measured. These include annual surveys and “mystery shopping”. The goal of these initiatives would be to gather feedback on how various Sandhills Center departments perform during random and anonymous monitoring. This system has provided excellent information that has been used to pinpoint the need for additional training of staff. Sandhills Center plans to expand the use of this tool to monitor provider customer services at some point in the future.

E. Corporate Compliance

Sandhills Center expects all its staff members to maintain ethical standards and to practice honesty, directness and integrity in dealings with one another, business partners, the public, the business community, internal and external stakeholders, “customers”, suppliers, elected officials, and government authorities.

1. Primary Area Covered by Corporate Compliance

Corporate compliance deals with the prohibition, recognition, reporting and investigation of suspected fraud, defalcation, misappropriation and other similar irregularities. The term “fraud” includes misappropriation and other irregularities including dishonest or fraudulent acts, embezzlement, forgery or alteration of negotiable instruments such as checks and drafts, misappropriation of an agency’s employee, customer, partner or supplier assets, conversion to personal use of cash, securities, supplies or any other agency assets, unauthorized handling or reporting of agency transactions, and falsification of an agency’s records, claims or financial statements for personal or other reasons.

The above list is not all-inclusive but intended to be representative of situations involving fraud. Fraud may be perpetrated not only by an agency’s staff members, but also by agents and other outside parties. All such situations require specific action.

Within any agency, management bears the primary responsibility for detection of fraud. Finance management in particular is responsible for monitoring the potential of fraudulent situations.

2. Corporate Compliance Plan

All providers, regardless of the amount reimbursed must develop a formal Corporate Compliance Plan that includes procedures designed to guard against fraud and abuse.

The plan should include:

a. An internal audit process to verify that services billed were furnished by appropriately credentialed staff and appropriately documented.

b. The plan will ensure that staff performing services under the Sandhills Center contract has not been excluded from participation in Federal Health Care Programs under either Section 1128 or 1128A of the Social Security Act. The agency consults with the Health and Human Services Office of the Inspector General’s list of Excluded Individuals, the Medicare Exclusion Databases (MED), and the System for Award Management (SAM).
c. Written policies, procedures and standards of conduct that articulate the agency’s commitment to comply with all applicable State and Federal standards for the protection against fraud and abuse.

d. Designation of a Compliance Officer and Compliance Committee.

e. A training program for the Compliance Officer and agency employees.

f. Systems for reporting suspected fraud and abuse by employees and members and protections for those reporting.

g. Provisions for internal monitoring and auditing.

h. Procedure for response to detected offenses and for the development of corrective action plans.

i. Reporting to monitoring and law enforcement agencies, including Sandhills Center.

Note: All providers must monitor for the potential for fraud and abuse and take immediate action to address reports or suspicion. Number 1 and number 2 above, are required of all Sandhills Center providers, regardless of the amount of funding received.

**F. Program Integrity Overview**

The Program Integrity Team began operating in January 2013. The team works under the supervision of the Corporate Compliance Officer and the Chief Medical Officer/Chief Clinical Officer, and in close coordination with Quality Management and Network Operations Monitoring. *(Reference – 10A NCAC 22F)*

**1. Scope of Work**

Develop, implement and maintain methods and procedures to detect, investigate and resolve cases involving fraud, abuse, error(s), overutilization or the use of medically unnecessary or medically inappropriate services. This includes, but is not limited to:

a) Investigate allegations of billing for services not provided, providing illegal kickbacks, operating in locations not endorsed or credentialed by the LME/MCO and various other violations of DHB policy and applicable rules or law.

b) Coordinate with other Sandhills Center Departments including QM, Network, Finance and Medical Records. The team also coordinates as needed with external agencies, including DHB, the Medicaid Investigations Division (MID) and other LME/MCOs.

c) The PI staff participates in a monthly PI forum to discuss procedures and standardization between LME/MCOs, participates in a quarterly meeting with DHB and MID to discuss specific cases and issues that affect LME/MCOs.

**2. Team Composition**

The team consists of four positions – the Director, Investigator, Clinical Analyst and Data Analyst

a) The PI Director is responsible for overseeing the team’s activities, assisting with investigations, and coordinating with other departments or agencies.

b) The Lead Investigator works with the team to screen and investigate cases. Focus is on regulatory violations (reviewing cases for potential violations of policy, rule, or law).
c) The Clinical Analyst works with the team to review cases from a clinical perspective, including reviewing for medical necessity and assisting with witness interviews.

d) The Data Analyst performs data mining necessary to identify potential cases, develop random samples for audits or investigations, and conduct claims analysis of providers under review. Data Analyst assists with investigations and interviews as needed.

3. Process Summary

a) Cases are referred through grievances, data mining, routine monitoring, audits, UM, care coordination and other sources.

b) Referrals are screened to determine whether they fall within the scope of Program Integrity. Cases are also reviewed by the Corporate Compliance Officer and Chief Medical Officer/Chief Clinical Officer.

c) Data mining may be used to generate leads and obtain additional information on referred providers.

d) PI investigations may include a review of consumer, personnel, and/or financial records, paid claims analysis, interviews of consumers and staff, site reviews, and evidence from other sources.

e) Clinical Analyst reviews consumer records for evidence of medical necessity

f) The findings are compiled into a written report to be reviewed by the Corporate Compliance Officer and Chief Medical Officer/Chief Clinical Officer.

g) If the investigation reveals evidence of fraud, the case is referred to the DHB for further review, and any additional LME/MCO actions are conducted in coordination with the DHB.

h) Potential outcomes include recoupment of improper billing, administrative sanctions, referral to DHB, contract termination, or any combination thereof. Providers may also be placed on prepayment review status to prevent ongoing loss by the LME/MCO.

Sandhills Center Program Integrity accepts referrals for investigations from internal and external sources, including but not limited to grievances, Quality of Care Concerns, Provider monitoring, and data mining. Sandhills Center Program Integrity may also generate leads for investigation through data mining techniques, which may include review of paid claims to identify outliers or aberrant billing practices and/or the use of fraud detection software.

Each referral or internally generated lead is tracked on a reporting form documenting the date of the referral, the provider’s name, whether the case was accepted for further investigation, and an estimate of the potential overpayment.

1. Each referral or internally generated lead is reviewed by Program Integrity staff to determine whether the referral is within the scope of Program Integrity’s assigned functions. In making this determination, Program Integrity staff shall consider the following:

a. Assigned functions as outlined in 10A NCAC 22F.0103: “cases involving fraud, abuse, error, overutilization or the use of medically unnecessary or medically inappropriate services.”
b. Specific components of the grievance.

c. Specific citations in federal regulations, state law, state rules, and DHHS policy.

2. When the grievance, if substantiated, would constitute a violation of an identified rule, policy, or law and that violation falls under the scope of 10A NCAC 22F, the referral should be accepted as a Program Integrity case.

3. Once a case has been accepted, the Program Integrity staff enters the case into an internal database, which contains details of active and closed cases. Program Integrity staff will then conduct a preliminary review to determine whether there is sufficient evidence to support a full investigation. The preliminary review includes, but may not be limited to, the following actions:


   b. Identification of essential components of any alleged violations, as related to identified rule, policy, or law.

   c. Identification of minimum evidence necessary to support or refute allegations.

   d. Collection of any preliminary evidence available remotely (ex: paid claims data, follow-up with grievant).

4. Paid claims data used for Program Integrity investigations conform to guidelines provided by the Division of Health Benefits in order to ensure statistical validity. When using random samples, the samples are generated using RAT-STATS software with a minimum sample size of 100 paid claims. The date range under review should include a minimum of three calendar months. Paid claims should be reviewed no earlier than thirty (30) days after the last date of service under review.

5. In compliance with 10A NCAC 22F.0202, if there is insufficient evidence to support the allegation(s), the case is closed. If there is insufficient evidence to support a full investigation, a final report is drafted and submitted to the Program Integrity Director for review.

6. If there is sufficient evidence to support a full investigation, the next steps are decided according to the Investigative Plan and consultation with the team, and may include the following in any order:

   a. On-site investigation

   b. Collection of member, personnel, and administrative records

   c. Witness interviews (staff, beneficiaries, others)

   d. Collection of ancillary evidence (sources outside the provider agency)

   e. Clinical review by appropriately licensed staff

   f. Consultation with subject-matter experts and other authorities
7. Once the investigation is complete, Program Integrity staff will generate a full report, which includes a description of the course of the investigation and the team’s findings. The report is reviewed by the Corporate Compliance Officer and Chief Medical Officer/Chief Clinical Officer prior to approval.

8. If the investigation results in findings of potential fraud (as defined in NC G.S. 108A-63), the report and all associated documentation and evidence is referred to the Division of Health Benefits (DHB) within twenty-four (24) hours of completing the investigation, and the LME/MCO will coordinate additional actions with DHB.

9. If the investigation results in findings of improper billing or other violations, but there is no evidence of potential fraud, the LME/MCO may proceed with administrative sanctions including but not limited to:
   a. Recoupment of improper billing paid by the LME/MCO
   b. Plan of Correction
   c. Prepayment Review
   d. Payment Suspension
   e. Suspension of Referrals
   f. Provider Termination

10. When administrative sanctions are imposed, Sandhills Center follows all applicable procedures regarding provider notification, reconsideration and appeal rights.

11. The outcome of each investigation, including assessed overpayments, collections from providers, and allegations of fraud reported to DHB Program Integrity, is tracked on Attachment Y of the DHB Contract.

12. Sandhills Center maintains electronic copies of all case records.

G. Monitoring and Auditing

Sandhills Center has taken reasonable steps to monitor and audit corporate compliance, including the establishment of monitoring practices and mechanisms to detect non-compliance, both internally and externally.

Identification of compliance issues include, but are not limited to:

- Provider Monitoring and/or Investigations;
- Data review and analysis;
- Staff or provider reporting;
- Needs Assessments; and
- Grievance Reporting.
Network Providers are expected to report any activity they believe to be inconsistent with policies or legal requirements to the Sandhills Center Corporate Compliance Officer or any Sandhills Center staff who are in an authoritative role. Communication may be made with the Corporate Compliance Officer in any manner, including telephone/voice mail, written communications and e-mail.

Face-to-face communication is welcome. Providers reporting possible compliance issues, in good faith, will not be subjected to retaliation or harassment as a result of the report.

Concerns about possible retaliation or harassment should be reported to the Corporate Compliance Officer or the Chief Executive Officer.

H. Investigations and Violations

If Sandhills Center receives information regarding an alleged corporate compliance violation, an investigation will occur to evaluate such information as to gravity and credibility. Sandhills Center may also disclose the results of investigations to regulatory and/or law enforcement agencies depending on the nature of the allegation.

I. Clinical and Business Records

Sandhills Center shall require network providers to maintain clinical records that meet the requirements in the NC DMH/DD/SAS Records Management and Documentation Manual for providers (APSM 45-2), Rules for MH/DD/SAS Facilities and Services (APSM 30-1), DMH/DD/SAS Records Retention and Disposition Schedule (APSM10-5), the NC MMIS Provider Claims and Billing Assistance Guide, DHB Clinical Coverage Policies and any other applicable federal and state laws, rules and regulations.

Full Clinical Service Records

A full clinical service record is one that is used to document the provision of the majority of the mental health, intellectual or developmental disabilities, and substance use services discussed in this manual and contains all the elements inherent in a complete clinical service record. All services, unless otherwise specified, must be documented in a full clinical service record.

1. Contents of a Full Clinical Service Record

All information developed or received by the provider agency about the individual during the course of treatment should be included in the service record. Information needed for reimbursement purposes may at times be filed in the clinical service record, but this is not required as long as the reimbursement records are maintained in a consistent format and safeguarded under all the appropriate protections and regulations. Providers must properly record and retain billing and reimbursement records and related information according to the specific requirements of the payers involved.

The clinical service record shall include the following information or items when applicable, as well as any other relevant information that would contribute to or address the quality of care for the individual:

- Consents
  - Written consent for the provider to provide treatment;
  - Informed written consent or agreement for proposed treatment and plan development –
required on the individual’s PCP or service plan, or a written statement by the provider stating why such consent could not be obtained [10A NCAC 27G .0205(d)(6)];
  o Informed written consent for planned use of restrictive intervention [10A NCAC 27D .0303(b)];
  o Written consent granting permission to seek emergency care from a hospital or physician;
  o Informed written consent for participation in research projects;
  o Written consent to release information [10A NCAC 26B .0202 and .0203];
• Demographic Information / In Case of Emergency / Advance Directives
  o Individual’s name [must be on all pages in the service record that were generated by the agency];
  o Service record number, with Medicaid Identification Number, and/or unique identifier when applicable, if a provider chooses to use its own number or coding system, which will crosswalk those they provide service to with his/her identity;
  o Demographic information entered on a service record face sheet, including, but not limited to, the individual’s full name [first, middle, last, maiden], contact information, service record number/unique identifier, date of birth, race, gender, marital status, admission date, and discharged date when services end;
  o Emergency information, which shall include the name, address, and telephone number of the person to be contacted in case of sudden illness or accident; the name, address, and telephone number of the individual’s preferred physician; and hospital preference;
  o Advance directives;
  o Health history, risk factors;
  o Documentation of history of mental illness, intellectual or developmental disability, or substance use disorder, according to the DSM-5 or any subsequent edition, and the ICD-10-CM or any subsequent edition.

Documentation of medication allergies, other known allergies, and adverse reactions, as well as the absence of known allergies.
• Medications and Lab Documents;
  o Documentation of medications, dosages, medication administration, medication errors, and a Medication Administration Record [MAR], per 10A NCAC 27G .0209;
  o Medication orders;
  o When applicable, orders for, and copies of, lab tests;
• Notification of Rights;
  o Evidence of a written summary of the individual’s rights given to the individual/legally responsible person, according to 10A NCAC 27D .0201, and as specified in G. S. § 122C, Article 3;
  o Documentation that the individual’s rights were explained to the individual/legally responsible person;
• Restrictive Interventions;
  o Written notifications, consents, approvals, and other documentation requirements per 10A NCAC 27E .0104 (e)(9) whenever a restrictive intervention is used as a planned intervention;
  o Inclusion of any planned restrictive interventions in the individual’s service plan according to 10A NCAC 27E .0104(f), whenever used;
  o Documentation in the service record that meets the specific requirements of 10A NCAC 27E.0104 (g)(2) and 10A NCAC 27E .0104(g)(6) when a planned restrictive intervention is used, including:
    ➢ Documentation of rights restrictions [10A NCAC 27E .0104(e)(15), per G.S.
§ 122C-62(e), and
- Documentation of use of protective devices [10A NCAC 27E.0104(G) and 10A NCAC 27E.0105].

- Screening, Assessments, Eligibility, Admission Assessments, Clinical Evaluations;
  - Clinical level of functioning measurement tools;
  - Screening, which shall include documentation of an assessment of the individual’s presenting problems/needs, and disposition, including recommendations and referrals;
  - Documentation of strategies used to address the individual’s presenting problem, if a service is provided prior to the establishment of a plan [10A NCAC 27G.0205(b)];
  - Admission/eligibility assessments and other clinical evaluations, completed according to the governing body policy and prior to the delivery of services, with the following minimum requirements:
    - Reason for admission, presenting problem;
    - Description of the needs, strengths, and preferences of the individual;
    - Diagnosis based on current assessment and according to the DSM-5 or any subsequent edition of this reference material published by the American Psychiatric Association; the DSM-5 diagnoses should always be recorded by name in the service record in addition to listing the code;
    - Social, family, medical history;
    - Evaluations or assessments, such as psychiatric, substance use, medical, vocational, etc., as appropriate to the needs of the individual;
    - Mental status, as appropriate;
    - Recommendations;

- Treatment Team / Service Coordination;
  - Identification of other team members;
  - Documentation of coordination with the rest of the individual’s team;
  - Treatment decision-making process, including thought processes and the issues considered;

- Service Plan‡
  - PCP [must include Medicaid ID number for Medicaid-eligible individuals];
  - Service plan / treatment plan / individual support plan when a PCP is not required;
  - Service order by one of the approved signatories, when required; [For all behavioral health services covered by Medicaid that require an order, and for all state-funded services where a service order is recommended or required, the service order is indicated by the appropriate professional’s signature entered on the PCP. If a format other than the PCP’s format is used, then a separate service order is required for services that require an order unless the format used provides for service orders to be signed on the service plan.

‡ When medication management is the only service being provided, a service plan is not required.

- Service Authorizations;
  - Authorization requests;
  - As applicable: reauthorization requests, denial appeals, service end-date reporting;

- Discharge Information;
  - Discharge plans;
  - Discharge summaries;

- Referral Information, sent or received;

- Service Notes or Grids: signed by the person who provided the service, which include interventions, treatment, effectiveness, progress toward goals, service coordination and other
case management activities, and for entering other important information;

- Incidents: Documentation of incidents, including description of the event, action taken on behalf of the individual, and the individual’s condition following the event [NOTE: Completed incident reports are to be filed separately from the service record.];
- Release/Disclosure of Information;
  - Documentation of written notice given to the individual/legally responsible person upon admission that disclosure may be made of pertinent confidential information without his or her expressed consent, in accordance with G. S. § 122C-52 through 122C-56;
  - Log of releases and disclosures of confidential information.
- Legal Information: Copies of any relevant legal papers, such as guardianship/legally responsible person designation;
- Other Correspondence: Incoming and outgoing correspondence, including copies of all letters relating to services provided that do not fit into the other mentioned categories.

Electronic Medical Records
An electronic medical record, or EMR, is a digital version of a person’s paper record. The EMR is an electronic system that contains the medical and treatment information on individuals seen by the provider. For the most part, electronic medical records lack interoperability [i.e., they do not interface with other information systems]. EMRs have limited functionality outside of the agency or practice setting. For example, when the information in the EMR needs to be sent to the LME-MCO for utilization review, pertinent information may need to be printed and then faxed or mailed to the requesting party, using HIPAA-compliant methods of transmission.

Electronic Health Records
Some providers have moved from the use of paper records or electronic medical records to a bona fide electronic health record. An EHR is distinguished from a paper or EMR in that the EHR focuses on the total care of an individual’s treatment across all the providers involved in the person’s care, e.g., pharmacists, laboratories, and specialists. The EHR improves care coordination and efficiency while at the same time maintaining privacy and security across all providers. The individual in treatment also has access to his or her EHR.

EHRs facilitate the sharing of information across authorized providers in real time. The Centers for Medicaid and Medicare Services [CMS], and the Office of the National Coordinator for Health Information Technology [ONC] have established standards for certifying bona fide EHR systems. ONC maintains a list of EHR technology products that have been tested and found to meet their standards, which can be accessed by clicking on their website link at https://www.healthit.gov/

Sandhills Center monitors Medical Record documentation to ensure that standards are met. Sandhills Center has the right to inspect provider records without prior notice. Sandhills Center Network Provider contracts require providers to transfer original Medical Records to Sandhills Center within sixty (60) days in the event that the provider closes its North Carolina business operations, whether the closure is due to retirement, bankruptcy, relocation to another state, or any other reason.

Requirements for medical records are communicated to providers in the Sandhills Centers Provider Manuals. Medical records shall be maintained at the provider level; therefore, members may have more than one record if they receive services from more than one provider. Sandhills Center shall monitor medical record documentation to ensure that standards are met.
J. **Network Provider Compliance with Confidentiality and HIPAA Privacy Regulations**

Each provider must adhere to and follow the below State and Federal Confidentiality Rules and Regulations:

- General Statutes 122C – North Carolina MH/DD/SA Laws
- APSM 45-1 – State of North Carolina Confidentiality Rules
- 42 CFR Part 2 – Confidentiality of Alcohol and Drug Abuse Patient Records
- HIPAA Privacy Regulations, Parts 160 and 164
- HIPAA Security Regulations

Each Provider must comply with HIPAA Privacy Regulations
(See HIPAA resource website below)

- [https://www.nctracks.nc.gov/content/public/providers/provider-trading-partners.html](https://www.nctracks.nc.gov/content/public/providers/provider-trading-partners.html)
- [https://www.sandhillscenter.org/for-providers/corporate-compliance/](https://www.sandhillscenter.org/for-providers/corporate-compliance/)
- [https://www.hhs.gov/hipaa/index.html](https://www.hhs.gov/hipaa/index.html)

K. **Management Information Systems**

Each Provider must have Internet Capacity
Each Provider must comply with HIPAA Security Regulations

Please go to CMS web site as a further resource. Follow the link [https://www.cms.gov/](https://www.cms.gov/)

L. **Reporting Fraud, Waste and Abuse**

Sandhills Center will receive any referral for suspected provider or recipient fraud, waste, or abuse. You can make a referral through any of the following methods:

1. Call Sandhills Center customer service at 1-800-256-2452 to file a grievance
2. Call Sandhills Center Program Integrity Department at (336) 389-6136
3. Use DHB’s confidential online grievance form found at [https://medicaid.ncdhhs.gov/reportfraud](https://medicaid.ncdhhs.gov/reportfraud)
4. Contact the Attorney General’s Medicaid Investigation Division at (919) 881-2320
SECTION 12: Provider Violations and Dispute Resolution  
(Medicaid & State Funds)

A. Participating Provider Violations and Dispute Resolution Process Medicaid/State
   1. Procedure for Panel Disputes Concerning Professional Competence or Conduct
   2. Procedure for Disputes Involving Administrative Matters
   3. Dispute Resolution Form *(Refer to Sandhills Center Website Providers Tab for Form)*

B. Participating Provider Violations and Dispute Resolution Flow Chart
   Medicaid/State
A. Medicaid and State Reconsideration Process

Scope of Dispute Resolution Procedure

The dispute resolution process is available only to Sandhills Center network providers and practitioners for disputes of Sandhills Center decisions/actions related to Administrative Matters, and those related to Professional Competence or Conduct. The Dispute Resolution process does not cover provider non-compliance with requirements identified in the contract as cause for termination. The procedure is consistent with accreditation standards, and North Carolina Department of Health and Human Services regulations. The Dispute Resolution policy and procedure is reviewed at least annually, with the involvement of participating providers. The Provider Dispute Resolution Form can be accessed through Sandhills Center’s website at the following link: https://www.sandhillscenter.org/for-providers/provider-forms/

1. Procedure for Panel Disputes Concerning Professional Competence or Conduct

Step 1: The provider makes Sandhills Center aware of its dispute concerning a decision/course of action by Sandhills Center through the submission of a completed Provider Request for Dispute Resolution of an Action form. This form, along with the process for Dispute Resolution is outlined in the Provider Manual, and is reviewed with providers during the Provider Orientation. The form, with accompanying information to support the dispute, must be submitted in writing, return receipt requested within 7 calendar days of notification of the decision/action (Medicaid) or within 30 calendar days of notification of the decision/action (State funded) to the Network Director or designee. If delivered in person, a receipt shall be issued to the provider by Sandhills Center. It is the provider’s responsibility to request a receipt if one is not offered. The provider must provide any additional written documentation to be considered during the reconsideration process at the time the request for reconsideration is filed.

Step 2: All requests for reconsideration are recorded and the documents date stamped with the date of receipt.

Step 3: A letter will be sent to the provider by registered mail, return receipt requested, indicating the date of receipt. Reimbursement will continue during the reconsideration process unless the provider is cited for gross negligence, suspected of committing fraud or abuse, or in the sole discretion of Sandhills Center, continued reimbursement is likely to increase any payback amount due.

The provider may be required to submit documentation of services provided in order to continue to receive reimbursement during the reconsideration process.

Step 4: The Network Operations Director or designee in consultation with the Chief Medical Officer/Chief Clinical Officer convenes the First Level Dispute Panel. Panel membership consists of the Chief Compliance Officer and at least three qualified individuals, which will consist of Sandhills Center staff and a participating provider who is a clinical peer who was not involved in the action or decision that led to the dispute and have adequate clinical expertise to evaluate the issue(s) in question. The Network Operations Director or designee will also convene the Panel for any dispute that is in response to an action taken by the Credentialing Committee and will participate as a non-voting member. A quality management staff member will also participate on the panel as a non-voting member. At least one of the providers reviewing the dispute will be a clinical peer of the provider who filed the dispute. The Provider representatives shall not have participated in any prior dispute resolutions activities. The First Level Panel will make an ad hoc appointment of a provider, who is a clinical peer, when needed. If a clinical peer from the provider network is not available, a clinical peer from outside the provider network will be identified for this purpose.
Step 5: Any identifying information will be “blinded” prior to review by providers participating on the Panel. The Panel reviews the information submitted by the provider and within 14 calendar days of the receipt of the request makes a decision by majority vote. The Panel responds by registered mail return receipt requested within 7 calendar days of the decision (Medicaid), and within 30 days of the receipt of the request (State), outlining the decision and further steps in the dispute process. The return receipt will be maintained with the reconsideration documents. The Chief Executive Officer will be advised of the decision.

Step 6: Notice of the final decision of the Panel will be communicated to Finance, Network, Quality Management and Corporate Compliance.

All paybacks are due and payable by the provider upon completion of the reconsideration. All payment to the provider shall cease unless and until the required payback is paid in full. Paybacks shall be paid by withholding reimbursement payments due to the provider or by direct repayment to Sandhills Center, as specified in an approved payment plan. Approval of a payback payment plan shall be made by the Finance Director in writing. All payments due to the provider shall continue to be withheld until either the payback is paid in full or a payback payment plan is approved in writing.

Step 7: If the provider presents information to challenge the findings of the process outlined in steps 1-5, a Second Level Dispute Panel process will be used. The provider has 7 calendar days (Medicaid), 30 calendar days (State) from receipt of the First Level Panel response to submit the request form by return receipt requested to the Network Director with any new information for reconsideration by the Second Level Panel. If delivered in person, a receipt shall be issued to the provider by Sandhills Center. It is the provider’s responsibility to request a receipt if one is not given. The provider must provide any additional written documentation to be considered during the reconsideration process at the time the request for reconsideration is filed.

Step 8: All requests for reconsideration are recorded and the documents date-stamped with the date of the receipt.

Step 9: A letter will be sent to the provider by registered mail with return receipt requested indicating the date of receipt. Reimbursement will continue during the reconsideration process unless the provider is cited for gross negligence, suspected of committing fraud or abuse, or in the sole discretion of Sandhills Center, continued reimbursement is likely to increase any payback amount due.

The provider may be required to submit documentation of services provided in order to continue to receive reimbursement during the reconsideration process.

Step 10: The Network Operations Director or designee, in consultation with the Chief Medical Officer/Chief Clinical Officer convenes the Second Level Dispute Panel, but is not a voting member of the Second Level Dispute Panel. Panel membership consists of at least three qualified individuals, who will consist of Sandhills Center staff and a participating provider who is a clinical peer who was not involved in the action or decision that led to the dispute and have adequate clinical expertise to evaluate the issue(s) in question. The Quality Management Director and the Chief Medical Officer/Chief Clinical Officer will also participate on the panel as non-voting members. At least one of the providers reviewing the dispute will be a clinical peer of the provider who filed the dispute. The providers serving on the Second Level Panel will not have served on the First Level Panel for the same dispute. The Second Level Panel will make an ad hoc appointment of a provider who is a clinical peer, when needed. If a clinical peer from the provider network is not available, a clinical peer from outside the provider network will be identified for this purpose.

Step 11: Any identifying information will be “blinded” prior to review by providers participating on the Panel. The Panel reviews the information submitted by the provider and within 14 calendar days of receipt of the request and makes a decision by majority vote. The Panel responds by registered mail, return receipt
Step 12: Notice of the final Sandhills Center decision will be communicated to Finance, Network, Quality Management and the Sandhills Center Chief Legal Counsel.

All paybacks are due and payable by the provider upon completion of the reconsideration. All payment to the provider shall cease unless and until the required payback is paid in full. Paybacks shall be paid by withholding reimbursement payments due to the provider by direct repayment to Sandhills Center, as specified in an approved payment plan. Approval of a payback payment plan shall be made by the Finance Director in writing. All payments due to the provider shall continue to be withheld until either the payback is paid in full or a payback payment plan is approved in writing.

Step 13: After a provider has exhausted the reconsideration process at Sandhills Center, if the provider is not satisfied with the final Sandhills decision involving Medicaid funded services, the provider may request a contested case hearing pursuant with Chapter 150B of the General Statutes with the Office of Administrative Hearings at the following address:

For State funded services, if the provider is not satisfied with the final Sandhills Center decision, an appeal may be made to the State Mental Health, Developmental Disabilities and Substance Abuse Appeals Panel within 15 days of the LME-MCO decision under G.S. 122-151.4. Community Support providers not satisfied with the decision must file an appeal using the procedure in Session Law 2009-526 Section 10.15 A. (e2) for appeals filed on or after July 1, 2008 and not G.S. 122-151.4.

Hearings Division (for Medicaid ONLY)
Office of Administrative Hearings
6714 Mail Service Center
Raleigh, NC 27699-6714

Providers have the right to file an appeal with the Office of Administrative Hearings within thirty (30) calendar days of the receipt of the final notification from Sandhills Center. If the request is not received within the 30 days, Sandhills Center’s decision is considered final.

The request for reconsideration review must be in writing, signed by the provider and contain provider name, address and telephone number. It must state the specific reason for the request and be mailed to the address above.

The NC Medicaid State Plan (“State Plan under Title XIX of the Social Security Act”) provides the process and procedures for the OAH hearing and decision. See attachment 1.1B (c) and (d) at NC Medicaid: Medicaid State Plan Public Notices (ncdhhs.gov).

The final Sandhills Center decision, including the requirement for a payback, is not stayed by a reconsideration review request to the Office of Administrative Hearings.

2. Procedure for Disputes Involving Administrative Matters

Step 1: The provider makes Sandhills Center aware of its dispute concerning a decision/course of action by Sandhills Center through the submission of a completed Provider Request for Dispute Resolution form. This form, along with the process for Dispute Resolution, is outlined in the Provider Manual, and is reviewed with providers during the Provider Orientation. The form, with accompanying information to support the dispute, must be submitted in writing, return receipt requested, within 7 calendar days (Medicaid) or 30 calendars days (State) of notification of the decision/action to the Network Director or designee. If delivered in person, a receipt requested within 7 calendar days (Medicaid) and 30 calendar days (State) of the decision, outlining the decision and further steps in the dispute process. The return receipt will be maintained with the reconsideration documents. The Chief Executive Officer will be advised of the decision.
shall be issued to the provider by Sandhills Center. It is the provider’s responsibility to request a receipt if one is not offered. The provider must provide any additional written documentation to be considered during the reconsideration process at the time the request for reconsideration is filed.

Step 2: All requests for reconsideration will be recorded and the documents date-stamped with the date of receipt.

Step 3: A letter will be sent to the provider by registered mail return receipt requested indicating the date of the receipt. Reimbursement will continue during the reconsideration process unless the provider is cited for gross negligence, suspected of committing fraud or abuse or in the sole discretion of Sandhills Center, continued reimbursement is likely to increase any payback amount due. The provider may be required to submit documentation of services provided in order to continue to receive reimbursement during the reconsideration process.

Step 4: The Chief Compliance Officer, Deputy Director/Chief Operating Officer, and the Quality Management Director or designees review the information submitted by the provider within 14 calendar days of receipt of the request and responds by registered mail, return receipt requested within 7 calendar days (Medicaid) or 30 calendar days (State) of the decision, outlining the decision and further steps in the dispute process. The receipt will be filed with the reconsideration information. The Chief Executive Officer will be advised of the decision.

The above named positions will designate qualified staff to participate on the committee for any dispute that is in response to an action taken by the Credentialing Committee regarding a provider’s re-credentialing status. The Network Operations Director or designee will convene the committee and participate as a non-voting member. A quality management staff member will also participate on the panel as a non-voting member.

Step 5: Notice of the final Sandhills Center decision will be communicated to Finance, Network, Quality Management, and Corporate Compliance.

All paybacks are due and payable by the provider upon completion of the reconsideration. All payment to the provider shall cease unless and until the required payback is paid in full. Paybacks shall be paid by withholding reimbursement payments due to the provider or by direct repayment to Sandhills Center, as specified in an approved payment plan. Approval of a payback payment plan shall be made by the Finance Director in writing. All payments due to the provider shall continue to be withheld until either the payback is paid in full or a payback payment plan is approved in writing.

Step 6: After a provider has exhausted the reconsideration process at Sandhills Center, if the provider is not satisfied with the final Sandhills decision involving Medicaid funded services, the provider may request a contested case hearing with the Office of Administrative Hearings pursuant to Chapter 150B of the General Statutes at the following address:

For State funded services, if the provider is still not satisfied with the decision, an appeal may be made to the State Mental Health, Developmental Disabilities and Substance Abuse Appeals Panel under G.S. 122-151.4. Provider not satisfied with the decision must file an appeal within 7 calendar days of the LME-MCO decision using the procedure in Session Law 2009-526 Section 10.15 A. (e2) for appeals filed on or after July 1, 2008 and not G.S. 122-151.4.

Hearings Division (for Medicaid ONLY)
Office of Administrative Hearings
6714 Mail Service Center
Raleigh, NC 27699-6714

Medicaid/State Provider Manual 180 of 237 Updated 11/04/2020
Providers have the right to file an appeal with the Office of Administrative Hearings with thirty (30) calendar days of the receipt of the final notification from Sandhills Center. If the request is not received within the 30 days, Sandhills Center’s decision is considered final.

The request for reconsideration review must be in writing, signed by the provider and contain provider, name, address and telephone number. It must state the specific reason for the request and be mailed to the address above.

The NC Medicaid State Plan (“State Plan under Title XIX of the Social Security Act”) provides the process and procedures for the OAH hearing and decision. See attachment 1.1B (c) and (d) at NC Medicaid: Medicaid State Plan Public Notices (ncdhhs.gov).

The final Sandhills Center decision, including the requirement for a payback, is not stayed by a reconsideration review request to the Office of Administrative Hearings.

State appeal requests only:

If the provider is still not satisfied with the decision, an appeal may be made to the State Mental Health, Developmental Disabilities and Substance Abuse Appeals Panel under G.S. 122-151.4. Community Support providers not satisfied with the decision must file an appeal using the procedure in Session Law 2009-526 Section 10.15 A. (e2) for appeals filed on or after July 1, 2008 and not GS 122-151.4.

3. Dispute Resolution Form (Refer to Sandhills Center website Providers Tab for Form) https://www.sandhillscenter.org/for-providers/provider-forms/
B. Medicaid/State Provider Dispute Resolution Flow Chart

Provider submits a completed Provider Request for Dispute Resolution Form within 7 calendar days (Medicaid), 30 days (State) of receipt of Sandhills Center Letter of Decision / Action.

**ADMINISTRATIVE MATTER DISPUTES**

- Designated Sandhills Center staff review information received.

- Sandhills Center makes a decision within 14 calendar days of receipt of request & responds in writing within 7 calendar days (Medicaid), 30 days (State).

  - If the Provider is not satisfied, an appeal to OAH Hearings Division may be made within 30 days of receipt of the decision.

  - If the Provider is not satisfied, an appeal to NC Division of MH/DD/SAS may be made.

**PROFESSIONAL COMPETENCE OR CONDUCT DISPUTES**

- Sandhills Center convenes the First Level Dispute Panel, reviews information & makes a decision

- Sandhills Center makes a decision within 14 calendars days of receipt of request & responds in writing within 7 days (Medicaid), 30 days (State).

  - If the Provider wishes to challenge this decision, they submit the Provider Request for Dispute Resolution form 2nd Level within 7 calendar days of receipt of Sandhills Center’s 1st Level Response.

  - Sandhills Center convenes a 2nd Level Panel, reviews information & makes a decision.

  - Sandhills Center makes a decision within 14 calendar days of receipt of request & responds in writing within 7 (Medicaid), 30 (State) calendar days.

  - If the Provider is not satisfied, an appeal to OAH Hearings Division may be made within 30 days of receipt of decision

  - State: If the Provider is not satisfied, an appeal to NC Division of MH/DD/SAS may be made
SECTION 13:  GLOSSARY OF TERMS
Glossary of Terms

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


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

**Active Course of Treatment:** Treatment whose discontinuation could cause a recurrence or worsening of a condition under treatment and interfere with anticipated outcomes. Treatment typically involves regular visits with the practitioner to monitor the status of an illness or disorder, provide direct treatment, prescribe medication or other treatment or modify a treatment protocol.

**Active Treatment:** means that the member has regular visits with the practitioner to monitor the status of an illness or disorder, provide direct treatment, prescribe medication or other treatment or modify a treatment protocol. Active treatment does not include routine monitoring for a chronic condition.

**Adjudicate:** A determination to pay or reject a claim

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

**Adverse Benefit Determination:**

Pursuant to 42 CFR § 438.400, “adverse benefit determination” is defined as the denial or limited authorization of a requested service, including determinations based on the type or level of service; requirements for medical necessity, appropriateness, setting or effectiveness of a covered benefit; the reduction, suspension, or termination of a previously authorized service; the denial, in whole or in part, of payment for a service; the failure to provide services in a timely manner, as defined by the State; the failure of the LME/MCO to act within the timeframes provided in 42 CFR § 438.408(b)(1) & (2) regarding the standard resolution of grievances and appeals; the denial of a member’s request to dispute a financial liability, including the cost sharing, copayments, premiums, deductibles, coinsurance and other member financial liabilities; and, for a rural area resident with only one LME/MCO, the denial of a member’s request to obtain services outside the Network under any of the following circumstances or where the Parties mutually agree that the other circumstances warrant out-of-network agreements:

a. When services from any other Provider (in terms of training, experience, and specialization) are not available.
b. From a Provider not part of the LME/MCO Closed Network who is the main source of a service to the member – provided that the Provider is given the same opportunity to become a participating Provider as other similar Providers. If the Provider does not choose to join the Network or does not meet the qualifications, the member shall be given a choice of participating Providers and shall be transitioned to a participating Provider within sixty (60) calendar days;
c. Because the only plan or Provider available does not provide the service the member seeks because or moral or religious objections; or
d. Because the member’s Provider determines that, the member needs related services that would subject the member to unnecessary risk if received separately and not all related services are available within the Network.
**Adverse Event**: An injury that occurs in the course of a member receiving health care services from a practitioner.

**Advocacy**: Activities in support of, or on behalf of, people with mental illness, intellectual/developmental disabilities or addiction disorders including protection of rights, legal and other service assistance, and system or policy changes.

**Ambulatory**: A setting where non-acute care is provided on an outpatient basis to patients who leave the setting on the same day they receive treatment (e.g., urgent care center, walk-in clinic, outpatient surgery center).

**American Society of Addiction Medicine (ASAM)**: An international organization of physicians dedicated to improving the treatment of people with substance abuse disorders by educating physicians and medical students, promoting research and prevention, and informing the medical community and the public about issues related to substance use. In 1991, ASAM published a set of patient placement criteria that have been widely used and analyzed in the alcohol, tobacco and other drug field.

**Appeal**: A request for review of an adverse benefit determination, as that term is defined in 42 CFR § 438.400.

**Applicant**: A Provider who is seeking to participate in the Closed Network of the LME/MCO, as set forth at N.C.G.S. § 108D-1(1).

**Assessment**: A procedure for determining the nature and extent of need for which the individual is seeking services.

**Basic Augmented Services**: The Basic Augmented Benefit package includes those services that will be made available to Medicaid-entitled individuals and, to the extent, the resources are available, to non-Medicaid individuals meeting the Priority population criteria. A member requiring this level of benefit is in need of more that the automatically authorized outpatient visits in order to maintain or improve his/her level of functioning. An Authorization for the services available in this level will need to be requested to Sandhills Center Care/Utilization Management Unit. Authorization is based on the member's need and medical necessity criteria for the services requested.

**Basic Benefit Plan**: The Basic Benefit package includes those services that will be made available to Medicaid-entitled individuals and, to the extent, resources are available, to non-Medicaid individuals according to local business plans. These services are intended to provide brief interventions for individuals with acute needs. The Basic Benefit package is accessed through a simple referral from the Local Management Entity, through its screening, triage and referral system.

**Benchmark**: A standard by which something can be measured, judged, or compared.

**Beneficiary**: An individual who is eligible for the North Carolina Medicaid program and whose eligibility arises from the residence in one of the counties in the LME/MCO catchment area.

**Best Practices**: Recommended practices, including Evidence Based Practices that consist of those clinical and administrative practices that have been proven to consistently produce specific, intended results.

**Billing Audit**: An audit conducted by Sandhills Center to assess the presence of appropriate documentation to support claims submitted for payment.

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

**Capitation Payment**: The amount to be advanced monthly to the LME/MCO for each member covered by the LME/MCO’s Benefit Plan based on Eligibility Category and age, regardless of whether the member receives services during the period covered by the payment.
Care Management: A multidisciplinary, disease centered approach to managing medical care using outcome measures to identify best practices. The purpose of care management is to identify levels of risk, stratify of services according to risk, and prioritize recipients for services. The approach utilizes collaboration of services, systematic measurement and reporting and resource management.

Catchment Area: The geographic part of the State of North Carolina served by the LME/MCO, as defined in N.C.G.S. § 122C-3(5).


CFAC: Consumer and Family Advisory Committee, which is comprised of members and family members representing all disability groups. CFACs meet on a regular basis to support and communicate their concerns and provide advice and comment on all state and local plans.

C.F.R.: Code of Federal Regulations

Children: Members who have not reached their respective twenty-first (21st) birthday, unless otherwise defined in the DHB contract.

Clean Claim: Means as defined in 42 CFR § 447.45(b). A clean claim means one that can be processed without obtaining additional information from the provider of the service or from a third party. It includes a claim with errors originating in a State’s claims system. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity.

Clinical Advisory Committee (CAC): The Clinical Advisory Committee is a rotating membership composed of licensed independent practitioners—MD’s, practicing psychologists, LCSW’s, LCAS’s, and PLC’s—who are representative of our provider network with regards to discipline, specialty, clinical competencies, geographic locations, and agency size. Additionally, this committee has representatives from the LME/MCO’s CCNC Network and members who are academic experts in the mental health field. These experts are not members of the provider network, but they reside within the Sandhills Center LME/MCO geographic area.

Health Call Center: Sandhills Center is responsible for timely response to the needs of members and for quick linkages to qualified providers of the network. To accomplish this, Sandhills Center maintains a 1-800 call system to receive all inquiries. Callers needing an emergency/crisis screening, triage and referral, an appointment, making a grievance or appeal, information, or other inquiry and/or assistance may access these services through this number. The call system utilizes information systems management software to assist in tracking and responding to calls. This tracking system establishes an electronic record of all interaction with that individual.

Closed Provider Network (also referred to as Network, Closed Network, Provider Network, and LME/MCO Closed Provider Network): The group of providers that have contracted with the LME/MCO to furnish covered mental health, intellectual or developmental disabilities, and substance abuse services to members, as set forth at N.C.G.S. § 108D-1(2)

CMS: Centers for Medicare and Medicaid Services
Concurrent Review: A review conducted by the LME/MCO (Prepaid Inpatient Health Plan) during a course of treatment to determine whether services meet medical necessity and quality standards and whether services should continue as prescribed or should be terminated, changed or altered.

Co-Payment: A fixed amount paid by the patient for a covered health care service after the deductible has been paid.

Covered Services:

For Medicaid - The Behavioral Health services identified on the Division of Health Benefits website https://medicaid.ncdhhs.gov/providers/clinical-coverage-policies/behavioral-health-clinical-coverage-policies under Clinical Policies which the LME/MCO agrees to provide or arranges to provide to all pursuant to the terms of the contract.

For State Funded (IPRS) - The services identified on the Division of Mental Health/Developmental Disabilities/Substance Abuse Services website at https://www.ncdhhs.gov/divisions/mhddsas/servicedefinitions, which the LME/MCO agrees to provide or arranges to provide to all pursuant to the terms of the Contract.

Credentialing: The pre-contract screening and decision process, including primary source verification (PSV), conducted by the LME/MCO to verify that the Applicant is qualified to deliver services to members and eligible to participate and be enrolled and contracted in the LME/MCO’s Closed Provider Network. The process includes obtaining a provider enrollment application, verifying the information received from the Applicant, and assessing the required qualifications, certifications, endorsements and licensure of the Applicant, as well as additional credentialing elements required by the LME/MCO’s accrediting body. In addition, this also includes criminal background and Federal and State database checks. The LME/MCO is not required to enroll or contract with a credentialed provider. Enrollment in the LME/MCO’s Closed Network is distinct from enrollment in the NC Medicaid Program. Clean and unclean credentialing/re-credentialing applications are defined as follows:

a. The Credentialing committee has delegated authority to the Chief Medical Officer/Chief Clinical Officer to approve “clean” credentialing applications” as defined as: Credentialing/re-credentialing applications with no open actions from any regulatory body/law enforcement agency and credentialing/re-credentialing applications with no closed/resolved actions from any regulatory body/law enforcement agency within the last five (5) years. The previous definition also applies to matters of re-credentialing in addition to having no negative entries in the provider profile system.

b. The definition of an “unclean” application for credentialing & re-credentialing is any application with adverse actions of five (5) years or younger & COMPLETED QM issues. Unclean credentialing & re-credentialing applications are discussed monthly by the Credentialing Committee & minutes documented. The credentialing committee is composed ONLY of non-Sandhills Center staff who hold active & unrestricted licensure in their field & these members are the only ones casting votes on credentialing/re-credentialing matters. The Chief Medical Officer/Chief Clinical Officer chairs the committee and in the case of a tie vote, the Sandhills Center Chief Medical Officer/Chief Clinical Officer casts the deciding vote.

Crisis Interventions: Unscheduled assessment and treatment for the purpose of resolving an urgent/emergent situation requiring immediate attention.

Critical Time Intervention: Critical Time Intervention is a focused, time-limited approach to connect people with community support as they transition into housing from homelessness, or from institutional settings, such as prisons and hospitals, into ongoing community-based services.
Cultural Competency: The understanding of the social, linguistic, ethnic, and behavioral characteristics of a community or population and the ability to systematically translate that knowledge into practices in the delivery of behavioral health services. Such understanding may be reflected, for example, in the ability to: Identify and value differences; Acknowledge the interactive dynamics of cultural differences; Continuously expand cultural knowledge and resources with regard to populations served; Collaborate with the community regarding service provisions and delivery; and Commit to cross-cultural training of staff and develop policies to provide relevant, effective programs for the diversity of people served.

Days: Except as otherwise noted, refers to calendar days. The terms “working day” and “business day” shall each mean a day on which DHB/DMH/DHHS and the LME/MCO are officially open to conduct their affairs.

DHB: The Division of Health Benefits, which is overseen by DHHS.

DHHS or Department: The North Carolina Department of Health and Human Services, which is the designated single state Medicaid agency for the State of North Carolina.

Disaster: A disaster is any natural or human-caused event, which threatens or causes injuries, fatalities, widespread destruction, distress and economic loss. Disasters result in situations that call for a coordinated multi-agency response. A disaster calls for responses that usually exceed local capabilities.

Dispute Resolution Process: Sandhills Center’s process to address written disputes by providers in a consistent manner.

Disenrollment: Action taken by DHB to remove a member’s name from the monthly Enrollment following DHB’s determination that the member is no longer eligible for enrollment in the LME/MCO.

DJJDP: Department of Juvenile Justice and Delinquency Prevention

DMH/DD/SAS: The Division of Mental Health, Developmental Disabilities and Substance Abuse Services

DRG: Diagnostic Related Grouping

DSS: The County Department of Social Services

Durable Medical Equipment: Equipment that is primarily and customarily used to serve a medical purpose, is generally not useful to an individual in the absence of a disability, illness or injury, can withstand repeated use, and can be reusable or removable.

Early Periodic Screening, Diagnostic and Treatment Services (EPSDT): Early and Periodic Screening, Diagnosis and Treatment is a Medicaid program for Title XIX individuals under the age of 21. This mandatory preventive child health program for Title XIX children requires that any medically necessary health care services identified in a screening be provided to an EPSDT recipient. The MH/DD/SA component of the EPSDT diagnostic and treatment services for Title XIX members under age 21 years are covered by this contract.

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) is the federal law that says Medicaid must provide all medically necessary health care services to Medicaid eligible children. Even if the service is not covered under the NC Medicaid State Plan, it can be covered for recipients under 21 years of age if the service is listed at 1905 (a) of the Social Security Act and if all EPSDT criteria are met.

Eligibility: The determination that an individual meets the requirements to receive services as defined by payer.
Emergency Medical Condition: A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

   a. Placing the health of the member (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.
   b. Serious impairment to bodily functions, or
   c. Serious dysfunction of any bodily organ or part.

Emergency Services: With respect to an emergency service, covered inpatient and outpatient services that:

   a. Are furnished by a Provider that is qualified to furnish such services; and
   b. Are needed to evaluate or stabilize an emergency medical condition as defined above.

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

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

Enrollee (also known as Member): A Medicaid beneficiary whose Medicaid eligibility arises from residency in a county covered by SANDHILLS CENTER or who is currently enrolled in a LME/MCO.

Enrollment: When referring to Enrollees/members, this means an action taken by DHB to add a Medicaid beneficiary’s name to the monthly Enrollment Report following the receipt and approval by DHB of Medicaid Eligibility for a person living in the defined catchment area. When referring to Providers, this means the process of submitting a credentialing application for consideration to become a Provider in the LME/MCO’s Closed Network, unless the context is referring to the process of submitting an online enrollment application via NC Tracks for consideration to become a Provider in the NC Medicaid or Health Choice programs.

Enrollment Period: The time span during which a recipient is enrolled with a LME/MCO.

Evidence Based Practice: is the integration of a) clinical expertise/expert opinion, b) external scientific evidence, and c) client/patient/caregiver perspectives to provide high-quality services reflecting the interests, values, needs and choices of the individuals we serve.

Excluded Services: Health care services that are not covered or paid for by a health insurer.

Facility: Any premises (a) owned, leased, used or operated directly or indirectly by or for a LME/MCO for purposes related to the Contract; or (b) maintained by a subcontractor to provide services on behalf of a LME/MCO as part of the Contract.

Federally Qualified Health Center - (FQHC): Federally qualified health centers include all organizations receiving grants under Section 330 of the Public Health Service Act (PHS). FQHCs qualify for enhanced reimbursement from Medicare and Medicaid, as well as other benefits. FQHCs must serve an underserved area or population, offer a sliding fee scale, provide comprehensive services, have an ongoing quality assurance program, and have a governing board of directors.
**Fee-for-Service:** A method of making payment directly to health care providers enrolled in the State Medicaid program for the provision of health care services to Medicaid beneficiaries based on the payment methods set forth in the State Plan and the applicable policies and procedures of DHB.

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

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

**Foster Children:** Medicaid beneficiaries who are receiving foster care or adoption assistance (Title IV-E), are in foster care, or are otherwise in an out-of-home placement.

**Fraud:** An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person, including any act that constitutes fraud under applicable Federal or State law.

**Geographic Accessibility:** A measure of access to services, generally determined by drive/travel time or number and types of providers in a service area. The contract standard is 30 minutes/30 miles for urban areas and 45 minutes/miles for rural areas.

**Global Eligibility File (GEF):** A report created by the State or its agents that contains information about members, and the respective aid categories for which they have been approved, in the State Medicaid program.

**Grievance:** Pursuant to 42 CFR § 438.400, an expression of dissatisfaction by or on behalf of a member about any matter other than an “adverse benefit determination” as defined in Attachment H. The term is also used to refer to the overall system that includes grievances and appeals handled at the LME/MCO level and access to the State Fair Hearing process. Possible subjects for grievances include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the member’s rights regardless of whether remedial action is requested. Grievance includes a members’ right to dispute an extension of time proposed by the LME/MCO to make an authorization decision.

**Grievance and Appeal System:** the processes the LME/MCO implements to handle appeals of an adverse benefit determination and handle grievances, as well as the processes to collect and track information about grievances and appeals.

**Habilitation Services and Devices:** Training, care, and specialized therapies undertaken to assist a client in maintaining his current level of functioning or in achieving progress in developmental skills areas.

**Health Insurance:** A plan that covers or shares the expenses associated with health care.

**Health Plan Employer Data and Information Set (HEDIS):** a collection of standardized performance measures designed to reliably compare the performance of managed health care plans.

**Hearing (also referred to as State Fair Hearing):** A formal proceeding before an Administrative Law Judge of the North Carolina Office of Administrative Hearings in which parties affected by an adverse benefit determination of a LME/MCO or an action taken by DHB shall be allowed to present testimony, documentary evidence and argument as to why such an adverse benefit determination or action should or should not be taken.

**HHS:** U.S. Department of Health and Human Services

**HIEA:** (Health Information Exchange Authority) Health Information Exchange (HIE) systems have been in development nationwide since a federal law was passed in 2009 to promote the use of electronic movement and use of health information among health care providers.
The NC HIEA operates NC’s state-designated health information exchange, NC HealthConnex, a secure, standardized electronic system in which providers can share important patient health information. The use of this system promotes the access, exchange and analysis of health information. The new law also requires that as of February 1, 2018, all Medicaid providers must be connected and submitting data to the HIE in order to continue to receive payments for Medicaid services provided. By June 1, 2018, all other entities that receive state funds for the provision of health services (e.g. State Health Plan), including local management entities/managed care organizations, also must be connected. The NC HIEA is housed within the NC Department of Information Technology’s (DIT) Government Data Analytics Center (GDAC).

**HIPAA:** Acronym for the Health Insurance Portability and Accountability Act of 1996.

**Home Health Care:** Items and services furnished to an individual by a home health agency, or by others under arrangements with such others made by the agency, on a visiting basis, and excepts for paragraph “e”, in place of temporary or permanent residence used as the individual’s home as follows: a) Part-time or intermittent nursing care provided by or under the supervision of a registered nurse; b) Physical, occupational or speech therapy; c) Medical social services, home health aide services, and other therapeutic services; d) Medical supplies, other than drugs and biologicals and the use of medical appliances; e) Any of the foregoing items and services which are provided on an outpatient basis under arrangements made by the home health agency at a hospital or nursing home facility or rehabilitation center and the furnishing of which involves the use of equipment of such a nature that the items and services cannot readily be made available to the individual in his home, or which are furnished at such facility while he is there to receive any such item or service, but not including transportation of the individual in connection with any such item or service.

**Hospice Services:** The provision of palliative and supportive medical and other health services to meet the physical, psychological, social, spiritual, and special needs of patients and their families, which are experienced during the final stages of terminal illness and during dying and bereavement.

**Hospitalization:** Admission to hospital – an institution primarily engaged in providing, by or under the supervision of physicians, inpatient, diagnostic and therapeutic services or rehabilitation services.

**Hospital Outpatient Care:** Care in a hospital that usually doesn’t require an overnight stay.

**IBT or Individual Budget Tool:** The IBT is used during the annual service planning process for members on the Innovations Waiver. The IBT is composed of four (4) tables that specify the IBT amounts that a member assigned to a particular level is authorized to receive without additional authorization (in the form of a temporary increase or intensive review during the utilization review process).

**ICD:** The International Classification of Diseases diagnostic tool for epidemiology, health management and clinical purposes.

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

**Individuals with Disabilities Education Act:** (IDEA): A Federal law (PL 99-457) which requires States and public agencies to provide early intervention, special education and related services to children with disabilities from birth to the twenty-first (21st) birthday.

**Initial Authorization (also called Pre-Authorization):** Approved medically necessary services at a given level of care prior to services being rendered.

**In lieu of services:** Alternative services or settings that are substituted for services or settings covered under the State Plan or that are otherwise covered by the DHB contract, but that are more medically appropriate, cost-effective substitutes for the State Plan services included within Attachment J – Schedule of Benefits.
Innovations Waiver: The Section 1915(c) Home and Community Based Services (HCBS) Waiver that a LME/MCO operates in the geographic area covered by the contract. The Innovations Waiver replaced the Community Alternatives Program for Persons with Intellectual Developmental Disabilities (CAP-I/DD) Waiver in these counties.

In-Plan Services: Services which are included in the behavioral health capitation rate and are the payment responsibility of the LME/MCO.

Institution for mental diseases: Means as defined in 42 CFR § 435.1010. An intermediate Care Facility for individuals with Intellectual Disabilities is not an IMD.

Licensed Independent Practitioner: Medical Doctors (MD, DO) Practicing Psychologists (PhD), Psychological Associates (Master’s Level Psychologist [LPA]), Master’s Level Social Workers (LCSW), Licensed Marriage and Family Therapist (LMFT), Licensed Clinical Mental Health Counselor (LCMHC), Licensed Clinical Addiction Specialist (LCAS), Advanced Practice Psychiatric Clinical Nurse Specialists (APCNS), Psychiatric Nurse Practitioners (NP) and Licensed Physician Assistants (PA) who are eligible to bill under their own license.

Limited English Proficiency (LEP): Individuals who do not speak English as their primary language and who have a limited ability to read, speak, write, or understand English can be limited English proficient, or “LEP”. Including those individuals who are deaf, hard of hearing, and individuals who speak a language other than English.

LME: Local Management Entity, a local political subdivision of the state of North Carolina as established under General Statute 122C.

LME/MCO Authorization Request Form: The most currently approved Service Authorization Request used to request initial or continuing services. The abbreviation for this form is the “SAR”.

LOCUS: Level of Care Utilization System. A standard tool for measuring the level of care needs for adult members.

Managed Care Entity: Managed care organizations (MCOs), Prepaid Inpatient Health Plans (PIHPs), Prepaid Ambulatory Health Plan (PAHPs), Primary Care Case Manager (PCCMs), and Health Insuring Organizations (HIOs).

Managed Care Organization (MCO): Means an entity that has, or is seeking to qualify for, a comprehensive risk contract under this part, and that is (1) A Federally qualified HMO that meets the advance directives requirements or subpart I or part 489 of this chapter; or (2) Any public or private entity that meets the advance directives requirements and is determined by the Secretary to also meet the following conditions: (i) Makes the services it provides to its Medicaid enrollees as accessible (in terms of timeliness, amount, duration, and scope) as those services are to other Medicaid beneficiaries within the area served by the entity, (ii) Meets the solvency standards of 42 CFR § 438-116.

Medicaid Identification Card (MID): The Medical Assistance Eligibility Certification card issued monthly by DHB to eligible beneficiaries.

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

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

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

Medically Necessary Treatment Services or Supplies: According to NCGS § 58-3-200, Covered Services or supplies that are: (1) Provided for the diagnosis, treatment, cure, or relief of a health condition, illness, injury, or disease; and, except as allowed under N.C. G. S. § 58-3-255, not for experimental, investigational, or cosmetic purposes; (2) Necessary for and appropriate to the diagnosis, treatment, cure, or relief of a health condition, illness, injury, disease, or its symptoms; (3) Within generally accepted standards of medical care in the community; and (4) Not solely for the convenience of the insured, the insured’s family, or the provider.

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

Member(s) (also known as Enrollee): A Medicaid recipient that is currently enrolled in the LME/MCO.

NC DHHS: The North Carolina Department of Health and Human Services

NC Innovations Plan: A 1915 (c) Home and Community Waiver for Intellectually and Developmentally Disabilities. This is a waiver of institutional care; funds that could be used to serve a person in an ICF-IID facility can be used to serve people in the community.

NC Medicaid Program: The fee-for-service program operated by DHHS for the provision of health care services to Medicaid beneficiaries based on the payment methods set forth in the State Plan and the applicable policies and procedures of DHB. Enrollment into the LME/MCO Closed Network is distinct from Enrollment into the NC Medicaid Program.

NC MH/DD/SAS Health Plan: A 1915 (b) Medicaid Managed Care Waiver for mental health and substance abuse allowing for a waiver of freedom of choice of providers so that the LME/MCO can determine the size and scope of the provider network. This also allows for the use of Medicaid funds for alternative services.

NC Tracks: The multi-payer Medicaid Management Information System for the NC Department of Health and Human Services.

Network: Facilities, providers and suppliers contracted with a health insurer or plan to provide health care services.

Network Leadership Council (NLC): was established to ensure that provider perspectives are represented in the Sandhills Center Health Network processes and operations to assist in building and maintaining a diverse provider network that meets the requirements of the State. It provides a mechanism to ensure provider input in Sandhills Center’s network and quality management processes, hear provider concerns, create a forum for provider communications and to develop diversity within the provider network as evidenced by provider cultural competency plans. The Sandhills Center Network Leadership Council serves as a fair and impartial representative of services among providers within the Sandhills Center provider network. The NLC shall facilitate open exchange of ideas, shared values, goals, and visions to promote collaboration and mutual
accountability among providers. The NLC strives to promote best practices to empower members within our communities to achieve their personal goals.

**Network Provider:** Means as defined in 42 CFR 438.2. A Network Provider means any provider, group of providers, or entity that has a network provider agreement with a LME/MCO, or a subcontractor, and receives Medicaid funding directly or indirectly to order, refer or render covered services as a result of the state’s contract with an LME/MCO, PIHP, or PAHP. A network provider is not a subcontractor by virtue of the network provider agreement.

**No Reject:** Provider must have a no reject policy. Providers must agree to accept all referrals meeting criteria for service provided; provider capacity to meet individual referral needs will be negotiated between the LME/MCO and the provider.

**Non-Participating Provider:** A provider that has not entered into a contractual arrangement for participation in the closed network of any local management entity/managed care organization.

**Out-of-Area Services:** Covered services provided to a member while the member is outside the catchment area.

**Out-of-Plan or Non-Covered Services:** Health care services, which the LME/MCO is not required to manage or provide under the terms of the contract. The services are Medicaid covered services reimbursed on a fee-for-service basis.

**Out-of-Network Provider:** Any person or entity providing Covered Services who is not a member of the LME/MCO Provider Network.

**Plan of Correction (POC):** A written response to findings of an audit or review that specify corrective action, time frames and persons responsible for achieving the desired outcome.

**Participating Provider:** An appropriately credentialed provider of mental health, intellectual or developmental disabilities, and substance abuse services that has entered into a contract for participation in the closed network of one or more local management entity/managed care organizations.

**Physician Services:** Health care services that a licensed medical physician provides or coordinates.

**Plan:** A benefit plan that pays for health care services.

**Potential Member or Enrollee:** A Medicaid beneficiary who is subject to mandatory enrollment.

**Premium:** Any premium or other consideration payable for coverage under a group or individual policy.

**Prepaid Inpatient Health Plan (PIHP):** An entity that (1) provides medical services to members under contract with the State agency, and on the basis of prepaid capitation payments, or other payment arrangements that do not use State plan payment rates; (2) Provides, arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services for its members; and (3) does not have a comprehensive risk contract.

**Prescription Drug Coverage:** Health insurance or plan that helps pay for prescription drugs and medications.

**Prescription Drugs:** Drugs and medications that, by law, require a prescription.
Primary Care Physician: A physician (Medical Doctor or Doctor of Osteopathic Medicine) who directly provides or coordinates a range of health care services for a patient.

Primary Care Provider: A physician (Medical Doctor or Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist or physician assistant, as allowed under state law, who provides, coordinates or helps a patient access a range of health care services.

Primary Care Case Management (PCCM): A system under which a primary care case manager contracts with the State to furnish case management services which include the location, coordination, and monitoring of primary health care services (to Medicaid beneficiaries).

Prior Authorization: The act of authorizing specific services before they are rendered.

Protected Health Information (PHI): Individually identifiable health information that is or has been electronically transmitted by a covered entity, as well as such information when it takes any other form.

Provider: Any person or entity providing (MH) Mental Health, Individuals with Developmental Disabilities (IDD) and/or Substance Abuse (SA) services.

Provider Network: The agencies, professional groups, or professionals under contract to the LME/MCO that meet the LME/MCO’s standards and that provide authorized Covered Services to eligible and enrolled persons.

Quality Management (QM): The framework for assessing and improving services and supports, operations, and financial performance. Processes include QUALITY ASSURANCE, and QUALITY IMPROVEMENT.

Qualified Professional: Any individual with appropriate training or experience as specified by the North Carolina General Statutes or by rule of the North Carolina Commission on Mental Health, Developmental Disabilities and Substance Abuse Services in the fields of mental health or developmental disabilities or substance abuse treatment or habilitation, including physicians, psychologists, psychological associates, educators, social workers, registered nurses, certified fee-based practicing pastoral counselors, and certified counselors. (N.C.G.S. 122C-3).

QIP: Quality Improvement Project

RAT STATS: A free statistical software package that providers can download to assist in claims review by selecting random samples. The package created by OIG (Office of Inspector General) is also the primary statistical tool for OIG’s Office of Audit Services. Many providers download the software to fulfill the claims review requirements for corporate integrity or provider self-disclosure protocol.

Reconsideration Review: If a provider is not satisfied with the final local dispute resolution decision, they may request an informal hearing before a DHB Hearing Officer and Medical Policy Director. This appeal must be filed within 30 days of the receipt of the final Sandhills Center decision.

Rehabilitation Services and Devices: Health care services and devices that help one keep, get back, or improve skills and functioning for daily living that have been lost or impaired due to illness, injury or disability.

Routine Need (Mental Health): A condition in which the person describes signs and symptoms resulting in impaired behavioral, mental or emotional functioning which has impacted the person’s ability to participate in daily living or markedly decreased the person’s quality of life.
**Routine Need (Substance Abuse):** A condition in which the person describes signs and symptoms consequent to substance use resulting in a level of impairment which can likely be diagnosed as a substance use disorder according to the current version of the Diagnostic and Statistical Manual.

**SAR:** Service Authorization Request form.

**Screening:** A required element of the process for a provider to be enrolled by NC DHHS in the NC Medicaid program in accordance with the requirements of 42 CFR § Part 455, subparts B and E. Enrollment in the NC Medicaid program is distinct from enrollment in the SANDHILLS CENTER Closed Network.

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

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

**Skilled Nursing Care:** Nursing care services for individuals who require medical or nursing care.

**Specialist:** A physician who focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions or a non-physician provider who has more training in a specific area of health care.

**Spend Down:** Medicaid term used to indicate the dollar amount of charges a Medicaid member must incur before Medicaid coverage begins during a specified period of time.

**State:** The State of North Carolina.

**State Fair Hearing (also referred to as Hearing):** A formal proceeding before an Administrative Law Judge of the North Carolina Office of Administrative Hearings pursuant to N.C.G.S. Chapter 108D in which parties/members affected by an adverse benefit determination of SANDHILLS CENTER or an action taken by DHB shall be allowed to present testimony, documentary evidence and argument as to why such adverse benefit determination or action should or should not be taken.

**State Plan:** The North Carolina State Plan for Medical Assistance submitted under Title XIX of the Social Security Act and N.C.G.S. § 108A-54 and approved by CMS.

**Subcontract:** An agreement which is entered into by the LME/MCO.

**Subcontractor:** Any person or entity which has entered into a subcontract with a LME/MCO.

**Third Party Resource:** Any resource available to a Member for payment of expenses associated with the provision of Covered Services (other than those which are exempt under Title XIX of the Act), including but not limited to, insurers, tort-feasors, and worker’s compensation plans.

**Urgent Care:** Care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe that it requires emergency room care.

**Urgent Need (Mental Health):** A condition in which a person is not actively suicidal or homicidal; denies having a plan, means or intent for suicide or homicide but expresses feelings of hopelessness, helplessness or rage; has potential to become actively suicidal or homicidal without immediate intervention; displays a condition which could rapidly deteriorate without immediate intervention; and/or without diversion and intervention will progress to the need for emergent services and care.
Urgent Need (Substance Abuse): A condition in which the person is not imminently at risk of harm to self or others or unable to adequately care for self, but by virtue of their substance use is in need of prompt assistance to avoid further deterioration in the person’s condition which could require emergency assistance.

Utilization Management: The process of evaluating the necessity, appropriateness, and efficiency of behavioral health care services against established guidelines and criteria.
ACRONYMS

AACAP  American Academy of Child & Adolescent Psychiatry
AAIDD  American Association on Intellectual & Developmental Disabilities
ABA    Applied Behavioral Analysis or American Bankers Association
ABAM   American Board of Addiction Medicine
ABD    Adverse Benefit Determination
ABMS   American Board of Medical Specialties
ABPN   American Board of Psychiatry and Neurology
ACA    Affordable Care Act
ACCSU  Acute Clinical Care Specialty Unit
ACH    Adult Care Home
ACTT   Assertive Community Treatment Team
ADA    Americans with Disabilities Act
ADATC  Alcohol & Drug Abuse Treatment Center
ADHD   Attention Deficit Hyperactivity Disorder
ADSN   Adult with Developmental Disability (see Priority Populations)
ADT    Admission, Discharge and Transfer
AFDC   Aid to Families with Dependent Children
AHRQ   Agency for Healthcare Research & Quality
AIU    Adopt, Implement, Upgrade
ALJ    Administrative Law Judge
AMA    American Medical Association
AMH    Advanced Medical Homes
AMI    Adult with Mental Illness (see Priority Populations)
AMTCL  Adult Transitions to Community Living (see Priority Populations)
AMVET  All Military Veterans and Family Members (see Priority Populations)
AOA    American Osteopathic Association
AOD    Alcohol and Other Drugs
AP     Associate Professional
APCNS  Advanced Practice Certified Nurse Specialist
APN    Advanced Practice Nurse
APPCNS Advanced Practice Psychiatric Clinical Nurse Specialist
APRN   Advanced Practice Registered Nurse
APSM   Administrative Procedures Services Manual
ASAM   American Society of Addiction Medicine
ASCDR  Adult Substance Abuse IV Drug User/Communicable Disease Risk
ASD    Autism Spectrum Disorder or Acute Stress Disorder
ASIST  Applied Suicide Intervention Skills Training (training program)
ASOUD  Adult Substance Opioid Use Disorder
ASTER  Adult Substance Abuse Treatment Engagement and Recovery
ASWOM  Adult Substance Abuse Women
AVRS   Automated Voice Response System (NC Tracks)
BART  Behavioral Advanced Residential Treatment
BCABA  Board Certified Assistant Behavior Analyst
BCBA  Board Certified Behavior Analyst
BHUC  Behavioral Health Urgent Care
BOD  Board of Directors
CAC  Clinical Advisory Committee
CAGE-AID  Cut back, Annoyance, Guilt & Eye opening - Adapted to Include Drugs
CALOCUS  Child & Adolescent Level of Care Utilization System
CAP C  Community Alternative Program - Children
CAP DA  Community Alternative Program - Disabled Adult
CAP IDD  Community Alternative Program - Intellectual Developmental Disabilities
CAQH  Council for Affordable Quality Healthcare
CARF  Commission on Accreditation of Rehabilitation Facilities
CASP  Cross Area Service Programs
CBA  Credit Balance Audits
CBT  Cognitive Behavioral Therapy
CCA  Comprehensive Clinical Assessment
CCAS  Certified Clinical Addictions Specialist
CCBHC  Certified Community Behavioral Health Clinic
CCJP  Certified Criminal Justice Addictions Professional
CCM  Complex Case Management
CCME  Center for Carolina Medical Excellence
CCNC  Community Care of North Carolina - see CCNC website
CCPGM  Community Care Partners of Greater Mecklenburg
CCS  Community of Care - Sandhills or Certified Clinical Supervisor
CDS  Controlled Dangerous Substance (equivalent to DEA Certificate or Registration)
CDSA  Children's Developmental Service Agencies
CDSN  Child with Developmental Disability (see Priority Populations)
CDW  Consumer Data Warehouse
CEHRT  Certified Electronic Health Record Technology
CEP  Currently Enrolled Provider (NC Tracks)
CFAC  Consumer & Family Advisory Committee
CFBC  Child Facility Based Crisis
CFR  Code of Federal Regulations
CFT  Child & Family Team
CIP  Community Integration Plan
CISS  Change In Scope of Services
CIT  Crisis Intervention Team
CJ LEADS  Criminal Justice Law Enforcement Automated Dated Services
CLIA  Clinical Laboratory Improvements Amendment
CLT  Clinical Leadership Team
CM/UM  Care Management/Utilization Management
CMHSBG  Community Mental Health Services Block Grant
<table>
<thead>
<tr>
<th>Acronym</th>
<th>Term</th>
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<tbody>
<tr>
<td>CMPD</td>
<td>Case Management Program Description</td>
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<tr>
<td>CMS</td>
<td>Centers for Medicare &amp; Medicaid Services</td>
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<td>CMSED</td>
<td>Child with Serious Emotional Disturbance (see Priority Populations)</td>
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<td>COB</td>
<td>Coordination of Benefits</td>
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<tr>
<td>CoC</td>
<td>Continuum of Care (See CoC HUD funded program)</td>
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<td>CPIP</td>
<td>Crisis Prevention and Intervention Plan</td>
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<td>CSAPC</td>
<td>Certified Substance Abuse Prevention Consultant</td>
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<td>CST PSH</td>
<td>Community Support Team Permanent Supportive Housing</td>
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<tr>
<td>CT &amp; R</td>
<td>Clinical Triage &amp; Referral</td>
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<td>Critical Time Intervention</td>
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<td>Credentialing Verification Organization</td>
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<td>Drug Enforcement Agency</td>
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<td>Division of Medical Assistance - Now called DHB Division of Health Benefits</td>
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<td>Do Not Resuscitate</td>
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<td>Abbreviation</td>
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<tr>
<td>DO</td>
<td>Doctor of Osteopathic Medicine</td>
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<td>Department of Justice</td>
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<td>Diagnostic &amp; Statistical Manual of Mental Disorders - V (version 5)</td>
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<td>Division of Vocational Rehabilitation-Independent Living</td>
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<td>UNC Extension for Community Healthcare Outcomes-Medication Assisted Treatment</td>
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<td>EMDR</td>
<td>Eye Movement Desensitization &amp; Reprocessing</td>
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<td>EOB</td>
<td>Explanation of Benefits</td>
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<td>Eligible Professionals</td>
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<td>EPSDT</td>
<td>Early &amp; Periodic Screening, Diagnosis &amp; Treatment</td>
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<td>External Quality Review Organization</td>
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<td>Electronic Remittance Advice</td>
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<td>ESCII</td>
<td>Early Childhood Service Intensity Instrument</td>
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<td>FAMS</td>
<td>Fraud and Abuse Management System</td>
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<td>FASD</td>
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<td>Fee for Service</td>
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<td>FSMB</td>
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<td>File Transfer Protocol</td>
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<td>GAP</td>
<td>Generic Assessment Payment (see Priority Populations)</td>
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<td>GAST</td>
<td>Geriatric Adult Specialty Team</td>
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<td>GCQI</td>
<td>Global Continuous Quality Improvement</td>
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<td>HCPC</td>
<td>Healthcare Common Procedure Coding</td>
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<td>HEDIS</td>
<td>Health Plan Employer Data &amp; Information Set</td>
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<td>HIEA</td>
<td>Health Information Exchange Authority</td>
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<td>Health Information Technology for Economic &amp; Clinical Health</td>
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<td>HMS</td>
<td>Health Management Systems - see Medicaid Bulletin May 2019</td>
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<td>HRSA</td>
<td>Health Resources and Services Administration</td>
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<td>Human Services Research Institute</td>
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<td>Housing and Urban Development</td>
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<td>IAP</td>
<td>Improvement Action Plan (formerly POC - Plan of Correction)</td>
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<td>IBT</td>
<td>Individual Budget Tool</td>
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<td>ICD</td>
<td>International Classification of Diseases</td>
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<td>International Classification of Diseases-Tenth Revision-Clinical Modification</td>
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<td>Intermediate Care Facility - Individual with Intellectual Disabilities</td>
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<td>Individual Placement Support &amp; Supported Employment</td>
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<td>Incident Response and Improvement System</td>
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<td>ISP</td>
<td>Individual Support Plan</td>
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<td>Infant Toddler Program of the NC Division of Public Health</td>
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<td>JCAHO</td>
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<td>JJSAMHP</td>
<td>Juvenile Justice Substance Abuse Mental Health Partnership</td>
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<td>LBP</td>
<td>Local Business Plan</td>
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<tr>
<td>LCAS</td>
<td>Licensed Clinical Addiction Specialist</td>
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<td>LCMHC</td>
<td>Licensed Clinical Mental Health Counselor formerly known as Licensed Professional Counselor (LPC)</td>
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<td>Licensed Clinical Mental Health Counselor Associate formerly known as Licensed Professional Counselor Associate (LCMHC)</td>
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<td>LCMHCS</td>
<td>Licensed Clinical Mental Health Counselor Supervisor formerly known as Licensed Professional Counselor Supervisor (LCMHC)</td>
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<td>Limited English Proficiency</td>
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<td>Licensed Individual Practitioner (Solo clinician who holds a contract with an LME/MCO)</td>
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<td>LOC</td>
<td>Level of Care</td>
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<td>LOCUS</td>
<td>Level of Care Utilization System</td>
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<td>Licensed Qualified Autism Service Provider</td>
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<td>MAF</td>
<td>Medical Assistance to Families with Dependent Children</td>
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<td>Medication Administration Record</td>
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<td>MAT</td>
<td>Medication Assisted Treatment</td>
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<td>MBBS</td>
<td>Bachelor of Medicine / Bachelor of Surgery</td>
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<td>Managed Behavioral Health Organization</td>
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<td>MCL</td>
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<td>Major Depressive Disorder</td>
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<td>MFCU</td>
<td>Medicaid Fraud Control Unit</td>
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<td>MFP</td>
<td>Money Follows Person</td>
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<td>MHBG</td>
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<td>Acronym</td>
<td>Description</td>
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<tr>
<td>MIC</td>
<td>Medicaid for Infants &amp; Children</td>
</tr>
<tr>
<td>MID</td>
<td>Medicaid Identification Card or Medicaid Investigations Division</td>
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<tr>
<td>MIDD</td>
<td>Mental Illness/Developmental Disability</td>
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<tr>
<td>MISU</td>
<td>Mental Illness/Substance Use</td>
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<tr>
<td>MLR</td>
<td>Medical Loss Ratio</td>
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<td>MLTSS</td>
<td>Manage Long Term Services and Supports</td>
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<td>Medicaid Management Information System</td>
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<td>MOE</td>
<td>Maintenance of Effort</td>
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<td>MOST</td>
<td>Medical Orders for Scope of Treatment</td>
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<td>MPW</td>
<td>Medicaid for Pregnant Women</td>
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<td>MRF</td>
<td>Medicaid for Refugees</td>
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<td>MSB</td>
<td>Medicaid Special Assistance for the Blind</td>
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<td>Medical University of South Carolina</td>
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<td>NC ARP</td>
<td>North Carolina Association of Rehab Professionals</td>
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<td>NC Board of Licensed Clinical Mental Health Counselors formerly known as NC Board of Licensed Professional Counselors (NLCMHC)</td>
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<td>North Carolina Department of Health &amp; Human Services</td>
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<td>North Carolina Healthcare Information &amp; Communications Alliance</td>
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<td>NC SNAP</td>
<td>North Carolina Supports Needs &amp; Assessment Profile</td>
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<td>NC START</td>
<td>North Carolina Systemic, Therapeutic Assessment, Respite &amp; Treatment</td>
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<td>NC TOPPS</td>
<td>North Carolina Treatment Outcomes &amp; Program Performance System</td>
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<td>NCC</td>
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<td>NCIR</td>
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<td>NCMUST</td>
<td>North Carolina Medicaid Uniform Screening Tool</td>
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<td>National Child Traumatic Stress Network</td>
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<td>NDC</td>
<td>National Drug Code</td>
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<td>NE</td>
<td>Never Events (incorrect procedural intervention - i.e. correct procedure, wrong body part / patient.) Billing &amp; Claims payment</td>
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<td>NEMT</td>
<td>Non-Emergency Medical Transportation</td>
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<td>NGC</td>
<td>National Guide Clearinghouse</td>
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<td>NIMBY</td>
<td>Not In My Back Yard (See DMH contract)</td>
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<td>NLC</td>
<td>Network Leadership Council</td>
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<td>Abbreviation</td>
<td>Description</td>
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<td>--------------</td>
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<td>Nurse Practitioner</td>
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<td>National Practitioner Data Bank</td>
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<td>National Provider Identifier</td>
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<td>National Plan &amp; Provider Enumeration System</td>
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<td>Office of Administrative Hearings</td>
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<td>Office-based Opioid Treatment Practices</td>
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<td>OCPI</td>
<td>Office of Compliance and Program Integrity</td>
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<td>OCR</td>
<td>Office of Civil Rights</td>
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<td>ODD</td>
<td>Oppositional Defiant Disorder</td>
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<td>OIG</td>
<td>Office of Inspector General</td>
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<td>OPA</td>
<td>Office of Pharmacy Affairs</td>
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<td>Other Provider Preventable Conditions</td>
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<td>ORHCC</td>
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<td>OTP</td>
<td>Opioid Treatment Program</td>
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<td>Opioid Use Disorder</td>
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<td>P4CC</td>
<td>Partners for Community Care</td>
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<td>PA</td>
<td>Physician's Assistant - Psychological Associate - Prior Authorization</td>
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<td>Psychiatric Advanced Directive</td>
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<td>PADP</td>
<td>Physician Administered Drug Program</td>
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<td>PASRR</td>
<td>Preadmission Screening &amp; Resident Review</td>
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<td>Parent Child Interactive Therapy</td>
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<td>PDP</td>
<td>Physician's Drug Program</td>
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<td>PhD</td>
<td>Practicing Psychologist or Doctor of Philosophy</td>
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<td>PHI</td>
<td>Protected Health Information</td>
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<td>Abbreviation</td>
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<td>POA</td>
<td>Present On Admission</td>
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<td>Plan of Correction</td>
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<td>Provider Payment Agreement</td>
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<td>PPC</td>
<td>Patient Placement Criteria or Provider Preventable Conditions</td>
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<td>Post Payment Review</td>
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<td>Primary Source Verification</td>
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<td>Practice Transformation Network</td>
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<td>PTSD</td>
<td>Post-Traumatic Stress Disorder</td>
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<td>QIO (A)</td>
<td>Quality Improvement Organization (Audit)</td>
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<td>QIP</td>
<td>Quality Improvement Project</td>
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<td>Quality Management</td>
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<td>Quality of Care</td>
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<td>Qualified Substance Abuse Prevention Professional</td>
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<td>RAC</td>
<td>Recovery Audit Contractor - See Medicaid Bulletin May 2019</td>
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<td>Resource Access Control Facility - ID - See DMH Contract</td>
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<td>Regional Advanced Techniques Statistics</td>
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<td>RBBHT</td>
<td>Researched Based - Behavioral Health Treatment</td>
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<td>RCC</td>
<td>Residential Child Care</td>
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<td>RFA</td>
<td>Request for Application</td>
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<td>Request for Interest</td>
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<td>Review Oversight Committee (NCQA)</td>
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<td>Report of Findings</td>
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<td>Special Assistance for the Aged</td>
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<td>SABG</td>
<td>Substance Abuse Block Grant</td>
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<td>SACOT</td>
<td>Substance Abuse Comprehensive Outpatient Treatment</td>
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<td>SAD</td>
<td>Special Assistance for the Disabled</td>
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<td>SAIOP</td>
<td>Substance Abuse Intensive Outpatient Program</td>
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<td>System for Award Management</td>
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<td>Substance Abuse &amp; Mental Health Services Administration</td>
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<td>SAMMCRT</td>
<td>Substance Abuse Medically Monitored Community Residential Treatment</td>
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<tr>
<td>SANMCRT</td>
<td>Substance Abuse Non-Medical Community Residential Treatment</td>
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<td>Substance Abuse Prevention and Treatment Block Grant</td>
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<td>SAR</td>
<td>Service Authorization Request</td>
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SAS  Statistical Analysis System (technical support company for the HIEA)
SBI  State Bureau of Investigations
SBIRT Screening, Brief Intervention & Referral to Treatment - sbirtn.org
SCAP Sandhills Community Action Program
SDOH Social Determinants of Health
SED Serious Emotional Disturbance
SELTVS Supported Employment Long Term Vocational Support
SFTP Secure File Transfer Protocol
SIS Supports Intensity Scale
SMI Serious Mental Illness
SNP Special Needs Plan or Population
SO Tx Sex Offender Treatment
SOC System of Care
SOSE Sex Offender Specific Evaluation
SP Standard Plan
SPA State Plan Amendment
SPMI Severely & Persistent Mental Illness
SSA DMF Social Security Administration Death Master File
SSF Single Stream Funding
SSI Supplemental Security Income
STARS Specialized Treatment for Adolescents in a Residential Setting
STR State Targeted Response
SUD Substance Use Disorder
SWOC Strengths, Weaknesses, Opportunities & Challenges (business audit tool)
TANF Temporary Aid to Needy Families
TASC Treatment Accountability for Safer Communities
TBI Traumatic Brain Injury
TCLI Transition to Community Living Initiative
TCN Transaction Control Number (NC Tracks)
TF-CBT Trauma Focused Cognitive Behavioral Therapy
TMACT Tool for Measurement of ACT
TMS Transitional Management Services (Tenancy Support)
TP Tailored Plan
TPA Trading Partner Agreement
TPL Third Party Liability
TRACK Therapeutic Respite Addressing Crisis for Kids
TSS Tenancy Support Services
UCP United Cerebral Palsy
UCR Usual, Customary & Reasonable
URAC Utilization Review Accreditation Commission
WFFA Work First Family Assistance
WRAP Wellness Recovery Action Plan
SECTION 15:  APPENDICES

Appendix 1: Cultural Competency Plan (See SANDHILLS CENTER website for Resource Booklet)

Appendix 2: Code of Ethics

Appendix 3: Behavioral Health Screening Program

Appendix 4: Sanctions Grid
Appendix 1:

Sandhills Center
Cultural Competency Plan
SANDHILLS CENTER
CULTURAL COMPETENCY PLAN

Sandhills Center participates in the State’s efforts to promote the delivery of services in a culturally competent manner to all members, including those with limited English Proficiency and diverse cultural and ethnic backgrounds. (CFR 42. 438.206 c (2)

Sandhills Center maintains a closed provider network that provides culturally competent services by recognizing, respecting and responding to the unique and culturally defined needs of the populations served in the geographic area that goes beyond race or language identifiers. In order to achieve cultural competency, Sandhills Center requires providers to participate in its Cultural Competency Plan, which is developed and approved by the Network Leadership Council composed of members of the provider network. The Cultural Competency Plan ensures that Sandhills Center maintains a respectful service delivery network, free of offensive practices and conditions; recognizes each individual’s unique value, contributions and potential; and develops programs and services to meet identified needs of a culturally diverse population.

To this end, Sandhills Center strives to ensure that the people we serve have access to services provided by culturally competent network providers and Sandhills staff with whom they communicate. Sandhills Center recognizes, respects, and responds to the unique, culturally defined needs of the population served in the geographic area.

This is accomplished by both Sandhills staff and network providers understanding that cultural competence goes beyond race or language identifiers. Cultural competence encompasses understanding of one’s own culture and that there are diversities within each culture. In compliance with its Cultural Competency Policies and Procedures Sandhills Center shall:

• Maintain a respectful service delivery network, free of offensive practices and conditions;
• Recognize each individual’s unique value, contribution and potential;
• Develop approaches/programs/services to meet identified needs of a culturally diverse population and
• Orient/train Sandhills Center and Provider staff in the cultural diversity of its service population;
  o Provider training shall increase awareness and sensitivity to the needs of persons who may be disadvantaged by low income, disability and illiteracy, or who may be non-English speaking. Provider training shall include topics such as sensitivity to different cultures and beliefs, the use of bilingual interpreters, the use of Relay Video Conference Captioning, Relay NC, TTY machines and other communication devices.

Sandhills Center engages in the following goals and initiatives to address cultural competency of the provider network to meet the demographic needs of the population served:

• Identify cultural and language needs of the community though annual needs/gaps assessment to ensure that culturally diverse multi-lingual persons have access to MH/DD/SA services as needed. [https://www.sandhillscenter.org/about/regulatory-plans][Click on “Network Development Plan”].
• Recruit providers to address service gaps/needs; to ensure the workforce reflects the diversity of the community it serves.
• Provide cultural awareness training for network providers at least once during the year. Attendance will be tracked.
• Provide cultural awareness training for all Sandhills Center staff at orientation and as a part of the annual appraisal evaluation for existing staff.
• Review information/reports on an annual basis related to utilization and access issues which identify linguistics and ethnicity from Customer Service’s Care Coordination, Utilization Management and Grievance and Appeals data.
• Review information on an annual basis for foreign language and deaf and hard of hearing interpreter services with whom Sandhills Center contracts, as required.
• Research availability of emerging and effective Best Practice Standards for culturally diverse populations and communicate findings to providers via training or quarterly meetings.
• Ensure that cultural competency is embedded in Systems of Care and Person Centered Planning processes.
• Publish and maintain a Cultural Competency Resource Booklet for Sandhills Center staff, providers and members. This information can be found on the Sandhills Center website at https://www.sandhillscenter.org/for-providers/resources. Click on “Cultural Competency Resource Booklet”.
• The Cultural Competency Plan is posted on the Sandhills Center website at Regulatory Plans (sandhillscenter.org). Click on “Cultural Competency Plan”.
• Provider contracts require compliance with all Federal and State laws which require equal opportunity in employment and bar illegal employment discrimination on the grounds of race, gender, religion, sexual orientation, gender identity, national origin or disability.
• Demographic data from the most recent Provider Capacity, Local Needs Assessment and Gaps Analysis Report can be found at https://www.sandhillscenter.org/about/regulatory-plans/. Click on “Network Development Plan”.

Appendix 2:

Code of Ethics
Preamble

The Sandhills Center provider network shall facilitate an open exchange of ideas, share values, goals, vision, and promote collaboration and mutual accountability among providers. The provider network strives to achieve best practices to empower individuals served to achieve their personal goals.

- Assure that staff adheres to the code of ethics.
- Provide support to other member agencies.
- Advocate for the further development of resources on a local and state level for individuals served.

Purpose of Code

Sandhills Center (SANDHILLS CENTER) supports and encourages a network community which has an expectation that providers will adhere to the highest ethical standards.

Philosophy

Sandhills Center network providers agree to abide by the Code of Ethics. Member Agencies shall:

- Become familiar with and encourage their Board of Directors, Owners, and Agency personnel to adhere and follow the Code of Ethics.
- Agree that actions which violate the Code would be considered unethical.
- Agree that a lack of knowledge is not a defense for unethical conduct.
- Strive to achieve the highest standards of professional conduct.
- Acknowledge that all network providers be committed to best practices in their specific area through involvement with continued education, provider networking, and review of relevant research.
- Have an obligation to report in writing any direct knowledge of perceived violations of the code of ethics.
- Offer age appropriate services which promote dignity and empower the individual.
- Reflect the beliefs, values, heritage, and customs of individuals supported by offering culturally competent services.

CORE VALUES AND ETHICAL PRINCIPLES

The mission of the Sandhills Center provider network is founded in a set of core values. Network providers should embrace the core values, which serve as the foundation of the provider network. The principles set forth ideals to which all network providers should aspire.

VALUE: INTEGRITY

ETHICAL PRINCIPLE: Provide accurate and truthful representation.

- Network providers will not knowingly permit anyone under their supervision to engage in any practice that violates the Code of Ethics.
- Network providers will not engage in dishonesty, fraud, deceit, misrepresentation of themselves or other providers, or any form of conduct that adversely reflects on their profession, the provider network, or on the network providers’ ability to support individuals served professionally.
• Network providers will not commit unethical practices that include, but are not limited to deceptive billing, falsification of documentation, commission of a felony, gross neglect and fiduciary impropriety.

VALUE: COMPETENCE

ETHICAL PRINCIPLE: Honor responsibilities to achieve and maintain the highest level of professional competence for themselves and those in their employ.

• Network providers will represent their competence within their scope of practice.
• Network providers will engage in only those aspects of the profession that are within the scope of their competence, considering their level of education, training and experience.
• Network providers will allow individual staff to provide only those services that are within the staff member’s competence, considering the employee’s level of education, training and experience.
• Network provider agencies will demonstrate compliance with state and federal rules, regulations and laws regarding standards for training and credentials for supports provided.

VALUE: PROFESSIONAL CONDUCT

ETHICAL PRINCIPLE: Promote dignity and autonomy. Maintain collaborative relationships. All professional relationships should be directed to improving the quality of life of the individuals who receive supports and services from the network agency.

• Network providers will not participate in activities that produce a benefit for themselves over the individuals they support or may potentially support, always giving priority to professional responsibility over any personal interest of gain.
• Network providers will make all reasonable efforts to prevent any incidents of abuse, neglect and exploitation. Abuse means the infliction of mental or physical pain or injury by other than accidental means, or unreasonable confinement, or deprivation by an employee of services, which are necessary to the mental or physical health of the individual. Temporary discomfort that is a part of an approved and documented treatment plan or use of a documented emergency procedure shall not be considered abuse. Neglect means the failure to provide care or services necessary to maintain the mental or physical health and wellbeing of the individual.
• Network providers will promptly report and thoroughly investigate all allegations of abuse, neglect and exploitation.
• Under no circumstance will the support relationship between the program, staff and individuals receiving services, and/or their families or legal guardians be exploited. Exploitation is defined as the illegal or unauthorized use of a service user or a service user’s resources for another person’s profit, business or advantage.
• Network providers will train staff to recognize and report any suspected incidents of abuse, neglect or exploitation.

VALUE: INDIVIDUAL VALUE, DIGNITY, AND DIVERSITY

ETHICAL PRINCIPLE: Provide supports and services that promote respect and dignity of each individual.

• Network providers will comply with all Federal and State rules and laws related to confidentiality and protected health information, including but not limited to N.C.G.S.122C, HIPAA, and the Sandhills Center contract.
• Network providers will not discriminate in their relationships or services provided to individuals receiving supports, contractors, and colleagues on the basis of race or ethnicity, gender, age, religion, national origin, sexual orientation, or disability.
• Network providers will provide individuals and families a means of submitting grievances that is fair and impartial.
• Network providers will comply with N.C.G.S 354-A.1201, which allows for all people to be involved in decisions and choices that impact their lives.
• Network providers will make all reasonable efforts to ensure individuals and families participate in the development and revision of any plan for services.
• Network providers will not abandon individuals and families.
• Network providers will consistently demonstrate efforts to assure that their services eliminate the effects of any biases based upon individual and cultural factors.
• Network providers will support the recovery and self-determination of each individual.

VALUE: SOCIAL JUSTICE

ETHICAL PRINCIPLE: Assure that the rights of individuals receiving supports and those who make decisions regarding services have complete and accurate information on which to make choices.

• Network providers will accurately portray their services and capacities through public and private statements.
• Network providers will not engage in false and deceptive representation of their services.
• Network providers’ marketing strategies will not offer inducements to primary individuals receiving supports or their legal representatives in exchange for business gains.
• Network providers will accurately portray their ownership, board of directors and management through public and private statements.
• Network providers will follow required laws and standards regarding the hiring of staff.
• Network providers will not make initial contact with employees of other providers for the purpose of offering employment to that individual employee for the purpose of gaining clients. This does not preclude the individual client to make a choice.
• Network providers will use the standard means of advertising for hiring staff.

VALUE: SOCIAL CAPITAL

ETHICAL PRINCIPLE: Network providers support the importance of social capital for each individual supported.

• Network providers will support and promote opportunities for individuals they support to develop valued relationships with members of the community in which they live or work.
• Network providers will support and promote opportunities for individuals to be treated with respect and dignity within the community they live or work.
• Network providers will support and promote opportunities for individuals they support developing roles in the community in which they live or work.
• Network providers will discuss known violations of standard ethical practices by members with the offending colleague or agency director. In the event that this does not end in resolution of the issue, the member shall make a formal grievance to the LME/MCO.
VALUE: PARTNERSHIP

ETHICAL PRINCIPLE: Network providers will work together in partnership to develop and achieve individual desired outcomes.

- Network providers will work in partnership:
  - To assure continuity of care for individuals served;
  - To assure linkage for services;
  - With individuals served, stakeholders, parents, significant others, and Sandhills Center to support the attainment of each individual’s goals;
- Network providers shall collaborate to share resources that enhance the functions of the Network in developing solutions for gaps in services.

Approved By:

Victoria Whitt, CEO
Sandhills Center Chief Executive Officer (CEO)

Jerry Earnhardt, MS, LCMHCS, LCMHC
Network Leadership Council Provider Co-Chair
Daymark Recovery Services, Inc.,
Regional Operations Director

Anthony G. Carraway, M.D.
Sandhills Center
Chief Clinical Officer/Medical Director

Karen Kern, MS, LCMHC
Network Leadership Council Co-Chair
Sandhills Center Health Network Operations
Program Director
Appendix 3:

Behavioral Health Screening Program Description
The Sandhills Center Behavioral Health Screening Program is defined as, a formal process of evaluating whether a member warrants attention for a coexisting mental health, substance use, or medical disorder. Sandhills Center implements at least one screening program related to co-existing mental health and substance use disorders. NCQA QI 7 A.1 Coexisting disorders may include any combination of two or more mental health and substance use disorders identified in the Diagnostic and Statistical Manual of Mental Disorders—V (DSM-V). Additionally, Sandhills Center implements a secondary screening program to identify metabolic syndrome in children on antipsychotics. NCQA QI 7 A.2

The purpose of these Behavioral Health Screening Programs is to identify co-existing conditions that may complicate or deter effective treatment if not identified or addressed. Treatment that addresses all existing conditions promotes the efficacy of services and improved clinical outcomes for members.

1) **Screening Program for Co-Existing Mental Health and Substance Use Disorders**
   
   a) **Member Eligibility: NCQA QI 7B.1**
   
   Sandhills Center uses the following systematic approach to identify eligible members who then are administered the BH Screening. Through Sandhills Center’s Triage and Referral process, all members who call the Call Center to seek services are asked screening questions to identify Mental Health (MH) and Substance Use (SU) issues. All callers are asked questions to determine the presence of SU issues, depression, and suicidality or homicidally.

   b) **Indicated Screening Process: NCQA QI 7B.2, B.3**
   
   Identified members are administered both an MH and SU screening to determine the presence of co-existing conditions by a licensed clinician. The clinician assures the member is referred and linked to the most appropriate treatment provider to meet their clinical needs. Additionally, clinicians provide follow-up with all members identified as having Emergent or Urgent care needs.

   The results of this screening are made available to practitioners when a direct referral is made via the Alpha Slot Scheduler. Through this platform the practitioner is able to access the screening, triage, and referral information provided in the electronic enrollment or Call Center Screening document. Although, the BH screening is primarily administered through this identification process, members who are not identified can access this screening through their practitioner to detect a co-existing condition upon request. These tools can also be accessed on the website and administered by network practitioners.

   c) **Evidence Based Guidelines & Screening Tools: NCQA QI 7C**

      i) **Mental Health Screening**

          (1) Sandhills Center uses the Mental Health Screening Form-III (MHSF-III) to screen for potential mental health concerns. The MHSF-III was created in 2000 by Jerome F. Carroll and John L E McGinley, and published by the Alcohol and Drug Abuse Institute at the University of Washington. This tool was designed to address the need in the chemical dependency field for an easy-to-use, brief, no-cost instrument that would identify people experiencing co-occurring psychiatric difficulties. This tool consists of 18 yes/no questions to identify current and past symptoms of mental health concerns including but not limited to: psychosis, depression, and anxiety. The preferred mode of administration of the MHSF-III is for staff members to read each item, however, this tool can also be used as a self-report questionnaire.

      ii) **Substance Use Disorder Screening**

          (1) Sandhills Center uses the CAGE Adapted to Include Drugs (CAGE-AID) to screen for potential substance use problems. This tool consists of 4 questions to detect the presence of *substance abuse*. The CAGE is a self-report questionnaire that was developed in 1968 and focused on screening for potential alcohol problems. The CAGE questionnaire has been
extensively researched and found to be reliable and valid for use in identifying potential alcohol problems. The CAGE Adapted to Include Drugs (CAGE-AID) is a brief screening instrument that was developed in 1995 and is commonly used to determine if additional assessments for alcohol or drug use are needed.

iii) Review and Approval

(1) Sandhills Center reviews scientific evidence and updates its screening programs every two years, or more often, if indicated. The Clinical Advisory Committee is responsible to review published evidence and update the BH screening program as indicated to ensure alignment with current evidence based best practice. The Chief Medical Officer as well as other clinical experts are members of this committee.

2) Secondary Screening Program for Metabolic Syndrome in members on Antipsychotics

a) Member Eligibility: NCQA QI 7B.1

The Sandhills Center has developed a Metabolic Screening program with select providers to identify the need for and conduct metabolic screenings using specific evidence based quality indicators. All members who are 18 years or younger and are prescribed 2 or more anti-psychotic medications are eligible to participate in the Metabolic Screening program.

b) Indicated Screening Process: NCQA QI 7B.2, B.3

i) All participating providers screen eligible members using the following process:

(1) At intake administer the following lab tests as indicated by the AACAP to obtain baseline data:

(a) Weight (BMI)
(b) Fasting Hemoglobin AIC and current fasting blood glucose
(c) Vital signs (Include BP, Heart Rate, Respirations)
(d) Fasting lipid profile
(e) If member has history, personal or family, of cardiac abnormalities then a baseline EKG is completed.

(2) Results are reviewed by a licensed medical professional
(3) Appropriate clinical directives given by licensed medical professional
(4) Frequency of lab testing is determined by the licensed medical professional.
(5) All lab testing results are housed in the members’ electronic medical record.

ii) Technical assistance is offered from Sandhills Center as providers develop their clinical plans. Provider clinical plans specify their follow-up efforts that may include education on nutrition and physical exercise; consultation with parents/guardians if they decline labs being taken and adherence to treatment plan.

c) Evidence based guidelines used to develop the Metabolic Screening Program include: NCQA QI 7C

i) AACAP Practice Parameters studies have shown that weight gain associated with atypical antipsychotics may be greater in youth than adults.

(1) The AACAP supports guidelines established in the consensus statement of the American Diabetes Association and American Psychiatric Association for monitoring of BMI, blood pressure, glucose and lipid panels.

ii) The study performed by EH Morrato and others (Metabolic Screening in Children Receiving Antipsychotic Drug Treatment. Arch Pediatric Adolescent Med. 2010;164(4):344-351.) states that "the association between antipsychotic medication use and diabetes has been stronger in children and adolescents than adults."

iii) Review and Approval

Sandhills reviews scientific evidence and updates its screening programs every two years, or more often, if indicated. The Clinical Advisory Committee is responsible to review published evidence
and update the BH screening program as indicated to ensure alignment with current best practice. The Chief Medical Officer as well as other clinical experts are members of this committee.

3) **Stakeholder Involvement** NCQA QI 7B.4, B.5

   a) Sandhills Center seeks to obtain stakeholder input in all BH screening program design and implementation. Sandhills Center presents each BH screening program, including screening tools, policies, and protocols to the Clinical Advisory Committee for review and feedback. The Clinical Advisory Committee has a membership that includes a variety of practitioner and providers that represent the diversity of Sandhills provider network. Their input is considered and assimilated into the design and implementation of this program. As the BH screening program is revised and updated, continued guidance is sought from this committee to ensure continued efficacy.

4) **Promotion of BH Screening Programs** NCQA QI 7 B.6 D.1.2

   a) Sandhills Center informs practitioners and providers of the BH Screening Programs through its website. A description of each program as well as accessibility to screening tools is provided. Sandhills Center informs practitioners and providers of the existence of this program and where they can locate materials in the Provider Manual as well as on the Sandhills Center website. Practitioners and Providers are provided with this manual upon acceptance into the network. The BH Screening program information on the website and in the Provider Manual is updated upon revision, or at least every two years. Existing Practitioners and Providers are informed of updates via e-mail. For Practitioners who may not have internet access, all materials are provided in print format upon request.
Appendix 4:

Provider Sanctions Grids
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<th>Areas of Risk</th>
<th>Violations</th>
<th>Sanctions</th>
<th>Decision - Review Body</th>
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</table>
| Insurance Risk | Level I Violation: Loss of insurance in any or all of the following areas:  
  - Professional liability  
  - Comprehensive liability  
  - Automobile liability  
  - Workers compensation | Level I Sanction:  
  Immediate (required):  
  - Referrals are frozen until insurance is restored and retroactive.  
  - No ability to add new services until insurance is restored and retroactive.  
  - A Plan of Correction is required. *(required)*  
  Additional Sanction: The provider is required to take immediate action to obtain the required coverage. This action must result in retroactive insurance coverage such that the entire contract period with Sandhills Center is covered. *(required)* | Network Committee |
| Insurance Risk | Level II Violation: Provider has a second lapse in insurance during a 12 month period (rolling twelve months, not calendar or fiscal year). | Level II Sanctions:  
  Immediate (required):  
  - Referrals are Frozen  
  - No ability to add new services while in Plan of Correction status.  
  Additional:  
  1. Plan of Correction Required. Provider must develop Formal Plan of Correction to describe how it will maintain insurance coverage. *(required)*  
  2. Providers Relations conducts monthly audit via desk review to ensure coverage is maintained while providers is in Plan of Corrections status. *(required)* | Network Committee |
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<th>Areas of Risk</th>
<th>Violations</th>
<th>Sanctions</th>
<th>Decision - Review Body</th>
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</table>
| Insurance Risk | **Level III Violation:** Third lapse in insurance coverage during 12 month period (rolling 12 months, not fiscal or calendar year) | **Level III Sanctions:**  
Immediate *(required):*  
• Referrals are frozen until insurance is restored and retroactive.  
• No ability to add new services until insurance is restored and retroactive.  
Contract termination is considered by Network Committee. *(discretionary)*  
If the contract is *not* terminated, the following sanctions will be applied:  
1. Continued referral freeze for period of time (to be determined by Network Committee) after insurance is restored. *(term of sanction is discretionary)*  
2. No ability to add new services for period of time (to be determined by Network Committee) after insurance is restored. *(term of sanction is discretionary)* | Network Committee |
| **DHSR Type A or B Violations** | | | |
| Type A or B Violations | **Level I Violation:** One Type A or B violation within a 12 month period (rolling twelve months, not calendar or fiscal year). | **Level I Sanctions:**  
Immediate *(all below are required):*  
• Referrals are frozen for three months.  
• May not add new services for three months.  
• A Plan of Correction is required. | Network Committee |
| Type A or B Violations | **Level II Violation:** Two Type A, or two Type B, or a combination of one A and one B, within a 12 month period (rolling twelve months, not calendar or fiscal year). | **Level II Sanctions:**  
• Formal Plan of Correction required. *(required)*  
• Referrals are frozen during Plan of Correction period and for three months following satisfactory implementation of the Plan of Correction. *(required)* | |
### Areas of Risk

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<tr>
<th>Violations</th>
<th>Sanctions</th>
<th>Decision - Review Body</th>
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<tbody>
<tr>
<td><strong>Type A or B Violations</strong></td>
<td><strong>Level III Violations:</strong> Three or more violations in any combination of Type A and/or Type B, within a 12 month period (rolling twelve months, not calendar or fiscal year). OR ANY single Type A or B violation involving significant injury or death of a consumer will be considered a Pervasive Performance Issue and Level III Sanctions May be applied as determined by Network Committee. If DHSR suspends admissions or revokes the agency license, provider contract status is immediately evaluated and could be terminated.</td>
<td><strong>Level III Sanctions:</strong> • Issue referred to Network Committee for consideration of contract termination. <em>(discretionary)</em> If the contract is not terminated, the following sanctions will be applied: 1. Formal Plan of Correction required. <em>(required)</em> 2. Referrals are frozen during Plan of Correction period and for three months following satisfactory implementation of the Plan of Correction. <em>(required)</em> 3. May not add new services during Plan of Correction period and for six months following satisfactory implementation of the Plan of Correction. <em>(required)</em> 4. Network Operations on site monitoring and justified cause audits throughout Plan of Correction period. <em>(frequency of monitoring is discretionary)</em> 5. Network Operations monitoring review indicates Plan of Correction has been fully implemented and maintained for six months prior to return to regular network status. <em>(required)</em></td>
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<td>• Network Operations on site monitoring at least monthly, or more often, as determined by Network Committee. <em>(frequency of sanction is discretionary)</em> • Provider may not add new services during Plan of Correction period and for three months following satisfactory implementation of the Plan of Correction. <em>(required)</em></td>
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<td>Areas of Risk</td>
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<td>Health and Safety Risk</td>
<td><strong>Level I Violation:</strong></td>
<td><strong>Level I Sanctions:</strong></td>
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<td>Health and Safety</td>
<td>Any ONE of the following substantiated health and safety grievances:</td>
<td><strong>Immediate (all below are required):</strong></td>
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<tr>
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<td>1. Three or more substantiations of health and safety risk to consumer(s) within a twelve month timeframe by any of the following agencies:</td>
<td>• Referrals are Frozen</td>
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<td>• DHSR</td>
<td>• No ability to add new services</td>
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<td></td>
<td>• SANDHILLS CENTER</td>
<td>• Plan of Correction</td>
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<td>• DMH</td>
<td><strong>Additional</strong></td>
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<td>• DSS</td>
<td>1. Network Committee will determine the length of time that referrals are frozen and the provider is not able to add new services. (discretionary)</td>
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<td>2. Five or more Medication Errors within a three month timeframe.</td>
<td>2. The provider will be subject to unannounced on-site visits to monitor Plan of Correction and to ensure consumer health and safety, on a schedule determined by Network Committee. (frequency is discretionary)</td>
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<td>3. Three or more substantiated cases of consumer rights violations within a twelve month timeframe (rolling twelve months).</td>
<td>3. A Plan of Correction is required. Due to the nature of violations at this level, it is not expected to be extensive, but is needed for tracking purposes. (required)</td>
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<td>4. More than three consumers with unplanned restrictive interventions that exceed the four per month per consumer limit in any given month; or more than five consumers with unplanned restrictive interventions that exceed the four per month per consumer limit over a three month period.</td>
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<td>5. Three or more substantiated abuse/neglect/exploitation events (across all consumers served) within a 12 month period (rolling twelve months, not calendar or fiscal year).</td>
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<td>6. Two unreported Level II or III incidents, or any unreported restrictive interventions within a 3 month period.</td>
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<td>Areas of Risk</td>
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<tr>
<td>Health and Safety</td>
<td><strong>Level II Violations:</strong>&lt;br&gt;The provider meets criteria for violations of 2-3 risk areas identified below within the same three month period.</td>
<td><strong>Level II Sanctions:</strong>&lt;br&gt;Immediate <em>(required)</em>:&lt;br&gt;- Formal Plan of Correction required.&lt;br&gt;- Referrals are frozen during Plan of Correction period and for three months following satisfactory implementation of the Plan of Correction.&lt;br&gt;- May not add new services during Plan of Correction period and for three months following satisfactory implementation of the Plan of Correction.</td>
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<td>7. 10% or fewer staff records audited have violations of qualifications/training/certification or credentials or failure to complete background checks that occur during a 12 month period (such as lack of staff training or certifications, failure to meet required staffing ratios). <em>(Rolling twelve months, not calendar year)</em></td>
<td><strong>Network Committee</strong></td>
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<td><strong>Any single substantiated health and safety issue involving significant injury or death of a consumer is considered a Level III violation.</strong></td>
<td><strong>Network Committee</strong></td>
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### Areas of Risk

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<th>Violations</th>
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<td>exceed the four per month per consumer limit over a three month period.</td>
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<td>5. Three or more substantiated abuse/ neglect/ exploitation events (across all consumers served) within a 12 month period (rolling twelve months, not calendar or fiscal year).</td>
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<td>6. Three unreported Level II or III incidents, or any unreported restrictive interventions within a 3 month period.</td>
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<td>7. More than 10% but less than 15% of staff records audited have violations of qualifications/training/certification or credentials or failure to complete background checks that occur during a 12 month period (such as lack of staff training or certifications, failure to meet required staffing ratios). (Rolling 12 months, not calendar or fiscal year).</td>
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**Any single substantiated health and safety issue involving significant injury or death of a consumer is considered a Level III violation.**

### Health and Safety

**Level III Violation:**

Any single substantiated health and safety issue involving significant injury or death of a consumer.

OR

The provider meets criteria for violations of 5 or more risk areas identified below within three consecutive months, or six non-consecutive months over a 12 month period.

1. Three or more substantiations of health and safety risk to consumer(s) within a twelve

**Level III Sanctions:**

Possible Contract Termination to be determined by Network Committee. (*discretionary*)

If the contract is *not terminated*, the following sanctions may be applied:

1. Formal Plan of Correction required. (*required*)
2. Referrals are frozen during Plan of Correction period and for three months following satisfactory implementation of the Plan of Correction. (*required*)
3. May not add new services during Plan of Correction period and for six months following satisfactory

Network Committee
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<td>month timeframe by any of the following agencies:</td>
<td>implementation of the Plan of Correction.</td>
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<td>• DHSR</td>
<td>(required)</td>
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<td>• SANDHILLS CENTER</td>
<td>4. Network Operations on site monitoring and justified cause audits</td>
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<td>• DMH</td>
<td>throughout Plan of Correction period on a schedule determined by Network</td>
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<td>• DSS</td>
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<td>2. Five or more Medication Errors within a three month timeframe.</td>
<td>5. Network Operations monitoring review indicates Plan of Correction has</td>
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<td>been fully implemented and maintained for six months prior to return to</td>
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<td>regular network status. (required)</td>
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<td>3. Three or more substantiated cases of consumer rights violations within</td>
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<td>a twelve month timeframe (rolling twelve months).</td>
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<td>4. More than three consumers with unplanned restrictive interventions</td>
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<td>that exceed the four per month per consumer limit in any given month;</td>
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<td>or more than five consumers with unplanned restrictive interventions</td>
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<td>that exceed the four per month per consumer limit over a three month</td>
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<td>all consumers served) within a 12 month period (rolling twelve months,</td>
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<td>not calendar or fiscal year).</td>
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<td>6. Four unreported Level II or III incidents, or any unreported</td>
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<td>restrictive interventions within a 3 month period.</td>
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<td>7. More than 15% of staff records audited have violations of qualifications/</td>
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<td>training/certification or credentials or failure to complete background</td>
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<td>checks that occur during a 12 month period (such as lack of staff</td>
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<td>training or certifications, failure to meet required staffing ratios).</td>
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<td>(Rolling 12 months, not calendar or fiscal year).</td>
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<td>Areas of Risk</td>
<td>Violations</td>
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<tr>
<td><strong>Compliance with Billing and Documentation Requirements</strong></td>
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<td><strong>Compliance: billing and documentation</strong></td>
<td><strong>Level I Violations</strong></td>
<td><strong>Level I Sanction</strong></td>
<td>Network Committee</td>
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<tr>
<td></td>
<td>Clinical or Personnel Documentation is out of compliance, or billing audits reveal compliance issues such as:</td>
<td>Payback for Sandhills Center payments made for services that do not have required supporting documentation. <em>(required)</em></td>
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<td>• Unusual billing trends</td>
<td>A Plan of Correction is required. <em>(required)</em></td>
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<td>• Lack of or inadequate clinical documentation</td>
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<td>• Lack of or inadequate documentation of personnel training or qualifications</td>
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<td>• Lack of or inadequate documentation of staff supervision</td>
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<td>The dollar value of errors is less than 3% of provider’s annual payment for prior year. Fraud or abuse is not suspected.</td>
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<td><strong>Any payback that is $50,000 or more is automatically considered a Level IV violation.</strong></td>
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<td><strong>Any suspicion of fraud or abuse is automatically considered a Level IV violation.</strong></td>
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<tr>
<td><strong>Compliance: billing and documentation</strong></td>
<td><strong>Level II Violations</strong></td>
<td><strong>Level II Sanctions</strong></td>
<td>Network Committee</td>
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<td>On a single audit event, Provider is found to have violations of documentation or billing requirements (as noted above) that fall between 3% and 5% of prior year payments.</td>
<td>• The provider reimburses Sandhills Center for payments made for services that do not have required supporting documentation. <em>(required)</em></td>
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<td>If more than one audit has occurred within a 12 month period, the total dollar value of out of compliance issues does not exceed 5% of provider’s prior year payments.</td>
<td>• The Network Committee will approve any requests for payment plans. <em>(discretionary)</em></td>
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<td>Fraud or abuse is not suspected.</td>
<td>• A Formal Plan of Correction must be completed to address the out of compliance findings. <em>(required)</em></td>
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<td><strong>Any payback that is $50,000 or more is automatically considered a Level IV violation.</strong></td>
<td>• Network Operations will conduct billing audits and monitoring reviews on a schedule determined by the Network Committee. <em>(schedule is discretionary)</em></td>
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<tr>
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| Compliance: billing and documentation | Level III Violations  
On a single audit, Provider is found to have violations of documentation or billing requirements (as noted above) that are greater than 5% of prior year payments.  
If more than one audit has occurred within a 12 month period, the total dollar value of out of compliance issues does not exceed 9% of provider’s prior year payments.  
Fraud or abuse is not suspected.  
Any payback that is $50,000 or more is automatically considered a Level IV violation.  
Any suspicion of fraud or abuse is automatically considered a Level IV violation. | Level III Sanctions  
- The provider must reimburse Sandhills Center for payments made for services that do not have required supporting documentation. *(required)*  
- The Network Committee will approve any provider requests for Payment Plans. *(discretionary)*  
- A Formal Plan of Correction must be completed to address the out of compliance findings. *(required)*  
- Referrals are frozen until the Plan of Correction has been fully implemented and verified by Sandhills Center Network Operations. *(required)*  
- Provider may be required to submit supporting documentation prior to payment of future claims during the Plan of Correction Period, as determined by Network Committee. *(discretionary)*  
- Network Operations will conduct billing audits and monitoring reviews on a schedule determined by Network Committee. *(schedule is discretionary)* | Network Committee  
Upon approval by Network Committee, the Finance Department negotiates and executes a formal Payback Agreement which includes interest. |
| Compliance: billing and documentation | Level IV Violations  
Fraud and abuse is suspected.  
OR  
Multiple audits within a 12 month period (rolling months) reveal out of compliance findings of 10% or greater.  
OR  
Paybacks are $50,000 or greater over a 12 month period. | Level IV Sanctions  
Immediate *(required)*:  
- Referral Freeze  
- No new services can be added to the contract.  
- Reporting to higher authorities if Fraud and Abuse are suspected. *(required if suspected)*  
- Contract may be terminated, as determined by the Corporate Compliance Committee. *(discretionary)* | Corporate Compliance Committee |
<table>
<thead>
<tr>
<th>Areas of Risk</th>
<th>Violations</th>
<th>Sanctions</th>
<th>Decision - Review Body</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>- The provider must reimburse Sandhills Center for payments made for services that do not have required supporting documentation. <em>(required)</em></td>
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<td>If the contract is not terminated:</td>
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<tr>
<td></td>
<td></td>
<td>1. The Corporate Compliance Committee will approve any requests for Payment Plans. <em>(required)</em></td>
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<td>2. A Formal Plan of Correction must be completed to address the out of compliance findings. <em>(required)</em></td>
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<tr>
<td></td>
<td></td>
<td>3. Referrals are frozen until the Plan of Correction has been fully implemented and verified by Sandhills Center Network Operations. <em>(required)</em></td>
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<tr>
<td></td>
<td></td>
<td>4. Provider may be required to submit documentation prior to payment of future claims during the Plan of Correction Period, as determined by Corporate Compliance Committee. <em>(discretionary)</em></td>
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<td>5. Network Operations will conduct billing audits and monitoring reviews on a schedule determined by the Corporate Compliance Committee. <em>(schedule is discretionary)</em></td>
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<tr>
<td></td>
<td></td>
<td>6. Referrals may be frozen if Provider fails to reimburse Sandhills Center or falls behind in the Payment Plan, as determined by the Corporate Compliance Committee. <em>(discretionary)</em></td>
<td></td>
</tr>
</tbody>
</table>

**HIPAA and/or Confidentiality Violations**

**Level I Violations**

- One System Occurrence or one Individual Occurrence within a 12 month period (rolling 12 months).
- A single occurrence with extensive risk and/or liability associated with violation is automatically considered a Level III violation.

**Definitions:**

- **Level I Sanctions**
  - Plan to address root cause of violation; ameliorate damage from violation if possible. *(required)*
  - Network Operations to monitor to ensure the issue is addressed through training, procedure changes as per the improvement plan. *(required)*

**Decision - Review Body**

Network Committee
<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>PHI, release of PHI without proper consent.</td>
<td>System Occurrence: violation involves systematic violation of HIPAA or confidentiality laws, such as in improper storage of multiple records. Individual Occurrence: violation involves an individual consumer (only) such as a release of PHI without consent.</td>
<td>• A Plan of Correction is required. <em>(required)</em></td>
<td></td>
</tr>
<tr>
<td>HIPAA and/ or Confidentiality</td>
<td><strong>Level II Violations</strong>&lt;br&gt;Two System Occurrences or two Individual Occurrences within a 12 month period (rolling 12 months)&lt;br&gt;A single occurrence with extensive risk and or liability associated with violation is automatically considered a Level III violation.&lt;br&gt;&lt;br&gt;<strong>Definitions:</strong>&lt;br&gt;System occurrence: violation involves systematic violation of HIPAA or confidentiality laws, such as in improper storage of multiple records.&lt;br&gt;Individual occurrence: violation involves an individual consumer (only) such as a release of PHI without consent.</td>
<td><strong>Level II Sanctions</strong>&lt;br&gt;Immediate <em>(required)</em>:&lt;br&gt;• Referral Freeze.&lt;br&gt;• Inability to add services to contract.&lt;br&gt;<strong>Additional sanctions:</strong>&lt;br&gt;1. Formal Plan of Correction based on identified root cause of violation. <em>(required)</em>&lt;br&gt;2. Network Operations audits to ensure Plan of Correction has been fully implemented. Frequency determined by Network Committee. <em>(frequency is discretionary)</em></td>
<td>Network Committee</td>
</tr>
<tr>
<td>HIPAA and/ or Confidentiality</td>
<td><strong>Level III Violations</strong>&lt;br&gt;Three or more System occurrences or three or more Individual Occurrences within a 12 month period (rolling 12 months)&lt;br&gt;A single occurrence with extensive risk and or liability associated with the violation.&lt;br&gt;&lt;br&gt;<strong>Definitions:</strong>&lt;br&gt;System occurrence: violation involves systematic violation of HIPAA or confidentiality laws, such as in improper storage of multiple records.&lt;br&gt;Individual occurrence: violation involves an individual consumer (only) such as a release of PHI without consent.</td>
<td><strong>Level III Sanctions</strong>&lt;br&gt;Immediate <em>(required)</em>:&lt;br&gt;• Referral Freeze&lt;br&gt;• Inability to add services to contract&lt;br&gt;Contract termination is possible as determined by the Corporate Compliance Committee. <em>(discretionary)</em>&lt;br&gt;<strong>If the contract is not terminated, the following will apply:</strong>&lt;br&gt;1. Formal Plan of Correction based on identified root cause of violation. <em>(required)</em></td>
<td>Corporate Compliance Committee</td>
</tr>
<tr>
<td>Areas of Risk</td>
<td>Violations</td>
<td>Sanctions</td>
<td>Decision - Review Body</td>
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<td>Individual occurrence: violation involves an individual consumer (only), such as a release of PHI without consent.</td>
<td>2. Network Operations audits to ensure Plan of Correction has been fully implemented. Frequency determined by Corporate Compliance. <em>(frequency is discretionary)</em></td>
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</tbody>
</table>

### Failure to Meet Contract Requirements, Including Timeliness of Reporting

<table>
<thead>
<tr>
<th>Contract Requirements</th>
<th>Level I Violation</th>
<th>Level I Sanctions</th>
<th>Network Committee</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>One or two contract violations within a 12 month period.</td>
<td>• Provider addresses requirement; takes remedial action as necessary to comply. Network Committee approves remedial action. <em>(discretionary)</em>&lt;br&gt;• A Plan of Correction is required. <em>(required)</em></td>
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<td></td>
<td>ANY single serious contract breach (either a single occurrence or multiple incidents) where risk or impact is significant is considered a Level III violation.</td>
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</table>

<table>
<thead>
<tr>
<th>Contract Requirements</th>
<th>Level II Violation</th>
<th>Level II Sanctions</th>
<th>Network Committee</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Three contract violations, including repeated violations within a 12 month period.</td>
<td>• Provider addresses requirement; takes remedial action as necessary to comply. Network Committee approves remedial action. <em>(discretionary)</em>&lt;br&gt;• Referral Freeze for up to 3 months following correction of violation as determined by Network Committee. <em>(discretionary)</em>&lt;br&gt;• Inability to add new services to contract for up to three months following correction of violation as determined by Network Committee. <em>(discretionary)</em></td>
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<tr>
<td></td>
<td>ANY single serious contract breach (either a single occurrence or multiple incidents) where risk or impact is significant is considered a Level III violation.</td>
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</table>

<table>
<thead>
<tr>
<th>Contract Requirements</th>
<th>Level III Violations</th>
<th>Level III Sanctions</th>
<th>Network Committee</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>More than three contract violations, including repeated violations during a 12 month period (rolling 12 months)</td>
<td>• Contract may be terminated, as determined by Network Committee. <em>(discretionary)</em>&lt;br&gt;If the Contract is not terminated, the following sanctions apply:&lt;br&gt;1. Provider addresses requirement; takes remedial action as necessary to comply. <em>(required)</em>&lt;br&gt;2. Provider develops Formal Plan of Correction to address issues resulting in contract violation. <em>(required)</em></td>
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<tr>
<td></td>
<td>ANY single serious contract breach (either a single occurrence or multiple incidents) where risk or impact is significant.</td>
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</tbody>
</table>
### Areas of Risk

<table>
<thead>
<tr>
<th>Violations</th>
<th>Sanctions</th>
<th>Decision - Review Body</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>3. Monthly monitoring by Network Department. <em>(discretionary)</em></td>
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<td></td>
<td>4. Referral Freeze for up to 6 months following correction of violation as determined by Network Committee. <em>(length of time is discretionary)</em></td>
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<td></td>
<td>5. Inability to add new services to contract for up to 6 months following correction of violation as determined by Network Committee. <em>(length of time is discretionary)</em></td>
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</table>

### Performance Failures in Multiple Areas

<table>
<thead>
<tr>
<th>Failures in Multiple Areas</th>
<th>Network Status Warning Level</th>
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<th>Decision - Review Body</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Provider has 2 or fewer Level II violations or has been required to develop and implement two Formal Plans of Correction within a 12 month period (rolling months)</strong></td>
<td><strong>Provider Receives formal warning that a third Level II violation or a third Plan of Correction will result in major sanctions as reflected in Level II below and possible termination from the Sandhills Center SANDHILLS CENTER Provider Network.</strong> <em>(required)</em></td>
<td><strong>Network Committee</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Contract Termination:</strong></td>
<td><strong>Contract Termination:</strong></td>
<td><strong>Corporate Compliance Committee</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Provider has received more than three Level II Violations within a 12 month period, or three or more Level III violations, or three violations that are a combination of Level II and III violations.</strong></td>
<td><strong>Contract may be terminated.</strong> <em>(discretionary)</em></td>
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</tr>
<tr>
<td><strong>OR</strong></td>
<td><strong>If contract is not terminated, the Corporate Compliance Committee will determine safeguards needed to allow the provider to continue to provide services, including Plans of Correction and Monitoring Schedule, as well as appropriate sanctions.</strong> <em>(specifics are discretionary)</em></td>
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<tr>
<td><strong>There is a single sentinel event that presents ongoing risk to consumers and/or liability to Sandhills Center.</strong></td>
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</tbody>
</table>
# Sandhills Center
## External Assessments Sanctions Grid

The following are violations of state and federal laws and regulations. These Sanctions are final and are not negotiable.

<table>
<thead>
<tr>
<th>Area of Risk</th>
<th>Violation</th>
<th>Sanction</th>
<th>Decision/Review Body</th>
</tr>
</thead>
<tbody>
<tr>
<td>Loss of Agency License</td>
<td>1. Upon notification from DHSR that the provider’s license has been revoked, QM identifies the population served by the facility and Network Cross Functional Team Chair is informed. 2. Referrals for service are immediately frozen as well as the provider’s eligibility to add additional services. 3. If the facility serves children, consumers are immediately transferred to another provider/facility. 4. For adults, all consumers will be removed unless the provider chose to operate the location as an unlicensed single placement. Sandhills Center will consult with the consumer or guardian, and determine whether any Sandhills Center consumers could remain in the facility even in this circumstance. 5. As a result of the license revocation, the provider contract may be terminated and endorsement withdrawn. Network Cross Functional Team will determine whether to terminate the contract based on historical provider performance records. 6. Payback amounts are determined 7. The Corporate Compliance committee reviews the information to determine further reporting related to violations of false claims act.</td>
<td>Services will end at the site where the license is lost. Contract may be terminated. Endorsement may be withdrawn. Paybacks for any services provided after the license was revoked will be determined and the provider will be billed for this amount, or the amount may be withheld from final payments to the provider as allowed by Sandhills Center contract. Referrals to higher authorities will be made if indicated.</td>
<td>Network Committee</td>
</tr>
<tr>
<td>Loss of Practitioner License</td>
<td>1. Upon written notification, QM informs the Credentialing Committee. The practitioner’s credentials with Sandhills Center are automatically terminated. 2. For an individual practitioner, the contract will be terminated. 3. For a group practice, the individual practitioner would be terminated from the group practice contract. 4. For any lapse in license, the Corporate Compliance Committee reviews the information to determine further reporting related to violations of false claims act and extent of payback required. 5. After a decision is made to terminate the contract. The LME/MCO funded consumers are transferred to another provider.</td>
<td>Termination of credentials with Sandhills Center Termination of contract with Individual Practitioner, OR termination of Individual within group practice. Reporting to higher authorities if potential fraud and abuse are identified by the Corporate Compliance Committee.</td>
<td>Credentialing Committee Corporate Compliance Committee</td>
</tr>
<tr>
<td>Area of Risk</td>
<td>Violation</td>
<td>Sanction</td>
<td>Decision/Review Body</td>
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<tr>
<td>Fraud substantiated by DHB for Licensed Practitioner enrolled as an independent practitioner.</td>
<td>Sandhills Center responds immediately to any written notification received from DHB or other legal entity representing DHB. QM presents the information to the Corporate Compliance Committee and the Credentialing Committee. Contract is terminated. After a decision is made to terminate the contract and the provider is notified, LME/MCO funded consumers are transferred to another provider. The Corporate Compliance committee reviews the information to determine extent of payback required. Practitioner is required to make paybacks to Sandhills Center.</td>
<td>Contract termination. Consumers transferred to another provider. Payback assessment and notice to provider, or recoupment of funds through final payments as allowed by Sandhills Center contract with providers.</td>
<td>Corporate Compliance Committee</td>
</tr>
<tr>
<td>Fraud substantiated by DHB for Agency Providers and Practitioners.</td>
<td>Sandhills Center responds immediately to any written notification received from DHB or other legal entity representing DHB. QM presents the information to the Corporate Compliance Committee for the purpose of terminating the contract. Upon termination of the contract, provider endorsement is terminated. LME/MCO funded consumers are transferred to another provider. The Corporate Compliance committee reviews the information to determine extent of payback required.</td>
<td>Contract termination. Endorsement terminated. Consumers transferred to another provider. Payback assessment and notice to provider, or recoupment of funds through final payments as allowed by Sandhills Center contract with providers.</td>
<td>Corporate Compliance Committee</td>
</tr>
</tbody>
</table>