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A. Introduction

1. A Message from Anthony Ward, 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 behavioral health, traumatic brain injury, intellectual/developmental disabilities substance use disorders, and physical health needs in our catchment area receive quality, whole-person services.

Sandhills Center is currently operating as a Local Management Entity/Managed Care Organization (LME-MCO), however we launched the Medicaid Direct (PIHP) plan on April 1, 2023, and anticipate the launch of the BH/IDD Tailored Plan in 2024.

Our challenge in this environment is to do the very best we can with the resources that are available to us. Our achievements are evident through the strong working relationship we have cultivated with our Provider Network. We are honored to have 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 behavioral and *physical health services ( tailored Plan only). As a provider of services for Sandhills Center, it is important that you become familiar with and adhere to the policies and procedures described here. It includes information pertinent to the contract that you entered into with us. It is a binding part of the contract between Sandhills Center and providers of Medicaid and State-funded services.

We look forward to a positive relationship as we work to provide the best quality of care for the people we serve.

Sincerely,

Anthony Ward, Chief Executive Officer
2. Welcome to Sandhills Center Tailored Plan for BH, I/DD & TBI and Medicaid Direct/PIHP

As a provider for Sandhills Center, a BH/IDD Tailored Plan and/or Medicaid Direct, you become a part of a network dedicated to providing quality care for members residing in Anson, Davidson, Guilford, Harnett, Hoke, Lee, Montgomery, Moore, Randolph, Richmond, and Rockingham counties. By joining our provider network, you assist us in fulfilling our mission to assure that persons in need have access to quality behavioral health, traumatic brain injury, intellectual/developmental disabilities, substance use disorder, and physical health 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 maintain a closed behavioral health network; however, Sandhills Center’s Tailored Plan maintains an open network for physical health providers through a direct contract with Sandhills Center or through an amendment for the Sandhills Center BH/IDD Tailored plan through our physical health subcontractor, AmeriHealth Caritas of North Carolina. Sandhills Center Network Operations Department would like to remind all physical health provider partners of the following:

- Physical Health Care providers who have opted-in to the Sandhills Center BH/IDD Tailored Plan through AmeriHealth Caritas North Carolina are not “automatically” contracted to provide behavioral health/substance use disorder services for Sandhills Center BH/IDD Tailored Plan.
- Any provider that is delivering a behavioral health service for a Sandhills Center member must be contracted directly with Sandhills Center for those services to bill and be reimbursed.
- Claims submitted for a behavioral health/substance use disorder service by a physical health care provider that is not contracted directly with Sandhills Center to provide those services will result in a claim denial.
- Physical Health Care Providers are restricted to billing for services where there is a primary medical diagnosis for the receiving member listed on the claim; in the event that a claim lists a primary MH or SUD diagnosis for the member receiving the service, the claim will be denied.
- Sandhills Center operates a closed BH/SUD/IDD network and only services that are currently identified as a need will be eligible for consideration.
• Providers wishing to contract with Sandhills Center in order to provide behavioral health services must submit the request via the Provider Join Form available at the following link: https://www.sandhillscenter.org/for-providers/provider-regulations/provider-enrollment-contracting
• For a comprehensive list of physical health service codes, please utilize the following link for the Fee Schedules available on the DHHS website: https://medicaid.ncdhhs.gov/providers/fee-schedules

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.

3. Who We Are:

Sandhills Center is a Tailored Plan and Medicaid Direct/PIHP organization responsible for publicly funded behavioral health (mental health and substance use), TBI waiver, physical health and intellectual/developmental disability services and supports for people living in or whose Medicaid or State eligibility was established in the counties we serve. Sandhills Center serves an eleven-county geographic area with a total population of approximately 1 million people of varying ethnic and socioeconomic groups. The eleven counties (referred to as “catchment area”) cover a diverse geographic area, in both urban and rural areas. Sandhills Center is governed by an independent Board of Directors. Members of the Board represent each of the eleven counties we serve.

4. Mission Statement

The mission of Sandhills Center, a BH I/DD Tailored Plan and Medicaid Direct PIHP, is to develop, manage and assure that persons in need have access to quality behavioral health, physical health, intellectual/developmental disabilities, and substance use disorder services. Sandhills Center is committed to whole-person care, addressing the full set of factors that impact health through provider-based care management, improving the member experience, and maintaining broad provider participation to support and achieve the vision of creating a healthier North Carolina.
5. **Vision**

Sandhills Center, a BH I/DD Tailored Plan and Medicaid Direct PIHP partners with members, families, service providers, policy makers, and other community stakeholders in creating, managing, and supporting behavioral and physical health services that meet the needs of our community.

6. **Working Principles**

Sandhills Center, a BH I/DD Tailored Plan and Medicaid Direct PIHP strives to promote:

1. Access to a continuum of services to meet the behavioral and physical health needs of the citizens of Anson, Davidson, Guilford, Harnett, Hoke, Lee, Montgomery, Moore, Randolph, Richmond, and Rockingham counties of North Carolina.
2. Active partnerships among members, families, providers, and the community.
3. High quality behavioral and physical health, intellectual/developmental disabilities, and substance use disorder and TBI 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.

Sandhills Center shall submit the Provider Manual to Department for approval thirty (30) days after Contract Award. The BH I/DD Tailored Plan/Medicaid Direct/PIHP shall not use or distribute the Provider Manual prior to approval by Department.

7. **Disaster and emergency relief planning and response**

Sandhills Center, a BH I/DD Tailored Plan and Medicaid Direct PIHP has established disaster and emergency relief planning and responses in the event of a disaster or emergency situation that results in a major failure or disruption in care, including but not limited to: fire, flood, hurricanes/tornadoes, terrorist event, earthquake, and/or for an epidemic or pandemic disease.

Sandhills Center management staff have identified the following key systems and processes which must be maintained and have determined the priority in which those systems and processes should be restored to minimize impact on business and clinical activities resulting from any event which causes disruption in service or outage of information systems.

1. Screening Triage and Referral
2. Member Enrollment of Clients
3. Authorizations
4. Critical Incident Notification
5. Care Coordination
6. Complaints
7. Claims Processing

Disruptions in the availability of information systems, telephonic, electronic or paper, could potentially prevent the affected departments from performing the following functions critical to the successful operation of the agency.

1. Receive and document calls from, triage and schedule appointments for clients seeking access to care.
2. Enroll clients into Sandhills’ managed care software system.
3. Authorize clinical services for patients seeking treatment.
4. Document and report critical incidents as defined in 10A NCAC 27G.
5. Manage care coordination for individuals with special health care needs.
6. Receive document and investigate consumer complaints and grievances.
7. Process Medicaid and IPRS payments to clinical service providers.

B. UM Program

The purpose of the Utilization Management (UM) Department is to help 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 with secondary oversight and support from the UM Committee and subcommittees and the Quality Management Committee. Providers, through participation in the Clinical Advisory Committee, serve to support and advise UM functions. UM functions are implemented using an established UM Program Description and policies and procedures based upon regulatory requirements. The UM Department is nationally accredited.

1. Utilization Reviews

The primary function of the 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 UM Licensed Reviewers 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). For some select medical
procedures, Sandhills Center uses clinical policies developed in conjunction with AmeriHealth Caritas of North Carolina. In addition, UM Licensed Reviewers utilize nationally established evidence-based practice standards and community treatment standards when making medical necessity determinations. All clinical coverage policies (Medicaid) and State service definitions (State-funded) can be found on the Sandhills Center Website with appropriate links to the NC DHHS website. Evidence-based practice guidelines can be found on the Sandhills Center website.

UM decisions are based on the appropriateness of care, the availability of the requested service, and the member’s plan eligibility. 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 the regulatory requirements for review timeframes:

- **Expedited requests** 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.
  - Within 72 hours if the concurrent request is not submitted prior to the authorization start date.
  - Note: A member’s life, health, or ability to regain maximum function must be at **imminent** risk for a request to be expedited. Expedited requests are not to be used for the convenience of the provider or member.

- **Standard requests** 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. While the Sandhills Center UM Department has processes in place to identify these requests, providers can contact us to flag these 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 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.

Adverse Decision

If the licensed reviewer does not have information to support approving the request, Sandhills Center UM Licensed Reviewers or contracted licensed reviewers will make at least two attempts to gather more information to support the request prior to sending the request for a physician review for a possible denial, reduction, suspension, or termination of services.

If you are offered a peer review by the physician reviewer, Sandhills Center recommends that your highest-level clinical staff that’s familiar with the case participate in the peer review. 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 UM Licensed Reviewer will make at least two attempts to gather the required documents prior to administratively denying the request.

The member may appeal the decision, or a new request may be submitted with the required documents.

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 will begin on the day the new 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, duplicate SAR), we may not be able to process your request – it will be unable to process (UTP). In these situations, the UM Licensed Reviewer will UTP the request and a new request may be submitted. When you re-submit the request, we will allow backdating in many but not all circumstances (ex: the provider waits an
unreasonable amount of time to resubmit the request). Please check with your UM reviewer as to whether the re-submitted request can be backdated.

4. **Your Responsibility as a Provider**

- Ensure member eligibility and request services using the correct funding source (Medicaid or State-funded)
- Submit authorization requests timely; 14 days prior to the requested start date is recommended (non-urgent requests only)
  - Submitting authorization requests timely will ensure that members have access to needed services without delay.
- Provide additional clinical information as requested within the required timeframes
- Participate in peer reviews when offered
- Work collaboratively with Sandhills Center UM staff and contractors
- Notify members of service approvals within 72 hours of receiving the notification through the Sandhills Center managed care software system
  - Sandhills Center notifies members of approvals via the member online portal. Sandhills Center will notify members of any adverse decision via the member portal and U.S. Mail.

5. **Our Responsibility as a BH I/DD Tailored Plan/Medicaid Direct/PIHP**

- Ensure authorization requests contain the required elements
- Review SARs and render a decision within required timeframes
- Communicate with providers when additional information is necessary to approve a request or if problems arise
- Return phone calls and correspondences within one business day
- Utilize the appropriate medical necessity criteria/decision support tools and practice good clinical judgment when making authorization decisions
- Facilitate peer reviews
- Work collaboratively with providers to ensure members receive the right services, at the right level of care, at the right intensity, frequency, and duration with the right provider to accomplish the best clinical outcomes

6. **How to Contact UM**

UM staff are available from 8:30am-5:00pm during business days. On-call UM Licensed Reviewers are available during weekends, holidays, and other closures to ensure expedited requests are reviewed within the required 72-hour timeframe. You may contact UM Licensed Reviewers individually either by phone or email. You may also contact any UM staff at **1-800-241-1073**.
7. **Other UM Functions**

In addition to the primary function of utilization review, the UM Department engages in supportive activities so that 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.

- **Individual Care Oversight**: This is a whole person look at the overall service array of a member to offer appropriate care recommendations to achieve treatment 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, make Care Management referrals, identify areas of over- and under-utilization, and monitor high-cost services.

- **Quality Improvement Activities**: These are activities that help the UM Department make internal and provider-driven improvements to meet best practice and regulatory standards and to help ensure best outcomes for members. Quality Improvement Projects (QIPs) and Quality of Care Concerns (QOCs) are two mechanisms used to achieve improvement goals.

C. **Covered Services**

1. **Eligibility**

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

2. **Who is Eligible for Medicaid Services?**

- **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. Davidson
   3. Guilford
   4. Harnett
   5. Hoke
   6. Lee
   7. Montgomery
   8. Moore
   9. Randolph
  10. Richmond
  11. Rockingham

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.

- **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 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 eleven counties within the Sandhills Center’s catchment area: Anson, Davidson, Guilford, Harnett, Hoke, Lee, Montgomery, Moore, Randolph, Richmond, and Rockingham 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”.

3. 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, Davidson, Guilford, Harnett, Hoke, Lee, Montgomery, Moore, Randolph, Richmond, and Rockingham 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 Sandhills Center.

4. 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. Sandhills Center will coordinate payment for services to out-of-network providers ensuring the cost to the member is not greater than it would be if the services were furnished by a Network provider. Unauthorized behavioral health services from providers/practitioners not in the Sandhills Center Network are not covered unless it is an emergency. Physical Health services may be reimbursed at 90% of the published Medicaid rate. 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 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/](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.)
a. **Service Eligibility** - Services are divided into multiple service categories:

- **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.

- **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 needs more than the automatically authorized twenty-four (24) visits 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.

- **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.

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.

d. 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/media/16462/open](https://www.ncdhhs.gov/media/16462/open)
### Adult MH Priority Populations

<table>
<thead>
<tr>
<th>Individual at risk of harming self or others</th>
<th>Individuals at risk of harming self or others</th>
</tr>
</thead>
<tbody>
<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>

### Child MH Priority Populations

<table>
<thead>
<tr>
<th>Pregnant women who inject drugs</th>
<th>Homeless or at risk of homelessness</th>
</tr>
</thead>
<tbody>
<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>
</tr>
<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

<table>
<thead>
<tr>
<th>#</th>
<th>Benefit Plan</th>
<th>Abbreviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Generic Assessment Payment</td>
<td>GAP</td>
</tr>
<tr>
<td>2</td>
<td>All Military Veterans and Family Members</td>
<td>AMVET</td>
</tr>
<tr>
<td>3</td>
<td>Child with Serious Emotional Disturbance</td>
<td>CMSED</td>
</tr>
<tr>
<td>4</td>
<td>Adult with Mental Illness</td>
<td>AMI</td>
</tr>
<tr>
<td>5</td>
<td>Adult Transitions to Community Living</td>
<td>AMTCL</td>
</tr>
<tr>
<td>6</td>
<td>Child with SA Disorder</td>
<td>CSSAD</td>
</tr>
<tr>
<td>7</td>
<td>Adult Substance Abuse Treatment &amp; Engagement</td>
<td>ASTER</td>
</tr>
<tr>
<td>8</td>
<td>Adult Substance Abuse Women</td>
<td>ASWOM</td>
</tr>
<tr>
<td>No.</td>
<td>Diagnosis Description</td>
<td>Code</td>
</tr>
<tr>
<td>-----</td>
<td>----------------------------------------------------------------------</td>
<td>--------</td>
</tr>
<tr>
<td>9</td>
<td>Adult Substance Abuse Injecting Drug User/Communicable Disease</td>
<td>ASCDR</td>
</tr>
<tr>
<td>10</td>
<td>Adult Substance Opioid Use Disorder</td>
<td>ASOUD</td>
</tr>
<tr>
<td>11</td>
<td>Adult with Developmental Disability</td>
<td>ADSN</td>
</tr>
<tr>
<td>12</td>
<td>Child with Developmental Disability</td>
<td>CDSN</td>
</tr>
<tr>
<td>13</td>
<td>Adult Stimulant Use Disorder</td>
<td>ASTIM</td>
</tr>
<tr>
<td>14</td>
<td>Adult Substance COVID</td>
<td>ASCOV</td>
</tr>
<tr>
<td>15</td>
<td>Adult Substance Use Community Supervision Population</td>
<td>ASCSP</td>
</tr>
</tbody>
</table>

Please note that ALL Diagnoses must be ICD-10 Codes

5. Disenrollment of Members

Members may lose eligibility for the **Tailored Plan** for the following reasons:

- If they do not have a qualifying mental health disorder, substance use disorder, I/DD or TBI condition.
- Have not utilized certain behavioral health services over a 24-month period.
- They stay in a nursing home for more than 90 days in a row.
- They become eligible for and are transferred for treatment to a state-owned Neuro-Medical Center or a Department of Military & Veteran Affairs-operated Veterans Home.

Members may lose eligibility for the **Medicaid Managed Care program** for the following reasons:

- Change of Medicaid eligibility category.
- Incarceration.

Members will be automatically disenrolled from the NC MH/DD/SAS Health Plan if:

- The individual is deceased (and the state is notified of the death)
- The individual is admitted to a correctional facility for more than thirty (30) days.
- 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
- 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.

*When a member changes county of residence for Medicaid eligibility to a county other than Sandhills Center’s catchment area, the individual will continue to be enrolled in the NC MH/DD/SAS Health Plan with Sandhills Center 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.

6. 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.

7. 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 to provide both appropriate assessment and medically necessary services. Treatment Planning Case Coordination is a managed care tool that is designed to proactively intervene and help 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 to provide necessary support for individuals meeting the criteria defined below. The goal is to help 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 Sandhills Center has received notification of discharge.

- **Child Mental Health:**

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

  293-297.99 298.8-298.9 300-300.99 302-302.6 302.8-302.9 307-307.99 308.3 309.81 311-312.99 313.81 313.89 995.5-995.59 V61.21 AND Current CALOCUS Level of VI, OR who are currently, or have been within the past 30 days, in a facility (including a Youth Development Center and Youth
Detention Center) operated by the DJDP or DOC for whom the Sandhills Center has received notification of discharge.

- **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.

8. **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.
9. Telehealth Services

Telehealth services are real-time, two-way interactive audio and video sessions delivered through applications that allow for a HIPAA-compliant platform on any device with audio/visual capabilities. All telehealth services must be provided over a secure HIPAA compliant technology with live audio and video capabilities including (but not limited to), smart phones, tablets, and computers for Psychiatric, Behavioral Health and Intellectual and Developmental Disability services. Additionally, telephonic (audio-only) services may be provided only as specific Clinical Coverage Policies (CCP) allow. Telehealth/telephonic services must be provided at an intensity and quality that meet the needs of the individual, consistent with the individual’s goals, and the intended outcomes of the stated service.

- Providers must consider an individual’s behavioral, physical, and cognitive abilities to participate in services provided using telehealth interventions.
- The individual’s safety must be carefully considered for the complexity of the services provided. In situations where caregivers or facilitators are necessary to assist with the delivery of telehealth services, their ability to assist and their safety should also be considered when the individual needs physical assistance.
- Delivery of services using telehealth or telephonic interventions must conform to professional standards including, but not limited to, ethical practice, scope of practice, and other relevant federal, state, and institutional policies and requirements including relevant Practice Acts and Licensing Board rules.

Providers furnish telehealth and telephonic services from a distant site location. There are no restrictions on distant sites. Distant sites may be wherever the provider may be located. Providers should ensure that patient privacy is protected (e.g., taking calls from private, secure spaces, using headsets).

**Originating site** is the location in which the beneficiary is located. There are no restrictions on originating sites, except that the patient must be located within the state of North Carolina. Originating sites may include health care facilities, schools, community sites, the home, or wherever the beneficiary may be located.

Sandhills Center Utilization Management department is responsible for seeing that all services requested meet medical necessity per service specific CCP criteria. Through State-mandated biennial, Grievance, and Quality of Care reviews, the Network Monitoring department helps ensure services are practiced true to model of the service-specific CCP and maintains documentation compliant with the Medicaid Records and Documentation Manual.

- **Physical Health Services**
  - **Primary Care Selection & Assignment**
During the open enrollment period, the Enrollment Broker will engage in proactive outreach that explains the Enrollment Broker’s services, provides managed care education, and supports the Behavioral Health/IDD Tailored Plan/Medicaid Direct/PIHP and AMH/PCP selection to beneficiaries eligible for Medicaid Managed Care. If the member is automatically assigned to Sandhills Center and the Member does not select a PCP, Sandhills Center will assign the Member to an Advanced Medical Home/Primary Care practitioner (AMH+/PCP) within 24 hours of effectuation date of enrollment with Sandhills Center. If no PCP is selected via the Enrollment Broker, Sandhills Center will:

- Inform the member of their right to choose a PCP.
- Assist the member in selecting a PCP.
- Inform the member that each eligible family member has the right to choose his/her own PCP.
- Automatically assign a PCP to members who do not proactively choose a PCP within 24 hours of enrollment with the Plan.

The Plan considers the following when assigning a PCP:

a) Prior AMH+/PCP assignment;
b) Member claims history;
c) Family member’s AMH+/PCP assignment;
d) Family member’s claims history;
e) Geographic proximity;
f) Special medical needs; and
g) Language/cultural preference.

Members can change their AMH/PCP without cause twice per year. Members will be given thirty (30) days from receipt of notification of their AMH+ assignment to change their AMH/PCP without cause (1st instance) and will be allowed to change their AMH+/PCP without cause up to one time per year thereafter (2nd instance).

Pregnancy Management Program Policy for Tailored Plan Medicaid Members

The Pregnancy Management Program is a set of mandatory standards and clinical initiatives aimed at improving the quality of pregnancy care, improving maternal and infant outcomes, and reducing healthcare costs among participating providers. Sandhills Center incorporates the following requirements for providers of the Pregnancy Management Program into their contracts with providers of prenatal, perinatal, and postpartum care:

1. Complete the standardized risk-screening tool at each initial visit.
2. Allow Sandhills Center or Sandhills Center’s designated vendor access to medical records for auditing purposes to measure performance on specific quality indicators.
3. Commit to maintaining or lowering the rate of elective deliveries prior to thirty-nine (39) weeks’ gestation.
4. Commit to decreasing the cesarean section rate among nulliparous women.
5. Offer and provide 17 alpha-hydroxyprogesterone caproate (17p) for the prevention of preterm birth to women with a history of spontaneous preterm birth who are currently pregnant with a singleton gestation.

6. Complete a high-risk screening on each pregnant Sandhills Center member in the program and integrate the plan of care with Tailored Care Management and/or Care Management for High-Risk Pregnancy.

7. Decrease the primary cesarean delivery rate if the rate is over the Department’s designated cesarean rate (Note: The Department will set the rate annually, which will be at or below twenty (20) percent).

8. Ensure comprehensive postpartum visits occur within fifty-six (56) days of delivery.

Require Sandhills Center network providers send, within one (1) Business Day of the provider completing the screening, all screening information and applicable medical record information for members in care management for high-risk pregnancies to the applicable BH I/DD Tailored Plans, AMH+ practices or CMAs (as applicable), and the LHDs that are contracted for the provision of providing care management services for high-risk pregnancy.

- Advanced Medical Homes/Advanced Medical Homes + (AMH/AMH+)

North Carolina Advanced Medical Homes were developed as an advanced model of care to expand access to primary care services for Medicaid enrollees, and to strengthen the role of primary care in care management and care coordination. AMH allows providers to assume more advanced care responsibilities. AMH+ practices are primary care practices actively serving as AMH Tier 3 practices, with experience delivering primary care services to Sandhills Center Tailored Plan eligible members or otherwise able to demonstrate strong competency to serve that population.

CMAs are provider organizations with experience delivering behavioral health, I/DD, and/or TBI services to Sandhills Center Tailored Plan eligible population that will hold primary responsibility for providing integrated, whole-person care management under the Sandhills Center Tailored Care Management model.

Practices will be compensated for maintaining a high degree of access for Medicaid patients. AMH+ practices and CMAs will be required to gather, process, and share data with Sandhills Center BH I/DD Tailored Plan for the purpose of quality measurement and reporting. To promote a smooth transition to managed care, the NCDHHS has established a standardized payment framework for AMH+ practices that will differ by tier.

Practice Eligibility and Requirements

- To become certified as an AMH+ practice or CMA and be eligible to participate in the AMH+ program, an organization must meet the requirements for an AMH+ practice or CMA, given at Section V.B.3.ii. (ii)Delivery of Tailored Care Management.
- Each AMH+ applicant must attest that it has a patient panel with at least 100 active Medicaid patients who have:
• an SMI, SED, or severe SUD diagnosis;
• an I/DD; or a TBI.
• “Active” patients are those with at least two encounters with the AMH+ applicant’s practice team in the past 18 months.
• AMH+ practices will hold primary responsibility for providing integrated, whole-person care management under the Tailored Care Management model.
• To be eligible to become a CMA, an organization’s primary purpose at the time of certification must be the delivery of NC Medicaid, or State-funded services, other than care management, to Sandhills Center Tailored Plan eligible members. The “CMA” designation is new and will be unique to providers serving the BH I/DD Tailored Plan population.

Standard Terms and Conditions for Sandhills Center Tailored Plan Contracts with All Advanced Medical Home Providers

- Accept members and be listed as a PCP in Sandhills Center Tailored Plan’s member-facing materials for the purpose of providing care to members and managing their healthcare needs.
- Provide primary care and patient care coordination services to each member, in accordance with Sandhills Center policies.
- Provide or arrange for primary care coverage for services, consultation or referral, and treatment for emergency medical conditions, twenty-four (24) hours per day, seven (7) days per week. Automatic referral to the hospital emergency department for services does not satisfy this requirement.
- Provide direct patient care a minimum of thirty (30) office hours per week.
- Provide preventive services, in accordance with Sandhills Center Required Preventive Services.
- Maintain a unified patient medical record for each member following Sandhills Center Tailored Plan’s medical record documentation guidelines.
- Promptly arrange referrals for medically necessary healthcare services that are not provided directly and document referrals for specialty care in the medical record.
- Transfer the member’s medical record to the receiving provider upon the change of PCP at the request of the new PCP or BH I/DD Tailored Plan (if applicable) and as authorized by the member within thirty (30) days of the date of the request, free of charge.
- Authorize care for the member or provide care for the member based on the standards of appointment availability as defined by Sandhills Center’s network adequacy standards.
• Refer for a second opinion as requested by the member, based on Department guidelines and Sandhills Center standards.

• Review and use member utilization and cost reports provided Sandhills Center for the purpose of AMH-level UM and advise Sandhills Center of errors, omissions, or discrepancies if they are discovered.

• Review and use the monthly enrollment report provided by the Sandhills Center for the purpose of participating in Sandhills Center or practice-based population health or care management activities.
In addition, if Provider is a **Tier 3 AMH**, the additional requirements are as indicated below:

<table>
<thead>
<tr>
<th></th>
<th>Tier 1 and Tier 2</th>
<th>Tier 3</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Payment</strong></td>
<td>Same as Carolina ACCESS I &amp; II</td>
<td>Payment at the Carolina ACCESS II level plus additional care management.</td>
</tr>
<tr>
<td><strong>Practice requirements</strong></td>
<td>Same as Carolina ACCESS</td>
<td>In addition to Carolina ACCESS requirements – take on responsibility for additional care management responsibilities</td>
</tr>
</tbody>
</table>
| **Care Management responsibility** | PHP retains primary responsibility for care management | PHP delegates primary responsibility for delivering care management to the practice Practice can provide care management in-house or through a single Clinically Integrated Network (CIN) across all of their Tier 3 PHP contracts Practice must:  
  - Risk Stratify all patients  
  - Provide care management (with a care plan) to high-need patients  
  - Provide short-term transitional care management and medication management to patients who have an ER visit or hospital admission and are at high risk of readmission/other poor outcomes  
  - Receive claim data feeds (directly or via a CIN/partner) and meet state security standards for storage and use |

A fourth tier will be developed in later years of the contract.

For more information about Advanced Medical Homes, contact Sandhills Center Provider Help Desk

See BH I/DD Tailored Plan Provider Manual for Tailored Care Management

[https://medicaid.ncdhhs.gov/media/10743/open](https://medicaid.ncdhhs.gov/media/10743/open)
10. 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 covered services, including inpatient and related inpatient services, according to Medical Necessity requirements. Sandhills Center shall provide authorization for 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.

11. Support Services

a. Interpreter Services

Sandhills Center evaluates the provider network in regard 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 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.

b. 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.

c. For the Blind:

• You can also use our Cultural Competency Resource Booklet located at our website. [https://tp.sandhillscenter.org/for-providers/](https://tp.sandhillscenter.org/for-providers/); also in Spanish, just click the link for “Cultural Competency Resource Booklet”.

d. 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 Sandhills Center Behavioral Health I/DD Tailored Care Management plan is required to provide transportation to medical appointments for all Medicaid eligible members who need and request assistance with transportation. Transportation is for medical appointments or getting prescriptions at the drug store. Riders must 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.

Non-Emergency Medical Transportation

Transportation issues and impact an individual’s ability to obtain needed health services due to lack of vehicle access, inadequate transportation infrastructure, long distances, and lengthy time to reach needed services, and transportation costs. Sandhills Center is aware of the transportation issues that some on our communities’ face. We serve on the transportation committee of a five-county Opioid Response Consortium. Established in May 2020, this committee is intended to improve the availability and coordination of transportation services to connect rural residents to recovery and other support services. As part of this committee, members conducted a transportation gaps analysis, engaged transportation partners from all five counties, developed materials with current resources to distribute to partners, developed a pilot transportation voucher system (currently being rolled out), and conducted sustainability planning for a pilot project. To better address unmet needs in this area, we will leverage the materials and resources developed through our work on this committee to connect members to transportation services.
ModivCare™ is our NEMT broker for the BH/IDD Tailored Care Plan. ModivCare already has a broad reach in each of North Carolina’s regions through transportation management Medicare programs in the State.

We offer non-emergency medical transportation (NEMT) for our members. We inform members regarding the availability of and how to arrange for NEMT in our welcome letter.

We will be using industry leading processes and procedures for coordinating and facilitating NEMT to help ensure that members have coordinated, timely, safe, clean, reliable, and medically necessary transportation. Our care coordination staff will connect members with transportation needs to services to help ensure that lack of transportation does not create a barrier to care. We will utilize NCCARE360 to assist members in identifying transportation resource for those without Medicaid and/or if transportation is needed for other than medical services. Finally, as a result of the public health emergency due to COVID 19, we have made our providers aware of new telehealth codes that enable many services to be provided via telehealth. Increased use of telehealth services can help meet some of the transportation challenges our members may face, should they be amenable and able to take advantage of telehealth visits.

| Table 1: Services Carved Out of Medicaid Managed Care  
(N.C. Gen. Statute § 108D-35) |
<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td><strong>Services provided through the Program of All-Inclusive Care for the Elderly (PACE)</strong></td>
</tr>
<tr>
<td><strong>Services documented in an Individualized Education Program (IEP), Individual Family Service Plan (IFSP), a Section 504 Accommodation Plan pursuant to 34 C.F.R. § 104.36, an Individual Health Plan (IHP), or a Behavior Intervention Plan (BIP) as appropriate for each covered service and provided or billed by Local Education Agencies (LEAs).</strong></td>
</tr>
<tr>
<td><strong>Services provided and billed by Children's Developmental Services Agency (CDSA) that are included on the child's Individualized Family Service Plan.</strong></td>
</tr>
<tr>
<td><strong>Dental services defined as all services billed as dental using the American Dental Association’s Current Dental Terminology (CDT) codes, apart from the two CDT codes (D0145 and D1206) associated with the “Into the Mouths of Babes” (IMB)/Physician Fluoride Varnish Program.</strong></td>
</tr>
<tr>
<td><strong>Services for Medicaid applicants provided prior to the first day of the month in which eligibility is determined in cases where retroactive eligibility is approved (with exception of deemed newborns) unless otherwise defined in the Contract. The Department is considering pursuing authority to carve these services into managed care.</strong></td>
</tr>
<tr>
<td><strong>Fabrication of eyeglasses, including complete eyeglasses, eyeglasses lenses, and ophthalmic frames.</strong></td>
</tr>
</tbody>
</table>
### Table 2: Behavioral Health Services covered in Standard Plans and BH I/DD Tailored Plan/Medicaid Direct/PIHPs

<table>
<thead>
<tr>
<th>BH, I/DD and TBI Services covered by <strong>Both</strong> Standard Plans and BH I/DD Tailored Plans and Medicaid Direct/PIHP</th>
<th>BH, I/DD and TBI Services covered <strong>Exclusively</strong> by BH I/DD Tailored Plans and Medicaid Direct/PIHP (or LME/MCOs prior to Launch)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Enhanced BH Services are Italicized</strong></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>State Plan BH and I/DD Services</th>
<th>State Plan BH and I/DD Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>▪ Inpatient BH services</td>
<td>▪ Residential Treatment Facility services</td>
</tr>
<tr>
<td>▪ Outpatient BH emergency room services</td>
<td>▪ Child &amp; Adolescent Day Treatment services</td>
</tr>
<tr>
<td>▪ Outpatient BH services provided by direct enrolled providers</td>
<td>▪ Intensive In-Home services</td>
</tr>
<tr>
<td>▪ Psychological services in health department and school-based health centers sponsored by health departments</td>
<td>▪ Multi-systemic Therapy services</td>
</tr>
<tr>
<td>▪ Peer Supports</td>
<td>▪ Psychiatric Residential Treatment Facilities (PRTFs)</td>
</tr>
<tr>
<td>▪ Partial Hospitalization</td>
<td>▪ Assertive Community Treatment (ACT)</td>
</tr>
<tr>
<td>▪ Mobile Crisis Management</td>
<td>▪ Community Support Team (includes tenancy supports)</td>
</tr>
<tr>
<td>▪ Facility-based Crisis services for children and adolescents</td>
<td>▪ Psychosocial Rehabilitation</td>
</tr>
<tr>
<td>▪ Professional treatment services in facility-based crisis program</td>
<td>▪ Substance Abuse Non-Medical Community Residential Treatment</td>
</tr>
<tr>
<td>▪ Outpatient Opioid Treatment</td>
<td>▪ Substance Abuse Medically monitored residential treatment</td>
</tr>
<tr>
<td>▪ Ambulatory detoxification</td>
<td>▪ Substance abuse intensive outpatient program (SAIOP)</td>
</tr>
<tr>
<td>▪ Researched-based BH treatment for Autism Spectrum Disorder (ASD)</td>
<td>▪ Substance abuse comprehensive outpatient treatment program (SACOT)</td>
</tr>
<tr>
<td>▪ Diagnostic Assessment</td>
<td>▪ Intermediate care facilities for individuals with intellectual disabilities (ICF-IID)</td>
</tr>
<tr>
<td>▪ Non-Hospital medical detoxification</td>
<td></td>
</tr>
<tr>
<td>▪ Medically Supervised or Alcohol &amp; Drug Abuse Treatment Center (ADATC) detoxification Crisis Stabilization</td>
<td></td>
</tr>
<tr>
<td>▪ Early &amp; Periodic Screening, Diagnostic &amp; Treatment (EPSDT) services *Medicaid</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Waiver Services</strong></td>
</tr>
<tr>
<td></td>
<td>▪ Innovations waiver services</td>
</tr>
<tr>
<td></td>
<td>▪ TBI waiver services</td>
</tr>
</tbody>
</table>
Sandhills Center’s Tailored Plan/Medicaid Direct/PIHP covers Innovations and TBI waiver services for members enrolled in the waivers as defined in Tables 4 & 5 below. *Please note that the TBI Waiver is through the BH/IDD Tailored Plan for everyone except for individuals who are in the tribal option who have opted out of managed care.

### Table 4 Innovations Waiver Services
(Only BH I/DD Tailored members who are enrolled in the Innovations waiver will have access to these services)

<table>
<thead>
<tr>
<th>Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assistive Technology</td>
</tr>
<tr>
<td>Community Living &amp; Support</td>
</tr>
<tr>
<td>Community Navigator</td>
</tr>
<tr>
<td>Community Networking</td>
</tr>
<tr>
<td>Community Transition</td>
</tr>
<tr>
<td>Crisis Services</td>
</tr>
<tr>
<td>Day Supports</td>
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<tr>
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### Table 5 TBI Waiver Services

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Below documents the list of Clinical Coverage Policies the Department (State of NC) maintains currently for its NC Medicaid Direct program for Medicaid covered benefits that are covered by Sandhills Center’s Tailored Plan/Medicaid Direct/PIHP. Full details on the policies are available at [https://medicaid.ncdhhs.gov/providers/clinical-coverage-policies](https://medicaid.ncdhhs.gov/providers/clinical-coverage-policies).

Key References

NC’s Medicaid State Plan is available here:
Medicaid clinical coverage policies are available here:

https://medicaid.ncdhhs.gov/providers/clinical-coverage-policies

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### Intravascular Ultrasound

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### Chiropractic Services

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<td>Early and Periodic Screening, Diagnostic and Treatment (EPSDT)</td>
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<td>NC Clinical Coverage EPSDT Policy Instructions</td>
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<td>Section V.B.2.ii. Early and Periodic Screening, Diagnostic and Treatment (EPSDT) for Medicaid Members</td>
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<td>Family Planning Services</td>
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<td>NC Health Choice State Plan Section 6.2.9</td>
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<td>NC Clinical Coverage Policy 1E-7, Family Planning Services</td>
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**Summary of Medicaid Covered Services & Clinical Coverage Policies**

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| Federally Qualified Health Center (FQHC) services | SSA, Title XIX, Section 1905(a)(2)(C)  
42 C.F.R. § 405.2411  
42 C.F.R. § 405.2463, 42 C.F.R. § 440.20  
NC Medicaid State Plan, Att. 3.1-A, Page 1  
NC Clinical Coverage Policy 1D-4, Core Services Provided in Federally Qualified Health Centers and Rural Health Clinics | Yes | No | Yes |
| Freestanding Birth Center Services (when licensed or otherwise recognized by the State) | SSA, Title XIX, Section 1905(a)(28)  
NC Medicaid State Plan Att. 3.1-A, Page 11  
OB Policy 1E-5 | Yes | No | Yes |
| Gynecology | NC Medicaid State Plan Att. 3.1-B, Page 7(a)  
NC Clinical Coverage Policy 1E-1, Hysterectomy  
NC Clinical Coverage Policy 1E-2, Therapeutic and Non-therapeutic Abortions | Yes | No | Yes |
| Hearing Aids | NC Medicaid State Plan, Att. 3.1-A.1, Pages 6, 7a; Att. 3.1-B, Page 1  
NC Clinical Coverage Policy 7, Hearing Aid Services | Yes | No | Yes |
| HIV Case Management Services | Supplement 1 to Attachment 3.1-A, Part G, Page 1  
NC Clinical Coverage Policy 12B, Human Immunodeficiency Virus (HIV) Case Management | Yes | No | Yes |
| Home Health Services | SSA, Title XIX, Section 1905(a)(7)  
42 C.F.R. § 440.70  
NC Medicaid State Plan, Att. 3.1-A, Page 3; Att. 3.1-A.1, Pages 13, 13a-13a.4  
NC Clinical Coverage Policy 3A | Yes | No | Yes |
| Home Infusion | NC Medicaid State Plan Att. 3.1-A.1, Page | Yes | No | Yes |
### Summary of Medicaid Covered Services & Clinical Coverage Policies

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| Hospice Services                 | SSA, Title XIX, Section 1905(a)(18)  
                                | 42 C.F.R. § 418  
                                | NC Medicaid State Plan 3.1-A, Page 7  
                                | NC Clinical Coverage Policy 3D, Hospice Services                                                                 | Yes | No | Yes |
| ICF-IID Services                 | 42 C.F.R. § 440.150  
                                | 8E: Intermediate Care Facilities for Individual with Intellectual Disabilities                                                                 | Yes | Yes | No  |
| Innovations Waiver Services      | 8P: North Carolina Innovations                                                                                                           | Yes (Innovations waiver enrollees only) | Yes (Innovations waiver enrollees only) | No              |
| Inpatient Hospital Services      | SSA, Title XIX, Section 1905(a)(1)  
                                | 42 C.F.R. § 440.10  
                                | NC Medicaid State Plan, Att. 3.1-A, Page 1  
                                | NC Medicaid State Plan, Att. 3.1-E  
<pre><code>                            | NC Clinical Coverage Policy 2A-1, Acute Inpatient                                                                 | Yes | No | Yes |
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<td>Inpatient Psychiatric Services for Individuals under age 21</td>
<td>NC Clinical Coverage Policy 8A: Enhanced Mental Health and Substance Abuse Services limited to services listed:</td>
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<td>Child &amp; Adolescent Day Treatment</td>
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<td>Mobile Crisis Management</td>
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<td>NC Clinical Coverage Policy 8A-1: Assertive Community Treatment (ACT) Program</td>
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## Summary of Medicaid Covered Services & Clinical Coverage Policies

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<td>Laboratory and X-ray Services</td>
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<td>Maternal Support Services</td>
<td>NC Medicaid State Plan, Att. 3.1-B, Pages 7(a), 7(a.1)</td>
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NC Clinical Coverage Policy 1S-1, Genotyping & Phenotyping for HIV Drug Resistance Testing

NC Clinical Coverage Policy 1S-2, HIV Tropism Assay

NC Clinical Coverage Policy 1S-3, Laboratory Services

NC Clinical Coverage Policy 1S-4, Genetic Testing

NC Clinical Coverage Policy 1S-8, Drug Testing for Opioid Treatment and Controlled Substance Monitoring

NC Clinical Coverage Policy 1K-1, Breast Imaging Procedures

NC Clinical Coverage Policy 1K-2, Bone Mass Measurement

NC Clinical Coverage Policy 1K-6 Radiation Oncology

NC Clinical Coverage Policy 1K-7, Prior Approval for Imaging Services

1; Att. 3.1-A.1, Pages 6a, 7a, 11; Att. 3.1-B, Page 2; Att. 3.1-C
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<td>Outpatient and Residential BH services (only covered by Medicaid)</td>
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<td>NC Clinical Coverage Policy 9E, Off Label Antipsychotic Safety Monitoring in Beneficiaries 18 and older</td>
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<td>1A-8 Hyperbaric Oxygenation Therapy</td>
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<td>1A-12 Breast Surgeries</td>
<td>Yes</td>
<td></td>
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<td>1A-13 Ocular Photodynamic Therapy</td>
<td>No</td>
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### Summary of Medicaid Covered Services & Clinical Coverage Policies

<table>
<thead>
<tr>
<th>Service</th>
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<tr>
<td></td>
<td>Tailored Plan</td>
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<tr>
<td>Podiatry Services</td>
<td>Yes</td>
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<tr>
<td>SSA, Title XIX, Section 1905(a)(5)</td>
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<tr>
<td>42 C.F.R. § 440.60</td>
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<tr>
<td>Prescription Drugs and Medication Management</td>
<td>SSA, Title XIX, Section 1905(a)(12)</td>
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<td>NC Medicaid State Plan, Att. 3.1-A, Page 5, Att. 3.1-A.1, Pages 14-14h</td>
<td>NC Preferred Drug List</td>
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<tr>
<td>NC Clinical Coverage Policy 9, Outpatient Pharmacy Program</td>
<td>NC Clinical Coverage Policy 9A, Over the Counter Products</td>
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<tr>
<td>NC Clinical Coverage Policy 9C, Mental Health Drug Management Program Administrative Procedures</td>
<td>NC Clinical Coverage Policy 9D, Off Label Antipsychotic Safety Monitoring in Beneficiaries through age 17</td>
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<td>NC Medicaid Pharmacy Newsletters Section</td>
<td><a href="https://medicaid.ncdhhs.gov/2023-pharmacy-newsletters">https://medicaid.ncdhhs.gov/2023-pharmacy-newsletters</a></td>
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<td>Service</td>
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<tr>
<td>Private Duty Nursing (PDN)</td>
<td>SSA, Title XIX, Section 1905(a)(8)</td>
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<td></td>
<td>42 C.F.R. § 440.80</td>
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<td>NC Medicaid State Plan, Att. 3.1-A, Page 3a; Att. 3.1-A.1, Page 13b</td>
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<td></td>
<td>NC Clinical Coverage Policy 3G-1, Private Duty Nursing for Beneficiaries age 21 and older</td>
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<td>NC Clinical Coverage Policy 3G-2, Private Duty Nursing for Beneficiaries under 21 years of age</td>
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<td>Yes  No Yes</td>
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<td>Prosthetics, Orthotics and supplies</td>
<td>SSA, Title XIX, Section 1905(a)(12)</td>
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<td>42 C.F.R. § 440.120</td>
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<td>NC Medicaid State Plan, Att. 3.1-A, Page 5; Att. 3.1-A.1, Page 7b</td>
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<td>NC Clinical Coverage Policy 5B, Orthotics and Prosthetics</td>
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<td>Reconstructive Surgery</td>
<td>NC Clinical Coverage Policy 1-O-1, Reconstructive and Cosmetic Surgery</td>
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<td>NC Clinical Coverage Policy 1-O-2, Craniofacial Surgery</td>
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<td>NC Clinical Coverage Policy 1-O-3, Keloid Excision and Scar Revision</td>
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<td>NC Clinical Coverage Policy 1-O-5, Rhinoplasty and/or Septorhinoplasty</td>
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<td>Respiratory Care Services</td>
<td>SSA, Title XIX, Section 1905(a)(20)</td>
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<td>SSA, Title XIX, Section 102(e)(9)(A)</td>
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<td>NC Medicaid State Plan, Att. 3.1-A, Page 8a; Appendix 7 to Att. 3.1-A, Page 2; Att. 3.1-A.1, Page 7c</td>
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<td>Rural Health Clinic Services (RHC)</td>
<td>SSA, Title XIX, Section 1905(a)(9)</td>
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<td>42 C.F.R. § 405.2411</td>
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<td></td>
<td>42 C.F.R. § 405.2463</td>
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<td>42 C.F.R. § 440.20</td>
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<td>NC Medicaid State Plan, Att. 3.1-A, Page 4; Att. 3.1-A, Page 1</td>
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<td></td>
<td>NC Clinical Coverage Policy 1D-4, Core Services provided in Federally Qualified Health Centers and Rural Health Clinics</td>
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<tr>
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<td>Yes  No Yes</td>
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</table>

| Services for individuals age 65 or older in an Institution for Mental Disease (IMD) | SSA, Title XIX, Section 1905(a)(14)                                         |
|                                                                                 | 42 C.F.R. § 440.140                                                      |
|                                                                                 | NC Medicaid State Plan, Att. 3.1-A, Page 6; Att. 3.1-A.1, Page 15b        |
|                                                                                 | NC Clinical Coverage Policy 8B, Inpatient BH Services                      |
|                                                                                 | Yes  Yes No                                                             |

<p>| Speech, Hearing and Language Disorder Services                              | 42 C.F.R. § 440.110                                                     |
|                                                                                 | NC Medicaid State Plan, Att. 3.1-A.1, Pages 7c,7c.16                    |
|                                                                                 | NC Clinical Coverage Policy 10A, Outpatient Specialized Therapies        |
|                                                                                 | Yes  No Yes                                                             |</p>
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<th>Services</th>
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<tr>
<td>Transplants and Related Services</td>
<td>Tailored Plan</td>
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<td>Yes</td>
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NC Medicaid State Plan, Page 27, Att. 3.1-E, Pages 1-9
NC Clinical Coverage Policy 11A-1, Hematopoietic Stem-Cell or Bone Marrow Transplantation for Acute Lymphoblastic Leukemia (All)
NC Clinical Coverage Policy 11A-2, Hematopoietic Stem-Cell and Bone Marrow Transplant for Acute Myeloid Leukemia
NC Clinical Coverage Policy 11A-3, Hematopoietic Stem-Cell and Bone Marrow Transplantation for Chronic Myelogenous Leukemia
NC Clinical Coverage Policy 11A-5, Allogeneic Hematopoietic and Bone Marrow Transplant for Generic Diseases and Acquired Anemias
NC Clinical Coverage Policy 11A-6, Hematopoietic Stem-Cell and Bone Marrow Transplantation for Genetic Treatment of Germ Cell Tumors
NC Clinical Coverage Policy 11A-7, Hematopoietic Stem-Cell and Bone Marrow Transplantation for Hodgkin Lymphoma
NC Clinical Coverage Policy 11A-8, Hematopoietic Stem-Cell Transplantation for Multiple Myeloma and Primary Amyloidosis
NC Clinical Coverage Policy 11A-9, Allogeneic Stem-Cell and Bone Marrow Transplantation for Myelodysplastic Syndromes and Myeloproliferative Neoplasms
NC Clinical Coverage Policy 11A-10, Hematopoietic Stem-Cell and Bone Marrow Transplantation for Central Nervous System (CNS) Embryonal Tumors and Ependymoma
NC Clinical Coverage Policy 11A-11, Hematopoietic Stem-Cell and Bone Marrow Transplant for Non-Hodgkin's Lymphoma
NC Clinical Coverage Policy 11A-14, Placental and Umbilical Cord Blood as a Source of Stem Cells
NC Clinical Coverage Policy 11A-15, Hematopoietic Stem-Cell Transplantation for Solid Tumors of Childhood
NC Clinical Coverage Policy 11A-16, Hematopoietic Stem-Cell Transplantation for Chronic Lymphocytic Leukemia (CLL) and Small Lymphocytic Lymphoma (SLL)
NC Clinical Coverage Policy 11A-17, CAR-T Cell Therapy
NC Clinical Coverage Policy 11B-1, Lung Transplantation
NC Clinical Coverage Policy 11B-2, Heart Transplantation
NC Clinical Coverage Policy 11B-3, Islet Cell Transplantation
NC Clinical Coverage Policy 11B-4, Kidney Transplantation
NC Clinical Coverage Policy 11B-5, Liver Transplantation
NC Clinical Coverage Policy 11B-6, Heart/Lung Transplantation
NC Clinical Coverage Policy 11B-7, Pancreas Transplant
NC Clinical Coverage Policy 11B-8, Small Bowel and Small Bowel/Liver and Multivisceral Transplants

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<tr>
<td>Ventricular Assist Device</td>
<td>Yes, No, Yes</td>
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<td>NC Medicaid State Plan, Att. 3.1-E, Page 2</td>
<td>Yes, No, Yes</td>
</tr>
<tr>
<td>NC Clinical Coverage Policy 11C, Ventricular</td>
<td>Yes, No, Yes</td>
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### Assist Device

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<tr>
<th>Vision Services</th>
<th>NC Medicaid State Plan, Att. 3.1-A, Pages 5-6, Page 10a, Page 15; Att. 3.1-B, Pages 1, 4, and 5</th>
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<tr>
<td></td>
<td>NC Clinical Coverage Policy 6A, Routine Eye Exam and Visual Aids for Recipients under age 21</td>
</tr>
<tr>
<td></td>
<td>NC Clinical Coverage Policy 6B, Routine Eye Examination and Visual Aids for Beneficiaries 21 years of age or older</td>
</tr>
<tr>
<td></td>
<td>For eyeglasses, providers are required to request a prior authorization through NC Tracks. Eyeglasses will be received from the North Carolina optical laboratory. For the eyeglasses dispensing fee, providers are required to bill Sandhills Center</td>
</tr>
</tbody>
</table>

Additionally, Sandhills Center offers behavioral health services or settings that are medically appropriate, cost-effective substitutions for services covered by NC Medicaid. These “in lieu of” services are approved by NCDHHS, developed to improve member outcomes, and are alternates to other, often higher, levels of care. If the In Lieu of Service is not a medically appropriate, cost-effective substitute, or an issue is identified, a similar service or setting may be assigned. The In Lieu of Service may be declined by the beneficiary, and the beneficiary may opt to receive the original state plan or waiver service instead.

Providers may request to add an In Lieu of Service to their contracted service array by submitting this request via the Provider Join Form available through the link below, under Provider Enrollment /Contracting Instructions:

[https://www.sandhillscenter.org/for-providers/provider-regulations/provider-enrollment-contracting](https://www.sandhillscenter.org/for-providers/provider-regulations/provider-enrollment-contracting)

For more detailed information on In Lieu of Services, visit In Lieu of Services TP [sandhillscenter.org](http://sandhillscenter.org).

- Additional Benefits
  1. Behavioral Health Crisis Line
  2. Pharmacy Service Line
  3. Nurse Advice Line
  4. Non-Emergency Medical Transportation (NEMT)
  5. Non-Emergency Ambulance Transportation (NEAT)
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
See brochure: http://www.co.anson.nc.us/199/Transportation

Davidson
Phone: 336-883-7278
Fax: 336-242-2964
See Brochure: https://www.co.davidson.nc.us/258/Transportation

Guilford
Phone: (336) 641-4848
See Brochure: https://www.guilfordcountync.gov/our-county/human-services/transportation/services-and-programs

Harnett
Phone: (910) 814-4019
TDD/TTY: 800 799-4889 or 711
See Brochure: http://www.harnett.org/harts/

Hoke
Phone: (910) 875-8696
TDD/TTY: 800 735-2962
See website: http://hokecounty.org/158/Hoke-Area-Transit-Service-HATS

Lee
Phone: (919) 776-7201
TTD/TTY 800 735-2962
See Lee County (leecountync.gov)

Montgomery
Phone: (910) 572-3430 or 866 580-8726
TTY: 877 735-8200 or 711
See Brochure: Medicaid Transportation - Montgomery County (montgomerycountync.com)
D. Eligibility for State-Funded Services, including federal funding restrictions and requirements

Sandhills Center utilizes an initial screening of eligibility for State-funded Services that focuses on the following:

- Targeting State-funded Services to populations with low and modest incomes as detailed in the table below and/or who need specialized services that are not otherwise available to them.

- Encouraging uninsured State-funded Services recipients to apply for Medicaid to obtain comprehensive insurance coverage; and

- Maximizing the impact of limited state funds available for behavioral health and I/DD services by ensuring other available coverage and payments sources are pursued.

Medicaid beneficiaries enrolled in managed care will be able to access State-funded Services with Sandhills Center only if they are members of the Sandhills Center Behavioral Health I/DD Tailored Plan with the exception of those participating in such local health functions as Crisis/Involuntary Commitment (IVC), Disaster Emergency Response, local collaboratives like CFAC and other natural and community support resources. Additionally, populations that are excluded or delayed...
from joining managed care plans, can also access these State-funded Services while enrolled in NC Medicaid Direct. Recipients of State-funded Services through Sandhills Center will not be able to access Medicaid services covered by the Sandhills Center Behavioral Health I/DD Tailored Plan and Medicaid Direct/PIHP unless they are enrolled in Medicaid.

Currently, 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, Davidson, Guilford, Harnett, Hoke, Lee, Montgomery, Moore, Randolph, Richmond, or Rockingham 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 potential 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.

Federal funds provided shall not be used to supplant federal or non-federal funds for services or activities which promote the purposes of the grant or funding.

Federal funds provided shall not be utilized to supplement any reimbursement for services or staff activities provided through the NC Medicaid Program.

Federal funds provided shall not be utilized to supplement any reimbursement for services or staff activities supported through the Division’s payment of other UCR or non-UCR funds. Federal funds shall not be paid in advance to an LME/MCO, contractor, or any other entity. All contractors and subcontractors, including LME-MCOs and subrecipient contractors of these funds, shall comply with all requirements, restrictions, terms and conditions, and reporting requirements of the SAPTBG, as contained in 45 CFR Part 96 and any revisions to such regulations.

Funds shall be used in accordance with cost principles describing allowable and unallowable expenditures for nonprofit organizations in accordance with OMB Circular A-122.

Recipients of services reimbursed or supported through federal funds shall not be subject to income tests for recipient eligibility for such services unless required or permitted in federal statute or regulation.

Agencies or organizations receiving federal funds are required to receive prior written approval from the Chief of the Addictions and Management Operations Section regarding the use of evidence-based program nominal incentives, including the specification of the type(s) and equivalent dollar value(s) of any such nominal incentives offered, and the manner of utilization of any such approved incentives for clients, recipients, students, or other persons. “Nominal incentives” are restricted to those incentives of no more than twenty-five dollars ($25.00) in value, per recipient, per event. Programs are strictly prohibited from utilizing any incentive items that could potentially be converted to cash, or that could be used for the purchase of any age-restricted product, such as tobacco, alcohol, drugs, weapons, lottery tickets or other inappropriate products or materials. Incentives may not be offered to staff, interns, contractors, consultants, board members, consultants, volunteers, or any other individuals who are not enrolled as recipients in the program of behavioral health services. SAPTBG funds are prohibited to be used to make, or to allow to be made, any cash payments to any recipients or intended recipients of health or behavioral health services. The provision of cash or cash cards is strictly prohibited, as is the provision of gift cards, which are cash equivalents.

Federal funds shall not be utilized for law enforcement activities. Federal funds shall not be used to provide inpatient services.
Federal funds are prohibited to be used to satisfy any requirement for the expenditure of non-Federal funds as a condition of receipt of Federal funds. (i.e., Federal funds may not be used to satisfy any condition for any state, local or other funding match requirement).

Federal funds are prohibited to be used to provide financial assistance to any entity other than a public or nonprofit private entity.

Federal funds are prohibited to be used to provide individuals with hypodermic needles or syringes so that such individuals may use illegal drugs.

Federal funds are prohibited to be used to provide individuals with treatment services in penal or correctional institutions of the State.

Federal funds are prohibited to be used for the purchase or improvement of land, purchase, construction or permanent improvement (other than minor remodeling) of any building or other facility, or purchase of major equipment, including, but not limited to, medical equipment, IT equipment, and vehicles.

No part of any federal funding shall be used for publicity or propaganda purposes, for the preparation, distribution, or use of any kit, pamphlet, booklet, publication, radio, television, or video presentation designed to support or defeat legislation pending before the Congress or any State legislature, except in presentation to the Congress or any state legislative body itself.

No part of any federal funding shall be used to pay the salary or expenses of any grant or contract recipient, or agent acting for such recipient, related to any activity designed to influence legislation or appropriations pending before the Congress or any state legislature. Federal funds are prohibited to be used towards the annual salary of any contractor or subcontractor, including LME-MCO, provider, or contractor employee, consultant, or other individual that is in excess of Level I of the most current US Office of Personnel Management federal Executive Salary Schedule.

E. Tailored Care Management Delivered through the BH I/DD Tailored Plans

1. About North Carolina’s Medicaid

In September 2015, the General Assembly enacted North Carolina Session Law 2015-245 directing the transition of North Carolina’s Medicaid program from a predominately Fee-for-Service model to an integrated Medicaid Managed Care model. North Carolina State law requires the North Carolina Department of Health and Human Services, through the Division of Health Benefits (DHB), to implement a Medicaid Managed Care program.
As directed by the General Assembly, the NCDHHS delegated direct management of services, and financial risk to new Medicaid Managed Care Plans, including Standard Plans, BH-I/DD Tailored Plans, and a Statewide Specialized Foster Care Plan. Each of these plans receive a monthly, actuarially sound, capitated payment and contract with providers to deliver health services to our members. The NCDHHS is monitoring and overseeing the administrative, operational, clinical, and financial function of the Medicaid Managed Care Plans to ensure adherence to their contract and the NCDHHS’ expectations.

With the launch of Medicaid Managed Care on July 1, 2021, most North Carolina Medicaid populations have been mandatorily enrolled in Standard Plans.

With the upcoming launch of the Tailored Plan, populations eligible for the Tailored Plans are established in the N.C. General Statutes § 108D-40(a)(12). As directed by law, the NCDHHS exempted populations that will be eligible for BH-I/DD Tailored Plans from Medicaid Managed Care until such point that BH-I/DD Tailored Plans become available, at which point, they become eligible for BH-I/DD Tailored Plans.

a. About the NC BH I/DD Tailored Plan

Tailored Plan status applies to Sandhills Center members with Medicaid with more severe behavioral health conditions – including mental illness and severe substance use disorders – I/DD, and TBI 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 and physical health, intellectual/developmental disability, and substance use disorder service needs. BH-I/DD Tailored Plan/Medicaid Direct/PIHPs are solely responsible for managing the state’s non-Medicaid or state-funded behavioral health, developmental disabilities, substance use disorder, and TBI services, which are targeted to uninsured and underinsured North Carolinians.

Available services include 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 (DSOHF) as well as primary and specialty physical health services.

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

i. Transitions to Community Living
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 Tailored Plan/Medicaid Direct/PIHPs, 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 priority 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 priority population about community-based mental health services and supported housing options.

ii. Transition Management

   a. Sandhills Center will confirm that organizations providing Tailored Care Management are able to receive notifications of each admission/discharge/transition (ADT) within a clinically appropriate time period.

      i. Sandhills Center will utilize the ADT data feeds to identify when members are admitted, discharged, or transferred to/from an emergency department or hospital in real time or near real time. Sandhills Center will have adequate staff to respond to high-risk alerts such as:

         1. Response to notifications of emergency department visits.
         2. Same-day or next-day outreach for designated high-risk subsets of the population, such as children with special health care needs admitted to the hospital.
         3. Additional outreach within several days after the alert to address outpatient needs or prevent future problems for other patients who have been discharged from a hospital or ED.

   b. Sandhills Center will verify that organizations providing Tailored Care Management carry out the following transitional care management functions:

      i. Confirm that a care manager is assigned to manage the transition.
      ii. Have a care manager assume coordination responsibility for transition planning.
iii. Have a care manager or care team member visit the member during their stay in an institution (e.g., acute, subacute and long-term stay facilities) and be present on the day of discharge.

iv. Conduct outreach to the member’s providers.

v. Obtain a copy of the discharge plan and review the discharge plan with the member and facility staff.

vi. Facilitate clinical handoffs.

vii. Refer and assist members in accessing needed social services and supports identified as part of the transitional care management process, including access to housing.

viii. Assist the member in obtaining needed medications prior to discharge, help ensure an appropriate care team member conducts medication reconciliation/management and support medication adherence.

ix. Develop a ninety (90) day post-discharge transition plan prior to discharge from residential or inpatient settings, in consultation with the member, facility staff and the member’s care team, that outlines how the member will maintain or access needed services and supports, transition to the new care setting, and integrate into their community.

1. The ninety (90) day post-discharge transition plan shall be implemented upon discharge and be an amendment to the Care Plan or Individual Service Plan (ISP)

2. To the extent feasible, a care management comprehensive assessment should be conducted to inform the ninety (90) day post-discharge transition plan.

3. The ninety (90) day post-discharge transition plan must incorporate any needs for training of parents and other caregivers to care for a child with complex medical needs post-discharge from an inpatient setting.

4. Development of a ninety (90) day post-discharge transition plan is not required for all ED visits but may be developed according to the care manager’s discretion.

5. The assigned organization providing Tailored Care Management shall communicate with and provide education to the member and the member’s caregivers and providers to promote understanding of the ninety (90) day post-discharge transition plan.

x. Assist with scheduling of transportation, in-home services, and follow-up outpatient visits with appropriate providers within a maximum of seven (7) Calendar Days post-discharge, unless required within a shorter timeframe.

xi. Confirm that the assigned care manager follows up with the member within forty-eight (48) hours of discharge.

xii. Arrange to visit the member in the new care setting after discharge/transition.

xiii. Conduct a care management comprehensive assessment within thirty (30)
days of the discharge/transition or update the current assessment.

xiv. Update the member’s Care Plan/ISP in coordination with the member’s care team within ninety (90) days of the discharge/transition based on the results of the care management comprehensive assessment.

c. For individuals with I/DD or TBI, Sandhills Center will help ensure the assigned organization providing Tailored Care Management conducts relevant transitional care management activities in the following “life transitions”:

i. Instances where a member is transitioning out of school-related services;

ii. Instances where a member experiences life changes such as employment, retirement or other life events;

iii. Instances where a member has experienced the loss of a primary caregiver or a change of primary caregiver; and

iv. Instances where a member is transitioning out of foster care.

v. For additional Care Coordination requirements for this population, please see the Additional Care Coordination Responsibilities for TBI and Innovations Waiver Members Policy and Procedure.

d. Sandhills Center will develop protocols for to help ensure that individuals moving between the following services and the Tailored Care Management model experience smooth transitions, such as warm-handoff and transition workflows:

i. ACT;

ii. ICF-IIIDs;

iii. Care Management for At-Risk Children; and

iv. High-Fidelity Wraparound program

iii. Diversion

a. Sandhills Center will help ensure that members are identified who are at risk of requiring care in an institutional setting or Adult Care Home (ACH) are provided diversion interventions as described below.

i. Sandhills Center will help ensure that diversion activities, including identification of eligible members, are the responsibility of the assigned organization providing Tailored Care Management.

ii. In the event that a member who is not actively engaged in Tailored Care Management is eligible for diversion, Sandhills Center will conduct outreach to engage the member in Tailored Care Management and conduct diversion activities.

iii. Sandhills will help ensure that the assigned organization providing Tailored Care Management consults with Sandhills Center medical staff or medical staff based at the organization providing Tailored Care Management to assess the medical needs of the member receiving diversion services.

b. Eligibility for Diversion

i. Members eligible for diversion activities include those meeting the following criteria:
1. Have transitioned from an institutional or correctional setting, or an ACH for adult members, within the previous six (6) months; or
2. Are seeking entry into an institutional setting or ACH; or
3. Meet one of the following additional criteria for members with I/DD or TBI:
   a. Member has an aging caregiver who may be unable to provide the recipient their required interventions; or
   b. Member’s caregiver is in fragile health, which may include but is not limited to member caregivers who have been hospitalized in the previous twelve (12) to eighteen (18) months, diagnosed with a terminal illness, or have an ongoing health issue that is not managed well (e.g., diabetes, heart condition, etc.); or
   c. Member with two parents or guardians if one of those parents/guardians dies: or
   d. Any other indications that a member’s caregiver may be unable to provide the member their required interventions; or
   e. Member is a child or youth with complex BH needs.

c. Diversion Activities
   i. Sandhills Center will help ensure that the assigned organization providing Tailored Care Management performs the following diversion activities in a timely manner:
      1. Screen and assess the member for eligibility for community-based services.
      2. Educate the member on the choice to remain in the community and the services that would be available to support that decision.
      3. Facilitate referral and linkages to community-based and other support services for assistance.
      4. Determine if the member is eligible for supportive housing, if needed.
      5. For those who choose to remain in the community:
         a. Develop a Community Integration Plan (CIP) that clearly documents that the member’s decision to remain in the community was based on informed choice, and the degree to which the member’s decision has been implemented.
         b. Integrate the member’s CIP as an addendum in the member’s Care Plan or ISP.
         c. For members with a CIP, refer and provide linkages to services and supports for which they are eligible, including supportive housing.
   ii. Sandhills Center will help ensure all diversion activities are documented and stored and made available to the Department for review upon request.
NC Child and Family Improvement Initiative Creates Standardized Referral Form for all Therapeutic Residential Placement Providers and Therapeutic Foster Care (TFC) Providers

What is happening?
North Carolina’s six Local Management Entities/Managed Care Organizations (LME/MCOs) launched the NC Child and Family Improvement Initiative on May 1, 2022, to create a statewide solution to the current pressing challenges of the service delivery system for children and youth. The Initiative’s goal is to implement a statewide model to ensure seamless access to quality care for youth and families served by the child welfare system regardless of where they live in North Carolina.

Building on the ongoing successes of the NC Child and Family Improvement Initiative, and with stakeholder feedback from a sample of residential providers, the LME/MCOs have created a standardized, statewide referral form (some providers may call it an application) for use by all Residential Providers and Therapeutic Foster Care (TFC) providers who contract with them. This standardized form will streamline the referral and evaluation process and support the timely identification of appropriate therapeutic placements for children and youth in North Carolina.

“We really appreciate the LME/MCOs working with their providers to streamline the placement process for children”, said Karen McLeod, President/CEO of Benchmarks. “Every effort to support access to care is needed during this unprecedented increase in behavioral health needs for North Carolina’s children. We are very grateful for the time and attention that the LME/MCOs are spending on this vulnerable population.”

When will the change take effect?
The standardized referral form will be available on each LME/MCO’s website beginning October 1, 2022. All Residential Providers and TFC providers who contract with LME/MCOs will be expected to use only the standardized referral form on or before December 1, 2022.

How does the change affect providers?
The NC Child and Family Improvement Initiative worked with a statewide stakeholder group of TFC and Residential Providers to identify the most important information needed to determine whether they can provide residential or TFC services for a specific child or youth. The priority data fields were then developed into a statewide referral form that is available to all TFC and Residential Providers beginning 10/1/2022.

All six LME/MCOs [administering Medicaid Direct PIHP as of 4/1/2023, and anticipating Tailored Plan launch in 2024] will require in-network and out-of-network providers to use this standardized form as their single referral document for all children and youth on or before December 1, 2022. LME/MCOs will update their respective Provider Manuals to reflect this requirement.
How will this change affect referring parties and children and families in NC?
Referring parties will be able to complete one standardized referral form that they can submit to multiple providers, reducing their administrative burden. Examples of potential referring parties include County Departments of Social Services, Juvenile Justice, behavioral health providers, residential providers preparing for stepdown, and care managers.

The referral document will support the standardization of shared information and efficient transitions of care for referring parties and providers. Most importantly, the document has been designed to facilitate timely and appropriate access to therapeutic placement for the children and families of North Carolina.

Where can providers access the fillable form?
The standardized referral form is available at https://www.sandhillscenter.org/for-providers/
The forms are located on the left-hand column under, NC Child & Family Improvement Initiative.
Both fillable PDF and fillable MS Word versions are available.

Who should providers contact with questions?
If you have questions, please contact us at providerhelpdesk@sandhillscenter.org or by phone at 1-855-777-4652

To learn more about the NC Child and Family Improvement Initiative, https://www.sandhillscenter.org/for-providers/ The information is located on the left-hand column under, NC Child & Family Improvement Initiative.
Universal Child and Adolescent Residential Placement Application

Instructions for completion:

Consistent with System of Care principles, the Universal Child and Adolescent Residential Placement Application offers a comprehensive clinical review of a child’s/adolescent’s needs for purposes of admission to a residential provider contracted with any of the six North Carolina Local Management Entities/Managed Care Organizations (LME/MCOs). Please note: All references to “member” in this form refer to a Medicaid member or a State-funded Services recipient.

Please follow the instructions below:

1. This application should be completed in its entirety. Answer each question to the best of your ability, indicating not applicable or not available where appropriate. Applications may be returned to the referring party if deemed incomplete.

2. Do not enter "see attached" in sections requiring specific detail. If you have a document that provides greater detail than can be entered, reference the document name, date, and page number at the end of your explanation. (e.g., Physical Assessment, 07.01.15, page 3). Submit any reference documentation along with this application.

3. The person completing this application is responsible for obtaining necessary releases/authorizations to disclose protected health information.

4. The Universal Application must be signed by the legally responsible person as defined at N.C.G.S. § 122C-3(20): “a parent, guardian, a person standing in loco parentis, or a legal custodian other than a parent who has been granted specific authority by law or in a custody order to consent for medical care, including psychiatric treatment.”

Disclaimer: This form was created for the convenience of referring agencies and individuals to streamline discharge planning and to eliminate time and redundancy associated with multiple, agency-specific placement applications. However, the use of this form does not, and should not be construed to guarantee authorization of residential or other treatment by the applicable LME/MCO or admission by any eligible provider. Moreover, responsibility for appropriate discharge from inpatient facilities remains with the discharging provider.
## Date of application: | Date service needed:
---|---

### Type of referral/Level of Care sought
- Residential Level I – Family type
- Residential Level II – Family type
- Residential Level II – Program type
- Residential Level III – Group home
- Residential Level IV – Secure
- Psychiatric Residential Treatment Facility (PRTF)
- Emergent Need Respite – internal referrals only
- Residential Supports, Alternative Family Living (AFL) – NC Innovations Waiver
- Residential Supports, Group home – NC Innovations Waiver
- Non-Medicaid-Funded Residential Services – Group home or AFL
- Long-Term Community Supports – intellectual/developmental disability (I/DD) residential services (Medicaid)
- Individual Supports – Mental health (Medicaid)
- Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID)

### Member name:

Is the member a Medicaid beneficiary? □ Yes □ No

If yes, Medicaid ID#: [ ]

LME/MCO or PHP benefit plan:

Does the member have a CCA? □ Yes □ No

If yes, date of most recent CCA:

Note: A CCA is required to approve the placement of a child/youth in a leveled Medicaid-supported plan.

### 1. REFERRAL SOURCE INFORMATION

Referring agency: □ Hospital □ Clinical home agency □ DJJ □ DSS, county: ________________________
□ Other: ___________________________________________________________________

Name of referring agency:

Contact Person: ________________________

Phone number: ________________________

Alternate contact number: ________________________

Fax number: ________________________

Reason for referral:

### 2. MEMBER DEMOGRAPHIC INFORMATION

Member name: ________________________

Preferred name: ________________________

Date of birth: ________________________

Age: ________________________

Gender assigned at birth: □ Male □ Female

Gender Identity: Choose an item

Pronouns: Choose an item

Sexual Orientation:

Race: ________________________

Place of birth: ________________________

Primary language: ________________________

Does the member speak English? □ Yes □ No

County from which Medicaid originates:

What counties are you open to placement in? □ Any □ Specific counties (please list below)
Current living arrangement:

**Special considerations:** (Examples include safety concerns, no pets, needs to be LGBTQ competent, can’t share a bedroom, no other children in home, gender-specific parent, single parent home, etc.)

---

3. LEGALLY RESPONSIBLE PERSON INFORMATION

Who is legally responsible for the child? ☐ Parent ☐ Guardian ☐ County DSS ☐ Other

<table>
<thead>
<tr>
<th>Name of guardian/custodian:</th>
<th>Relationship to member:</th>
</tr>
</thead>
</table>

If in DSS custody, county of legal custody:

<table>
<thead>
<tr>
<th>Has there been a termination of parental rights? ☐ Yes ☐ No</th>
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</thead>
<tbody>
<tr>
<td>If yes, date and by whom:</td>
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</table>

<table>
<thead>
<tr>
<th>Home phone:</th>
<th>Work phone:</th>
<th>Mobile phone:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mailing address:</td>
<td>Email:</td>
<td></td>
</tr>
</tbody>
</table>

4. FAMILY INFORMATION

Is the member adopted? ☐ Yes ☐ No

What distance is the family willing/able to travel to be involved in the child’s treatment?

Are there religious, spiritual, or cultural considerations?

Are there existing visitations? ☐ Yes ☐ No

If so, with whom, where, and how often?

5. CLINICAL/DIAGNOSTIC INFORMATION

**DSM-5 DIAGNOSTIC INFORMATION**

<table>
<thead>
<tr>
<th>CODE</th>
<th>DIAGNOSIS</th>
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<tr>
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<td></td>
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</table>

Primary diagnosis:  

<table>
<thead>
<tr>
<th>IQ:</th>
<th>High-functioning</th>
<th>Average-functioning</th>
<th>Low-functioning</th>
</tr>
</thead>
</table>
6. MEDICATION INFORMATION
☐ MEDICATION LIST ATTACHED (If list attached, it is not necessary to complete this section.)

<table>
<thead>
<tr>
<th>MEDICATION</th>
<th>DOSE/ROUTE</th>
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7. TREATMENT AND PLACEMENT HISTORY

Number of out-of-home placements:

Has the member been hospitalized? ☐ Yes ☐ No
If yes, how many times in the past year?

Has the member been in residential placement in the past year? ☐ Yes ☐ No
If yes, where?

8. CURRENT SYMPTOMS/OBSERVATIONS

Check all that apply. Provide specific details and/or the date of last incident, if known and applicable.

☐ Abandonment issues ☐ Anxiety ☐ Difficulties at school

☐ Stool/feces smearing ☐ Sexually inappropriate behavior ☐ Fire-starting/arson

☐ Bedwetting ☐ Eating disorders behaviors ☐ Problems with sleep

☐ Property destruction ☐ Homelessness ☐ Hyperactivity

☐ Impulsive ☐ Lying ☐ Low self-esteem

☐ Loss/grief ☐ Phobias ☐ Sibling-related difficulty
| ☐ Oppositional | ☐ Social immaturity | ☐ Stealing |
| ☐ Truancy | ☐ Cruelty to animals | ☐ Hygiene/cleanliness issues |
| ☐ Gang-related activity | ☐ History with weapons | ☐ Other |

Abuse/trauma history:
- ☐ None
- ☐ Victim of neglect
- ☐ Victim of physical abuse
- ☐ Victim of sexual abuse
- ☐ Witness to any of the above
- ☐ Other trauma (e.g., natural disaster, fire car crash, violence, systemic racism)

If any of the above are checked, provide a brief description:

---

### 9. RISK ASSESSMENT

**☐ Self-injurious behavior**

Check all that apply:
- ☐ Cuts on body
- ☐ Conceals cutting, indicate area:________________________
- ☐ Other forms of self-injury, Describe:________________________

Has self-injury ever required medical attention? ☐ Yes ☐ No

Explain:

---

**☐ Suicidal characteristics**

Check all that apply:
- ☐ Suicidal thoughts
- ☐ Past suicide attempts
- ☐ Suicidal plans

If checked above, describe:

__________________________________________________________

Describe methods used in previous attempts:

__________________________________________________________

Were attempts planned? ☐ Yes ☐ No ☐ Sometimes ☐ Unknown
- **Homicidal characteristics**
  - Check all that apply:
    - ☐ Homicidal thoughts
    - ☐ Past attempts to harm other
    - ☐ Homicidal plans
  - If checked above, describe:
    - 
  - Describe methods used in previous attempts:
    - 
  - Were attempts planned? ☐ Yes ☐ No ☐ Sometimes ☐ Unknown
  - Does the member have access to weapons? ☐ Yes ☐ No
  - Explain:
    - 

- **History of elopement**
  - Check all that apply:
    - ☐ Runs away from home
    - ☐ Has run from previous placements
  - In the past year, how many times has the member run away? 
  - Where does the member go? 
  - How long are they typically away from home/placement? 

- **Sexualized behaviors**
  - Check all that apply:
    - ☐ Sexual acting-out
    - ☐ Deviant sexual behavior
    - ☐ Sexual exploitation
    - ☐ Other (describe):

- **Psychotic symptoms**
  - Check all that apply:
    - ☐ Auditory hallucinations
    - ☐ Visual hallucinations
    - ☐ Delusions
    - ☐ Other: (describe)

### 10. SUBSTANCE USE INFORMATION

<table>
<thead>
<tr>
<th>TYPE OF SUBSTANCE</th>
<th>ROUTE</th>
<th>FREQUENCY</th>
<th>LAST USE</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Alcohol</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ Amphetamines</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ Cocaine</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>☐ Hallucinogens</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>☐ Heroin/opiates</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ Inhalants</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ Marijuana</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ Nicotine/e-cigs/JUULs</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>☐ Benzodiazepines/hypnotics</td>
<td></td>
<td></td>
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<tr>
<td>☐ Other: (specify):</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**11. MEDICAL INFORMATION**

<table>
<thead>
<tr>
<th>Allergies:</th>
<th>Drug allergies:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Special dietary needs:</td>
<td></td>
</tr>
</tbody>
</table>

**Immunization status:**
- ☐ Current
- ☐ Delayed
- ☐ Refused

**MEDICAL CONDITIONS (PAST AND PRESENT)**

<table>
<thead>
<tr>
<th>Most recent occurrence:</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Acne</td>
</tr>
<tr>
<td>☐ Anemia</td>
</tr>
<tr>
<td>☐ Asthma</td>
</tr>
<tr>
<td>☐ Chronic urinary/bowel problems</td>
</tr>
<tr>
<td>☐ Diabetes</td>
</tr>
<tr>
<td>☐ Eczema/rash</td>
</tr>
<tr>
<td>☐ Hepatitis</td>
</tr>
<tr>
<td>☐ HIV/AIDS</td>
</tr>
<tr>
<td>☐ Migraine/headaches</td>
</tr>
<tr>
<td>☐ Seizures/epilepsy</td>
</tr>
<tr>
<td>☐ Sexually transmitted infection</td>
</tr>
<tr>
<td>☐ Sickle cell anemia</td>
</tr>
<tr>
<td>☐ Thyroid disease</td>
</tr>
<tr>
<td>☐ Other:</td>
</tr>
<tr>
<td>☐ Other:</td>
</tr>
</tbody>
</table>

Are there any additional medical concerns or needs?

---

**12. EDUCATIONAL/SCHOOL INFORMATION**

<table>
<thead>
<tr>
<th>Last school enrolled:</th>
<th>Highest grade level completed:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is it important the member remain in their current school?</td>
<td>☐ Yes ☐ No</td>
</tr>
<tr>
<td>Can the member attend a full day of school?</td>
<td>☐ Yes ☐ No</td>
</tr>
<tr>
<td>Does the member have a current IEP?</td>
<td>☐ Yes ☐ No</td>
</tr>
<tr>
<td>Date:</td>
<td>Grade(s) repeated:</td>
</tr>
<tr>
<td>Special classes:</td>
<td>☐ EC ☐ LD ☐ Resource ☐ BED ☐ Homebound ☐ Other:</td>
</tr>
<tr>
<td>History of suspensions or expulsions?</td>
<td>☐ Yes ☐ No</td>
</tr>
<tr>
<td>If yes, please explain:</td>
<td></td>
</tr>
</tbody>
</table>

---

**13. LEGAL HISTORY**

| Does the member have a criminal record? | ☐ Yes ☐ No |
| Is the member on probation? | ☐ Yes ☐ No |
| Are there pending charges? | ☐ Yes ☐ No |

Charge(s) and counties where charge occurred:

Briefly describe prior offenses and conviction dates (if known):
14. DAILY LIVING SKILLS INFORMATION
(Required ONLY for members with I/DD or co-occurring I/DD and mental health diagnoses.)

**EATING**

- Does the member eat solid foods? □ Yes □ No  
  *If no, explain:*

- Does the member eat independently? □ Yes □ No  
  *If no, explain:*

- Does the member require special accommodations? □ Yes □ No  
  *If yes, explain:*

- Is there a history of choking/overfilling mouth? □ Yes □ No

**TOILETING**

- Is the member continent? □ Yes □ No  
  *If no, indicate brand/size of supplies:*

- Can the member use the bathroom alone? □ Yes □ No  
  *If no, explain assistance:*

- Does the member wear pull-ups/diapers at night? □ Yes □ No  
  *If yes, indicate brand/size of supplies:*

- Will the member tell someone if bathroom is needed? □ Yes □ No

- Is the member on a toileting schedule? □ Yes □ No

**SLEEPING**

- Does the member usually sleep through the night? □ Yes □ No

- Approximate time member goes to bed:

- List any issues related to sleeping, special equipment needed, etc.

**WALKING**

- Is the member ambulatory? □ Yes □ No  
  *If no, does the member use any of the following?* □ Walker □ Crutches □ Wheelchair □ Modified shoes

- Does equipment meet current needs? □ Yes □ No  
  *If no, explain below:*

**LANGUAGE**

- Is the member verbal? □ Yes □ No  
  *If no, complete the questions below:*

- How does the member make their needs known?

- Does the member understand one- or two-word commands? □ Yes □ No

- Does the member follow one/two-step commands? □ Yes □ No

- Explain any communication needs (devices, etc.):
### 14. DAILY LIVING SKILLS INFORMATION - CONTINUED
(Required ONLY for members with I/DD or co-occurring I/DD and mental health diagnoses.)

**BEHAVIOR**

Does the member have a history of any of the following?

- [ ] Property destruction
- [ ] Physical aggression
- [ ] Verbal aggression

What does this behavior usually look like?

If known, what are triggers for the behavior?

Does the member usually hurt themselves or others?  ☐ Yes  ☐ No

Describe any other inappropriate behaviors the member may have:

### 15. ADDITIONAL INFORMATION

Provide information related to the member’s current status, symptoms, notable improvements/changes, etc., and include any additional comments that may support this application.

### 16. REFERRAL CHECKLIST

*Please attach any of the following that are available:*

- [ ] Up-to-date person-centered plan and/or Individual Support Plan
- [ ] DSS records
- [ ] Inpatient treatment plan
- [ ] DJJ records
- [ ] Up-to-date CCA/psychiatric assessment/evaluations/diagnostic assessments
- [ ] Court orders
- [ ] Psychological testing
- [ ] Signed Authorization and Consent for Release of Information
- [ ] Physical assessments/medical information
- [ ] Other
<p>| | |</p>
<table>
<thead>
<tr>
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<tbody>
<tr>
<td><strong>17. SIGNATURES</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Legally responsible person printed name</strong></td>
<td>Date</td>
</tr>
<tr>
<td><strong>Legally responsible person signature</strong></td>
<td>Date</td>
</tr>
<tr>
<td><strong>Member signature</strong></td>
<td>Date</td>
</tr>
</tbody>
</table>

Revised 09.27.22
F. Provider Responsibilities

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

G. Network Requirements

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 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. Helps 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 Provider Monitoring activities are, but not limited to:
1. Helps to ensure 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 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://tp.sandhillscenter.org/for-providers/

i. Nondiscrimination

Sandhills Center’s policy prohibits discrimination against providers that serve high-risk populations or specialize in conditions that require costly treatment. Additionally, Sandhill Center’s prohibits discrimination in the participation, reimbursement, or indemnification of any provider who is providing a covered service and who is acting within the scope of his or her license or certification under applicable state law, solely on the basis of that license or certification. 42 C.F.R. § 438.12.

ii. Cultural and Linguistic Competency Expectations (See Cultural Competency Plan page 106-107)

iii. On-call Coverage

On-Call Coverage requirements as follows: Providers 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 is in place to respond to emergencies afterhours and on weekends.

iv. Provider Selection Criteria

Although the behavioral health network is closed, Sandhills Center will primarily use a Request for Proposals (RFP) process to solicit proposals from prospective qualified, responsible providers/practitioners to fulfill a described service need(s). Exceptions to join the closed behavioral network or add sites/services to existing contracts can be requested through the Network Operations department by completing a Provider Join Form. Exemption criteria are determined by
identified gaps in the network, and are reviewed by a licensed clinician, the Network Operations Director, and the Chief Medical Officer/Chief Clinical Officer. Sandhills Center’s physical health network is open to any willing provider.

We are open for all physical health providers for the Sandhills Center BH/IDD Tailored Plan scheduled to launch in 2024. Physical health providers may contract directly with Sandhills Center BH/IDD Tailored Plan by completing our Provider Join and Contract Information Forms. Physical health providers currently contracted with our physical health subcontractor, AmeriHealth Caritas of North Carolina (ACNC), may sign an amendment to their Standard Plan contract to participate in Sandhills Center’s BH/IDD Tailored Plan as well. The Sandhills Center Network Operations department would like to remind all physical health Tailored Plan provider partners of the following:

- Physical health care providers who have opted-in to the Sandhills Center Tailored Plan through AmeriHealth Caritas North Carolina are not automatically contracted to provide behavioral health/substance use disorder services for the Sandhills Center Tailored Plan.

- Any provider who signed an amendment through our subcontractor, ACNC that is delivering a behavioral health service for a Sandhills Center member must be contracted directly with Sandhills Center for those services in order to bill and be reimbursed.

- Tailored Plan launch; claims submitted for a behavioral health/substance use disorder service by a physical health care provider that is not contracted directly with Sandhills Center to provide those services will result in the denial of a claim.

- Sandhills Center operates a closed BH/SUD/IDD network and only services that are currently identified as a need will be eligible for consideration.

- Providers who wish to contract with Sandhills Center in order to provide behavioral health services must submit the request via the Provider Join Form, and if approved the Contract Information Form, and a W-9 form..

- For a comprehensive list of physical health service codes, please utilize the fee schedules available on the NCDHHS website.

v. Credentialing and Recredentialing Through DHHS Centralized Credentialing Process

Initial contracting decisions for our closed BH/IDD/SUD/TBI network are based on current identified needs and/or gaps in services, as well as the provider’s experience in the services they are requesting. Our physical health network is open to any willing provider. Sandhills Center reviews provider contracts for renewal no less frequently than every three (3) years utilizing the Department’s Centralized Credentialing process.

Sandhills Center utilizes the Provider Enrollment File (PEF) generated through this process to make contracting decisions regarding provider participation eligibility in the Sandhills Center Network. Sandhills Center accepts provider credentialing and verified information from the Department and does not request any additional credentialing information without the Department’s approval.
Sandhills Center’s credentialing and recredentialing policies prohibit discrimination in the participation, reimbursement, or indemnification of any provider who is providing a covered service and who is acting within the scope of his or her license or certification under applicable state law, solely on the basis of that license or certification. 42 C.F.R. § 438.12. 8, and prohibits PIHP to employ or contract with providers excluded from participation in federal health care programs under either Section 1128 or Section 1128A of the Social Security Act;"

Providers are responsible to ensure credentialing activities are completed through the Department’s Centralized Credentialing process before they can participate in the Sandhills Center network.

j. Access Requirements

i. 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.

b. 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 and state-funded members with physical and/or mental disabilities.

ii. No-reject Requirements

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.

iii. Notification of Changes in Address

To avoid a delay in reimbursement of submitted claims, providers must update any demographic or practice information in NC Tracks. Demographics include:
- 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.

iv. Licensure Requirements

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

v. Insurance Requirements

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 Tailored Plan/Medicaid Direct/PIHP Provider contract.

vi. Required Availability

a. 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.

b. 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 and state-funded members with physical and/or mental disabilities.

H. Telehealth

Sandhills Center provides access to services via Telehealth, Virtual Patient Communications and Remote Patient Monitoring to Medicaid members as an alternative service delivery model, including to increase access to substance use/opioid use disorder treatment, where clinically appropriate and in compliance with all state and federal laws, including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements. Services available via Telehealth, Virtual Patient Communications and Remote Patient Monitoring are available in an amount, duration and scope no less than the amount, duration, and scope for the same services furnished to beneficiaries under the NC Medicaid Direct program.

Telehealth
Telehealth is the use of two-way, real-time interactive audio and video sessions to provide and support healthcare services when participants are in different physical locations.

**Virtual Patient Communications**

Virtual Patient Communication is the use of technologies other than video to enable remote evaluation and consultation support between a provider and a member or between a provider and another provider.

**Remote Patient Monitoring**

Remote Patient Monitoring is the use of digital devices to measure and transmit personal health information from a member in one location to a provider in a different location.

**Hybrid Telehealth with Supporting Home Visit ("Hybrid Model")**

The Hybrid Model combines the use of Telehealth visits with a supporting home visit by a delegated staff member.

**Covered Modalities**

All Telehealth, Virtual Patient Communications, and Remote Patient Monitoring services must be provided over secure, HIPAA compliant technology. Providers must have a process to ensure the security of protected health information for all Telehealth, Virtual Patient Communications, and Remote Patient Monitoring. There are no specifically excluded modalities; however, all modalities must meet the criteria of this policy, including compliance with local, state, and federal laws, including HIPAA. Routine monitoring activities as well as targeted reviews in response to grievances, quality of care concerns, claims audits, or fraud/waste/abuse referrals are used to ensure provider compliance with the requirements of this policy.

**Telehealth:** The technology must allow for live audio and video capabilities including, but not limited to, smart phones, tablets and computers.

**Virtual Patient Communications:** Covered Virtual Patient Communication services are telephone conversations (audio only), virtual portal communications (secure messaging); and store and forward (transfer of data from beneficiary using a camera or similar device that records an image that is sent by telecommunication to another site for consultation).

**Remote Patient Monitoring:** Remote Patient Monitoring requires use of a device that is defined by the FDA as a medical device. Covered Remote Patient Monitoring services are self-measured blood pressure monitoring (SMBPM) and remote physiologic monitoring (RPM). SMBPM is a beneficiary’s regular use of a personal blood pressure monitoring device to assess and record blood pressure
across different points in time outside of a clinical setting, typically at home. RPM is the collection and interpretation of an established beneficiary’s physiologic data digitally transmitted to the eligible provider. RPM requires a device that is wirelessly synced so the provider can evaluate the data in real or near-real time.

**Eligible Providers**

**Telehealth**

- Certified Nurse Midwife
- Clinical Pharmacist
- Licensed Clinical Addictions Specialist
- Licensed Clinical Addictions Specialist – Associate
- Licensed Clinical Mental Health Counselor
- Licensed Clinical Mental Health Counselor – Associate
- Licensed Clinical Social Worker
- Licensed Clinical Social Worker – Associate
- Licensed Marriage and Family Therapist
- Licensed Marriage and Family Therapist – Associate
- Licensed Psychological Associate
- Licensed Psychologist
- Nurse Practitioner
- Physician

**Virtual Patient Communication**

- Certified Nurse Midwife
- Licensed Clinical Addictions Specialist
- Licensed Clinical Addictions Specialist – Associate
- Licensed Clinical Mental Health Counselor
- Licensed Clinical Mental Health Counselor – Associate
- Licensed Clinical Social Worker
- Licensed Clinical Social Worker – Associate
- Licensed Marriage and Family Therapist
- Licensed Marriage and Family Therapist – Associate
- Licensed Psychological Associate
- Licensed Psychologist
- Nurse Practitioner
- Physician

**Remote Monitoring**

- Certified Nurse Midwife
• Nurse Practitioner
• Physician
• Physician Assistant

Requirements for and Limitations on Coverage

Providers must consider member’s behavioral, physical and cognitive abilities to participate in Telehealth, Virtual Patient Communications, and Remote Patient Monitoring. The member’s safety must be carefully considered for the complexity of the services provided. In situations where caregivers or facilitators are necessary to assist with the delivery of telehealth services, their ability to assist and their safety should also be considered when the individual needs physical assistance.

Initial in-person examination is not required in order to receive care via Telehealth, Virtual Patient Communications, and Remote Patient Monitoring. Telehealth, Virtual Patient Communications, and Remote Patient Monitoring are available to new and existing patients.

Prior Authorization

Prior authorization requirements follow those for the same service provided via in-person service delivery.

Originating Site

The originating site is the location in which the member is located, which may be health care facilities, schools, community sites, the home, or wherever the beneficiary may be at the time they receive services via telehealth, virtual communications, or remote patient monitoring. There are no restrictions on originating sites.

Distant Site

The distant site is the location from which the provider furnishes the telehealth, virtual communications, or remote patient monitoring services. There are no restrictions on distant sites; however, providers must ensure member privacy is protected (e.g. taking calls from private, secure spaces; use of a headset).

Reimbursement

Providers shall report the most specific billing code that accurately and completely describes the procedure, product or service provided. Providers must be an NC Tracks-enrolled Medicaid provider and maintain an active Sandhills Center contract to provide Telehealth, Virtual Patient Communications, or Remote Patient Monitoring in order to bill these services.

Sandhills Center pays at least the in-person rate for the same service delivered via Telehealth, Virtual Patient Communications, or Remote Patient Monitoring (i.e., payment parity). For all
services provided via Telehealth, Sandhills Center reimburses for a facility fee at the originating site when the originating site is a Medicaid-enrolled provider.

Remote Physiologic Monitoring Billing Guidance (RPM)

Codes 99453 and 99454 are used for device set-up, training and supply – the following guidance applies to both of these codes:

- 99453 and 99454 can be used for blood pressure RPM if the device used to measure blood pressure meets RPM requirements. If the beneficiary self-reports blood pressure readings, the provider should instead bill SMBPM codes 99473/99474.
- 99453 and 99454 cannot be reported if monitoring is less than sixteen (16) days in duration.
- Providers should not report codes 99453 or 99454 if the services are included in any other codes covered by NC Medicaid for the duration of time of the RPM (for example, continuous glucose monitoring that is covered under code 95250).

RPM treatment management services are the use of the RPM results by the eligible provider to manage an established patient’s treatment plan. Codes 99457 and 99458 are used to report RPM treatment management services – the following guidance applies to both of these codes:

- Codes 99457 and 99458 require a live, interactive communication between the beneficiary or caregiver.
- Providers may not bill code 99457 or 99458 for interactions of less than 20 minutes.

For all RPM and RPM treatment management service codes: If the services described by codes 99453, 99454, 99457 or 99458 are provided on the same day a beneficiary presents for an evaluation and management service to the same provider (whether by telehealth or in-person), these services should be considered part of the E/M service and not billed under the RPM code.

Telehealth Originating Site Facility Fee

The following HCPCS code can be billed for the Telehealth originating site facility fee by the originating site (i.e. the site at which the beneficiary is located): Q3014.

When the originating site is a hospital, the originating site facility fee must be billed with RC780 and Q3014.

GT Modifier for Telehealth Claims

Modifier GT must be appended to the CPT or HCPCS code to indicate that a service has been provided via interactive audio-visual communication. This modifier should not be used for virtual patient communications, including telephonic evaluation and management services, or remote patient monitoring.
**KX Modifier for Telephonic Claims**

Modifier KX must be appended to the CPT or HCPCS code to indicate that a service has been provided via telephonic, audio-only communication.

**Place of Service Code**

Telehealth, virtual communication, and remote patient monitoring claims should be filed with the provider’s usual place of service code(s) and not place of service 02 (Telehealth).

Exception: Hybrid telehealth with supporting home visits should be filed with Place of Service (POS) 12 (home).

**Hybrid Telehealth**

If time is used as a determining factor, providers shall choose the code that corresponds with the length of the telehealth visit provided by the eligible provider, not the duration of the home visit performed by the delegated staff person.

Hybrid telehealth with supporting home visits should be filed with Place of Service (POS) 12 (home).

**Chronic Disease Management:** Providers shall use the home visit codes with appropriate modifiers.

**Perinatal Care:** Providers shall only use the home visit codes with appropriate modifiers if they are not billing the pregnancy global package code

**Vaccinations:** Any vaccinations, tests or screenings conducted in the home should be billed as if they were delivered within the office, without modifiers.

**Local Health Departments:** Local Health Departments may utilize the hybrid model when the telehealth visit is rendered by an eligible provider and may bill the home visit code.

**FQHCs, FQHC-Lookalikes, and RHCs:** FQHCs, FQHC-Lookalikes and RHCs may bill their core service code (T1015) and an originating site facility fee (Q3014) for hybrid model visits to reflect the additional cost of the delegated staff person attending the beneficiary’s home. To be reimbursed for the originating site facility fee, all of the following requirements must be met for each home visit:

1. The assistance delivered in the home must be given by an appropriately trained delegated staff person.
2. The fee must be billed for the same day that the home visit is conducted.
3. HCPCS code Q3014 must be appended with the GT modifier and billed with a place of service ‘12’ to designate that the originating site was the home.
4. The core service code (T1015) must be billed separately from the originating site facility fee code (Q3014).

Network Adequacy

Sandhills Center use Telehealth, Virtual Patient Communications and Remote Patient Monitoring as tools for facilitating access to needed services in a clinically appropriate manner that are not available from providers in the network and in accordance with Sandhills Center’s Telehealth, Virtual Patient Communications and Remote Patient Monitoring policy.

Sandhills Center may leverage telehealth in a “Request for Exception” to network adequacy standards, as clinically appropriate. Access to telehealth providers does not count toward meeting network adequacy standards unless approved as part of an exception to network requirements.

Telehealth, Virtual Patient Communications, and Remote Patient Monitoring are meant to ease access to services and facilitate communication between members and providers; however, Sandhills Center does not require members to receive services from Telehealth, Virtual Patient Communications, or Remote Patient Monitoring. If members do not have in-person access to an in-network provider and do not want to utilize Telehealth, Virtual Patient Communications, or Remote Patient Monitoring, Sandhills Center provides members access to in-person services from an out-of-network provider through a client-specific agreement.

Access to Technology

Sandhills Center supports providers’ in optimizing the use of Telehealth, Virtual Patient Communications, and Remote Patient Monitoring and will pilot new approaches for value-based payment using these technologies when appropriate to meet member needs. For any pilot, Sandhills Center may propose, for NC Medicaid’s review and approval, a waiver of payment parity requirements.

As directed by NC Medicaid, Sandhills Center assesses the capacity of select providers to ensure that members residing in covered facilities have access to remote communication options and devices to be used for communication with family and providers, including Telehealth and telephonic options, in cases of emergencies, where in-person visitation is restricted. Covered providers include:

- Community ICF-IIDs licensed under 10A NCAC 27G .2100
- Behavioral health residential treatment facilities licensed under 10A NCAC 27G .1300, .1700, .3100, .3200, .3400, .4100, .4300, .5600
- Adult care homes licensed under 10A NCAC 13F and 13G
I. Network Adequacy and Access Standards

A. Sandhills Center Network Adequacy Standards for Medicaid

Sandhills Center’s Medicaid network consists of hospitals, physicians, advanced practice nurses, SUD and mental health treatment providers, I/DD and TBI providers, emergent and non-emergent transportation services, safety net hospitals, and all other provider types necessary to support capacity to make all services sufficiently available.

The term “urban” is defined as non-rural counties, or counties with average population densities of two hundred fifty (250) or more people per square mile. This definition includes twenty (20) counties that are categorized by the North Carolina Rural Economic Development Center as “regional cities or suburban counties” or “urban counties which will be covered by the applicable BH I/DD Tailored Plan/Medicaid Direct/PIHP.” “Rural” is defined as a county with average population density of less than two hundred fifty (250) people per square mile.

In order to ensure that all members have timely access to all covered health care services, Sandhills Center shall ensure its network meets, at a minimum, the following time/distance standards as measured from the member’s residence for adult and pediatric providers separately through geo-access mapping at least annually. Please note that certain service types not subject to separate adult and pediatric provider standards. These service types are marked with a (*) and include: hospitals, pharmacies, occupational, physical, or speech therapists, pulmonology specialty, LTSS, and nursing facilities.

For purposes of network adequacy standards for physical health providers/services, except as otherwise noted, adult services are those provided to a member who is 21 years of age, or older and pediatric (child/children) services are those provided to a member who is less than 21 years of age.

For purposes of network adequacy standards for SUD and mental health treatment providers, except as otherwise noted, adult services are those provided to a member who is 18 years of age, or older and pediatric/adolescent (child/children) services are those provided to a member who is less than 18 years of age.

<table>
<thead>
<tr>
<th>Reference Number</th>
<th>Service Type</th>
<th>Urban Standard</th>
<th>Rural Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Primary Care</td>
<td>≥ 2 providers within 30 minutes or 10 miles for at least 95% of members</td>
<td>≥ 2 providers within 30 minutes or 30 miles for at least 95% of members</td>
</tr>
</tbody>
</table>

Section VII. Attachment F.1. Table 1: BH I/DD Tailored Plan Time/Distance Standards for Medicaid

Please note that there are differences in the time/distance standards for Tailored Plans and PIHP services.
<table>
<thead>
<tr>
<th></th>
<th>2</th>
<th>Specialty Care</th>
<th>≥ 2 providers (per specialty type) within 30 minutes or 15 miles for at least 95% of members</th>
<th>≥ 2 providers (per specialty type) within 60 minutes or 60 miles for at least 95% of members</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>Hospitals*</td>
<td>≥ 1 hospitals within 30 minutes or 15 miles for at least 95% of members</td>
<td>≥ 1 hospitals within 30 minutes or 30 miles for at least 95% of members</td>
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</tr>
<tr>
<td>4</td>
<td>Pharmacies*</td>
<td>≥ 2 pharmacies within 30 minutes or 10 miles for at least 95% of members</td>
<td>≥ 2 pharmacies within 30 minutes or 30 miles for at least 95% of members</td>
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<tr>
<td>5</td>
<td>Obstetrics1</td>
<td>≥ 2 providers within 30 minutes or 10 miles for at least 95% of members</td>
<td>≥ 2 providers within 30 minutes or 30 miles for at least 95% of members</td>
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<tr>
<td>6</td>
<td>Occupational, Physical, or Speech Therapists*</td>
<td>≥ 2 providers (of each provider type) within 30 minutes or 10 miles for at least 95% of members</td>
<td>≥ 2 providers (of each provider type) within 30 minutes or 30 miles for at least 95% of members</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Outpatient BH Services</td>
<td>≥ 2 providers of each outpatient BH service within 30 minutes or 30 miles of residence for at least 95% of members</td>
<td>≥ 2 providers of each outpatient BH service within 45 minutes or 45 miles of residence for at least 95% of members</td>
<td>Research-based BH treatment for Autism Spectrum Disorder (ASD): Not subject to standard</td>
</tr>
<tr>
<td>8</td>
<td>Location-Based Services</td>
<td>• Psychosocial rehabilitation, Substance Abuse Comprehensive Outpatient Treatment, Substance Abuse Intensive Outpatient Program, and Outpatient Opioid Treatment (OTP): ≥ 2 providers of each service within 30 minutes or 30 miles of residence for at least 95% of members</td>
<td>• Psychosocial rehabilitation, Substance Abuse Comprehensive Outpatient, Substance Abuse Intensive Outpatient Program, and Outpatient Opioid Treatment (OTP): ≥ 2 providers of each service within 45 minutes or 45 miles of residence for at least 95% of members</td>
<td>• Child and Adolescent Day Treatment Services: Not subject to standard</td>
</tr>
<tr>
<td>9</td>
<td>Crisis Services</td>
<td>• Professional treatment services in facility-based crisis program: The greater of: o 2+ facilities within each BH I/DD Tailored Plan Region, OR o 1 facility within each Region per 450,000 total regional population (Total regional population as estimated by combining NC OSBM</td>
<td></td>
<td></td>
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</tbody>
</table>
### County estimates
- Facility-based crisis services for children and adolescents: $\geq 1$ provider within each BH I/DD Tailored Plan Region
- Non-Hospital Medical Detoxification: $\geq 2$ provider within each BH I/DD Tailored Plan Region
- Ambulatory Detoxification, Ambulatory withdrawal management with extended on-site monitoring, Clinically managed residential withdrawal: $\geq 1$ provider of each crisis service within each BH I/DD Tailored Plan Region
- Medically supervised or alcohol drug abuse treatment center (ADATC) detoxification crisis stabilization (adult): Not subject to standard

<table>
<thead>
<tr>
<th>Number</th>
<th>Service Type</th>
<th>Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>10</td>
<td>Inpatient BH Services</td>
<td>$\geq 1$ provider of each inpatient BH service within each BH I/DD Tailored Plan region</td>
</tr>
<tr>
<td>11</td>
<td>Partial Hospitalization</td>
<td>$\geq 1$ provider of partial hospitalization within 30 minutes or 30 miles for at least 95% of members</td>
</tr>
<tr>
<td>12</td>
<td>Community/Mobile Services</td>
<td>$\geq 2$ providers of community/mobile services within each BH I/DD Tailored Plan Region. Each county in BH I/DD Tailored Plan Region must have access to $\geq 1$ provider that is accepting new patients.</td>
</tr>
<tr>
<td>13</td>
<td>All State Plan LTSS (except nursing facilities)*</td>
<td>$\geq 2$ LTSS provider types (Home Care providers and Home Health providers, including home health services, private duty nursing services, personal care services, and hospice services), identified by distinct NPI, accepting new patients available to deliver each State Plan LTSS in every county.</td>
</tr>
<tr>
<td>14</td>
<td>Nursing Facilities*</td>
<td>$\geq 1$ nursing facility accepting new patients in every county.</td>
</tr>
</tbody>
</table>
| 15     | Residential Treatment Services       | • Residential Treatment Facility Services: Access to $\geq 1$ licensed provider per BH I/DD Tailored Plan Region,  
• Substance Abuse Medically Monitored Residential Treatment: Access to $\geq 1$ licensed provider per BH I/DD Tailored Plan Region (refer to 10A NCAC 27G.3400)  
• Substance Abuse Non-Medical Community Residential Treatment:  
  o Adult: Access to $\geq 1$ licensed provider per BH I/DD Tailored Plan |
<table>
<thead>
<tr>
<th>Region</th>
<th>Services</th>
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</thead>
<tbody>
<tr>
<td><strong>Adolescent</strong>: Contract with all designated CASPs within the BH I/DD Tailored Plan’s Region</td>
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<tr>
<td><strong>Women &amp; Children</strong>: Contract with all designated CASPs within the BH I/DD Tailored Plan’s Region</td>
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<tr>
<td><strong>Substance Abuse Halfway House</strong>:</td>
<td></td>
</tr>
<tr>
<td><strong>Adult</strong>: Access to ≥1 male and ≥1 female program per BH I/DD Tailored Plan Region (Refer to 10A NCAC 27G.5600E)</td>
<td></td>
</tr>
<tr>
<td><strong>Adolescent</strong>: Access to ≥1 program per BH I/DD Tailored Plan Region (Refer to 10A NCAC 27G.5600E)</td>
<td></td>
</tr>
<tr>
<td><strong>Psychiatric residential Treatment Facilities (PRTFs) &amp; Intermediate Care Facilities for individuals with intellectual disabilities ICF-IID</strong>: Not subject to standard</td>
<td></td>
</tr>
<tr>
<td><strong>Community Living &amp; Support, Community Navigator, Community Networking, Residential Supports, Respite, Supported Employment, Supported Living</strong>: ≥ 2 providers of each Innovations waiver service within each BH I/DD Tailored Plan Region.</td>
<td></td>
</tr>
<tr>
<td><strong>Crisis Intervention &amp; Stabilization Supports, Day Supports, Financial Support Services</strong>: ≥ 1 provider of each Innovations waiver service within each BH I/DD Tailored Plan Region.</td>
<td></td>
</tr>
<tr>
<td><strong>Assistive Technology Equipment and Supplies, Community Transition, Home Modifications, Individual Directed Goods and Services, Natural Supports Education, Specialized Consultation, Vehicle Modification</strong>: Not subject to standard</td>
<td></td>
</tr>
<tr>
<td><strong>Outpatient BH services provided by direct-enrolled providers (adults and children)</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Office-based opioid treatment (OBOT)</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Research-based BH treatment for Autism Spectrum Disorder (ASD)</strong></td>
<td></td>
</tr>
</tbody>
</table>

16 1915(c) HCBS Waiver Services: NC Innovations

17 1915(c) HCBS Waiver Services: NC TBI Waiver (applicable to TBI Waiver participating counties only)
Section VI. Attachment E. Table 1: Medicaid Direct PIHP Time/Distance Standards for Medicaid

*Please note that there are differences in the time/distance standards for Tailored Plans and PIHP services.*

<table>
<thead>
<tr>
<th>Reference Number</th>
<th>Service Type</th>
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<tbody>
<tr>
<td>1</td>
<td>Outpatient BH Services</td>
<td>&gt;2 providers of each outpatient BH service within 30 minutes or 30 miles of residence for at least 95% of members&lt;br&gt;Research-based Behavioral Health treatment for Autism Spectrum Disorder (ASD): Not subject to standard</td>
<td>&gt;2 providers of each outpatient BH service within 45 minutes or 45 miles of residence for at least 95% of members&lt;br&gt;Research-based Behavioral Health treatment for Autism Spectrum Disorder (ASD): Not subject to standard</td>
</tr>
<tr>
<td>2</td>
<td>Location Based Services</td>
<td>Psychosocial Rehabilitation, Substance Abuse Comprehensive Outpatient Treatment, Substance Abuse Intensive Outpatient Program, and Outpatient Opioid Treatment (OTP): &gt;2 providers of each service within 30 minutes or 30 miles of residence for at least 95% of members&lt;br&gt;Child and Adolescent Day Treatment Services: Not subject to standard</td>
<td>Psychosocial Rehabilitation, Substance Abuse Comprehensive Outpatient Treatment, Substance Abuse Intensive Outpatient Program, and Outpatient Opioid Treatment (OTP): &gt;2 providers of each service within 45 minutes or 45 miles of residence for at least 95% of members&lt;br&gt;Child and Adolescent Day Treatment Services: Not subject to standard</td>
</tr>
<tr>
<td>3</td>
<td>Crisis Services</td>
<td>Professional treatment services in facility-based crisis program: The greater of:&lt;br&gt;  o 2+ facilities within each PIHP Region, OR&lt;br&gt;  o 1 facility within each Region per 450,000 total regional population (Total regional population as estimated by combining NC OSBM county estimates).&lt;br&gt;Facility-based crisis services for children and adolescents: &gt;1 provider within each PIHP Region&lt;br&gt;Non-Hospital Medical Detoxification: &gt;2 providers within each PIHP Region&lt;br&gt;Ambulatory Detoxification, Ambulatory withdrawal management with extended on-site monitoring, Clinically managed residential withdrawal:</td>
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<tr>
<td></td>
<td>&gt;1 provider of each crisis service within each PIHP Region</td>
<td>Medically supervised or alcohol drug abuse treatment center (ADATC) detoxification crisis stabilization (adult): Not subject to standard</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Inpatient BH Services</td>
<td>&gt; 1 provider of each inpatient BH service within each PIHP region</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Partial Hospitalization</td>
<td>&gt;1 provider of partial hospitalization within 30 minutes or 30 miles for at least 95% of members</td>
<td>&gt;1 provider of partial hospitalization within 60 minutes or 60 miles for at least 95% of members</td>
</tr>
<tr>
<td>6</td>
<td>Community Mobile Services</td>
<td>&gt;2 providers of community/mobile services within each PIHP Region. Each county in PIHP Region must have access to &gt;1 provider that is accepting new patients.</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>1915(i) HCBS</td>
<td>Community Living &amp; Support, Individual and Transitional Support, Respite, and Supported Employment (for IDD and MH/SUD): &gt;2 providers of each (i) Option service within each PIHP Region</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Residential Treatment Services</td>
<td>Residential Treatment Facility Services: access to &gt;1 licensed provider per PIHP Region Substance Abuse Medically Monitored Residential Treatment: Access to &gt;1 licensed provider per PIHP Region (refer to 10A NCAC 27G.3400) Substance Abuse Non-Medical Community Residential Treatment: o Adult: Access to &gt;1 licensed provider per PIHP Region (refer to licensure requirements to be determined by the Department) o Adolescent: Contract with all designated CASPs within the PIHP’s Region o Women &amp; Children: Contract with all designated CASPs within the PIHP’s Region Substance Abuse Halfway House: o Adult: Access to &gt;1 male and &gt;1 female program per PIHP Region (Refer to 10A NCAC 27G.5600). PIHP will also ensure that gender non-conforming Members have access to SUD halfway house services o Adolescent: Access to &gt;1 program per PIHP Region (refer to 10A NCAC 27G.5600) Psychiatric Residential Treatment Facilities (PRTFs) &amp; Intermediate Care Facilities for individuals with intellectual disabilities ICF-IID: Not subject to standard</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>1915(c) HCBS Waiver Services; NC Innovations</td>
<td>Community Living &amp; Support, Community Networking, Residential Supports, Respite, Supported Employment, Supported Living: &gt;2 providers of each Innovations waiver service within each PIHP Region. Crisis Intervention &amp; Stabilization Supports, Day Supports, Financial Support Services:</td>
<td></td>
</tr>
</tbody>
</table>
There is a table in the document, formatted as follows:

<table>
<thead>
<tr>
<th>Reference Number</th>
<th>Service Type</th>
<th>Urban Standard</th>
<th>Rural Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Outpatient BH</td>
<td>≥ 2 providers of each outpatient BH service within 30 minutes or 30 miles of residence for at least 95% of members. Assertive Engagement: To be determined</td>
<td>≥ 2 providers of each outpatient BH service within 45 minutes or 45 miles of residence for at least 95% of members. Assertive Engagement: To be determined</td>
</tr>
</tbody>
</table>

B. Sandhills Center Network Adequacy Standards for State-funded Services

Sandhills Center State-funded Services network shall consist of mental health, SUD, I/DD and TBI providers and Three-Way Contract inpatient care providers, and all other provider types necessary to support capacity to make all services sufficiently available.

The term “urban” is defined as non-rural counties, or counties with average population densities of two hundred fifty (250) or more people per square mile. This definition includes twenty (20) counties that are categorized by the North Carolina Rural Economic Development Center as “regional cities or suburban counties” or “urban counties which will be covered by the applicable BH I/DD Tailored Plan/Medicaid Direct/PIHP.” “Rural” is defined as a county with average population density of less than two hundred fifty (250) people per square mile.

In order to ensure that all members have timely access to all covered health care services, Sandhills Center shall ensure its network meets, at a minimum, the following time or distance standards as measured from the member’s residence for adult and pediatric providers separately through geo-access mapping at least annually.

For purposes of network adequacy standards for SUD and mental health treatment providers, except as otherwise noted, adult services are those provided to a member who is 18 years of age or older and pediatric/adolescent (child/children) services are those provided to a member who is less than 18 years of age.
|   | Location-Based Services | • Psychosocial rehabilitation, Substance Abuse Comprehensive Outpatient Treatment, Substance Abuse Intensive Outpatient Program, and Outpatient Opioid Treatment (OTP): ≥ 2 providers of each service within 30 minutes or 30 miles of residence for at least 95% of members  
• Child and Adolescent Day Treatment Services: Not subject to standard | • Psychosocial rehabilitation, Substance Abuse Comprehensive Outpatient, Substance Abuse Intensive Outpatient Program, and Outpatient Opioid Treatment (OTP): ≥ 2 providers of each service within 45 minutes or 45 miles of residence for at least 95% of members  
• Child and Adolescent Day Treatment Services: Not subject to standard |
|---|---|---|---|
|   | Crisis Services | • Facility based crisis for adults: The greater of:  
ob 2+ facilities within each BH I/DD Tailored Plan/Medicaid Direct/PIHP Region, OR  
ob 1 facility within each Region per 450,000 total regional population (Total regional population as estimated by combining NC OSBM county estimates for the most recent year available).  
• Non-Hospital Medical Detoxification: ≥ 2 provider within each BH I/DD Tailored Plan/Medicaid Direct/PIHP Region  
• Ambulatory Detoxification and BH Urgent Care: ≥ 1 provider of each crisis service within each BH I/DD Tailored Plan/Medicaid Direct/PIHP Region |   |
<p>|   | Inpatient BH Services | ≥ 1 provider of each inpatient BH service within each BH I/DD Tailored Plan/Medicaid Direct/PIHP region |   |
|   | Community/ Mobile Services | 100% of eligible recipients must have a choice of 2 provider agencies within each BH I/DD Tailored Plan/Medicaid Direct/PIHP Region. Each county in BH I/DD Tailored Plan/Medicaid Direct/PIHP Region must have access to ≥ 1 provider that is accepting new patients. |   |</p>
<table>
<thead>
<tr>
<th>Page</th>
<th>Service Area</th>
<th>Details</th>
</tr>
</thead>
</table>
| 6    | Residential Treatment Services | • Residential Treatment Facility Services: Access to ≥ 1 licensed provider per BH I/DD Tailored Plan/Medicaid Direct/PIHP Region,  
• Substance Abuse Halfway House:  
  o Adult: Access to ≥1 male and ≥1 female program per BH I/DD Tailored Plan/Medicaid Direct/PIHP Region (Refer to 10A NCAC 27G.5600E)2  
  o Adolescent: Access to ≥1 program per BH I/DD Tailored Plan/Medicaid Direct/PIHP Region (Refer to 10A NCAC 27G.5600E)  
• Substance Abuse Medically Monitored Community Residential Treatment: Access to ≥1 licensed provider  
• Substance Abuse Non-Medical Community Residential Treatment:  
  o Adult: Access to ≥ 1 licensed provider per BH I/DD Tailored Plan/Medicaid Direct/PIHP Region (refer to licensure requirements to be determined by the Department)  
  o Adolescent: Contract with all designated CASPs within the BH I/DD Tailored Plan/Medicaid Direct/PIHP’s Region  
  o Women & Children: Contract with all designated CASPs within the BH I/DD Tailored Plan/Medicaid Direct/PIHP’s Region  
• Substance Use Residential Supports & Mental Health Recovery Residential Services: To be determined |
| 8    | Employment and Housing Services | • Residential Services (I/DD and TBI and Adult MH), Respite Services, Individual Placement and Support (I/DD and TBI and Substance Use): 100% of eligible recipients must have a choice of two (2) provider agencies within each BH I/DD Tailored Plan/Medicaid Direct/PIHP Region.  
• Individual Placement and Support-Supported Employment (Adult MH): 100% of eligible individuals must have a choice of two (2) provider agencies within each BH I/DD Tailored Plan/Medicaid Direct/PIHP Region. Each county in BH I/DD Tailored Plan/Medicaid Direct/PIHP Region must have access to ≥1 provider that is accepting new patients.  
• Meaningful day and prevocational services: 100% of eligible recipients must have access to ≥1 provider agency within each BH I/DD Tailored Plan/Medicaid Direct/PIHP Region.  
• Clinically Managed Population-specific High Intensity Residential Programs: To be determined  
• TBI long-term residential rehabilitation services: Not subject to standard |
| 9    | Case Management | • Case Management (Adult BH, Child/HFW): To be determined |

Sandhills Center is required to meet the following appointment wait-time standards for adult and pediatric providers separately, which vary by the type of service:
### Primary Care

<table>
<thead>
<tr>
<th>Reference Number</th>
<th>Visit Type</th>
<th>Description</th>
<th>Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Preventive Care Service – adult, 21 years of age and older</td>
<td>Care provided to prevent illness or injury; examples include, but are not limited to, routine physical examinations, immunizations, mammograms and pap smears</td>
<td>Within thirty (30) calendar days</td>
</tr>
<tr>
<td>1a</td>
<td>Preventive Care Services – child, birth through 20 years of age</td>
<td>Care provided to prevent illness or injury; examples include, but are not limited to, routine physical examinations, immunizations, mammograms and pap smears</td>
<td>Within fourteen (14) calendar days for member less than six (6) months of age. Within thirty (30) calendar days for members six (6) months or age and older.</td>
</tr>
<tr>
<td>2</td>
<td>After-Hours Access – Emergent and Urgent</td>
<td>Care requested after normal business office hours.</td>
<td>Immediately (available twenty-four (24) hours a day, three hundred sixty-five (365) days a year)</td>
</tr>
<tr>
<td>3</td>
<td>Urgent Care Services</td>
<td>Care provided for a nonemergent illness or injury with acute symptoms that require immediate care; examples include, but are not limited to, sprains, flu symptoms, minor cuts and wounds, sudden onset of stomach pain and severe, non-resolving headache.</td>
<td>Within twenty-four (24) hours</td>
</tr>
<tr>
<td>4</td>
<td>Routine Checkup without symptoms</td>
<td>Non-symptomatic visits for routine health check-up.</td>
<td>Within thirty (30) calendar days</td>
</tr>
</tbody>
</table>

### Prenatal Care

<table>
<thead>
<tr>
<th>Reference Number</th>
<th>Visit Type</th>
<th>Description</th>
<th>Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>Initial Appointment – 1st or 2nd Trimester</td>
<td>Care provided to a member while the member is pregnant to help keep member and future baby healthy, such as checkups and prenatal testing.</td>
<td>Within fourteen (14) calendar days</td>
</tr>
<tr>
<td>5a</td>
<td>Initial Appointment – high risk</td>
<td>Care provided to a member while the member is pregnant to help keep member and</td>
<td>Within five (5) calendar days</td>
</tr>
<tr>
<td></td>
<td>Specialty Care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>-------------------------------------------------------------------------------</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>6</td>
<td>After-Hours Access – Emergent and Urgent</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Care requested after normal business office hours.</td>
<td></td>
<td>Immediately (available twenty-four (24) hours a day, three hundred sixty-five (365) days a year)</td>
</tr>
<tr>
<td>7</td>
<td>Urgent Care Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Care provided for a nonemergent illness or injury with acute symptoms that require immediate care; examples include, but are not limited to, sprains, flu symptoms, minor cuts and wounds, sudden onset of stomach pain and severe, non-resolving headache.</td>
<td></td>
<td>Within twenty-four (24) hours</td>
</tr>
<tr>
<td>8</td>
<td>Routine/Check-up without Symptoms</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Non-symptomatic visits for health check.</td>
<td></td>
<td>Within thirty (30) calendar days</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Behavioral Health, I/DD and TBI Services</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>9</td>
<td>Mobile Crisis Management Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Refer to Section VII. Attachment M.9. BH Service Classifications for Appointment Wait Time and Routine, Urgent and Emergent Care Standards for Medicaid Members and State funded Recipients</td>
<td></td>
<td>Within two (2) hours</td>
</tr>
<tr>
<td>10</td>
<td>Facility-Based Crisis Management Services (FBC for Child &amp; Adolescent, FBC for Adults, Non-Hospital Medical Detox)</td>
<td></td>
<td>Emergency Services available immediately (available twenty-four (24) hours a day, three hundred sixty-five (365) days a year)</td>
</tr>
<tr>
<td></td>
<td>Refer to Section VII. Attachment M.9. BH Service Classifications for Appointment Wait Time and Routine, Urgent and Emergent Care Standards for Medicaid Members and State funded Recipients</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>Emergency Services for Mental Health</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Refer to Section VII. Attachment M.9. BH Service Classifications for Appointment Wait Time and Routine, Urgent and Emergent Care Standards for Medicaid Members and State funded Recipients</td>
<td></td>
<td>Immediately (available twenty-four (24) hours a day, three hundred sixty-five (365) days a year)</td>
</tr>
<tr>
<td></td>
<td>Services for SUDs</td>
<td>Refer to Section VII. Attachment M.9. BH Service Classifications for Appointment Wait Time and Routine, Urgent and Emergent Care Standards for Medicaid Members and State funded Recipients</td>
<td>Immediately (available twenty-four (24) hours a day, three hundred sixty-five (365) days a year)</td>
</tr>
<tr>
<td>---</td>
<td>----------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>12</td>
<td>Emergency Services for SUDs</td>
<td>Refer to Section VII. Attachment M.9. BH Service Classifications for Appointment Wait Time and Routine, Urgent and Emergent Care Standards for Medicaid Members and State funded Recipients</td>
<td>Within twenty-four (24) hours</td>
</tr>
<tr>
<td>14</td>
<td>Urgent Care Services for Mental Health</td>
<td>Refer to Section VII. Attachment M.9. BH Service Classifications for Appointment Wait Time and Routine, Urgent and Emergent Care Standards for Medicaid Members and State funded Recipients</td>
<td>Within twenty-four (24) hours</td>
</tr>
<tr>
<td>15</td>
<td>Urgent Care Services for SUDs</td>
<td>Refer to Section VII. Attachment M.9. BH Service Classifications for Appointment Wait Time and Routine, Urgent and Emergent Care Standards for Medicaid Members and State funded Recipients</td>
<td>Within twenty-four (24) hours</td>
</tr>
<tr>
<td>16</td>
<td>Routine Services for Mental Health</td>
<td>Refer to Section VII. Attachment M.9. BH Service Classifications for Appointment Wait Time and Routine, Urgent and Emergent Care Standards for Medicaid Members and State funded Recipients</td>
<td>Within fourteen (14) calendar days</td>
</tr>
<tr>
<td>17</td>
<td>Routine Services for SUDs</td>
<td>Refer to Section VII. Attachment M.9. BH Service Classifications for Appointment Wait Time and Routine, Urgent and Emergent Care Standards for Medicaid Members and State funded Recipients</td>
<td>Within forty-eight (48) hours</td>
</tr>
</tbody>
</table>

Sandhills Center will use the provider types listed above as “specialty care” providers for purposes of Section VII. Attachment F.1. Table 1: BH I/DD Tailored Plan/Medicaid Direct/PIHP Time or Distance Standards for Medicaid and Section VII. Attachment F.1. Table 3: Appointment Wait Time Standards for Medicaid as found here:
Sandhills Center defines specialty care as:

<table>
<thead>
<tr>
<th>Reference #</th>
<th>Specialty Care Providers for Medicaid</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Allergy/Immunology</td>
</tr>
<tr>
<td>2</td>
<td>Anesthesiology</td>
</tr>
<tr>
<td>3</td>
<td>Cardiology</td>
</tr>
<tr>
<td>4</td>
<td>Dermatology</td>
</tr>
<tr>
<td>5</td>
<td>Endocrinology</td>
</tr>
<tr>
<td>6</td>
<td>ENT/Otolaryngology</td>
</tr>
<tr>
<td>7</td>
<td>Gastroenterology</td>
</tr>
<tr>
<td>8</td>
<td>General Surgery</td>
</tr>
<tr>
<td>9</td>
<td>Gynecology</td>
</tr>
<tr>
<td>10</td>
<td>Infectious Disease</td>
</tr>
<tr>
<td>11</td>
<td>Hematology</td>
</tr>
<tr>
<td>12</td>
<td>Nephrology</td>
</tr>
<tr>
<td>13</td>
<td>Neurology</td>
</tr>
<tr>
<td>14</td>
<td>Oncology</td>
</tr>
<tr>
<td>15</td>
<td>Ophthalmology</td>
</tr>
<tr>
<td>16</td>
<td>Optometry</td>
</tr>
<tr>
<td>17</td>
<td>Orthopedic Surgery</td>
</tr>
<tr>
<td>18</td>
<td>Pain Management (Board Certified)</td>
</tr>
<tr>
<td>19</td>
<td>Psychiatry</td>
</tr>
<tr>
<td>20</td>
<td>Pulmonology*</td>
</tr>
<tr>
<td>21</td>
<td>Radiology</td>
</tr>
<tr>
<td>22</td>
<td>Rheumatology</td>
</tr>
<tr>
<td>23</td>
<td>Urology</td>
</tr>
</tbody>
</table>

* Not subject to separate adult and pediatric provider standards.

J. Billing, Claim Editing, SNIP Editing and Clearinghouse Requirements

1. Payment of Claims and Claims Inquires

Providers will submit 837 files through our clearinghouse, Direct Data Entry in Portal or submit a paper claim, 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 365 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.
Claim Appeals

Providers may request an exception for payment of claims after the claim’s submission requirement date for the following reasons:

- System errors creating billing delay for providers
- Resubmission of denied claims
- Provider identifies billing errors which result in reworking of claims in a lengthy process (beyond established resubmission timeframe).

Process for Submission of Claim Corrections

Providers may submit claim corrections for originally paid claims within 180 days from the service date. Claim corrections submitted past 180 days from the service date will be denied for exceeding billing days and cannot be resubmitted.

2. Process for Submission of Replacement and Voided Claims

Providers may submit replacement or voided claims for originally paid claims within 180 days from the service date. Claims submitted past 365 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 Software System Claims Submission**

Providers are contractually required to submit billing electronically. Sandhills 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 System gives very specific instructions on what is needed to submit billing. The TPA and the Sandhills Center’s Software 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:

i. **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.

ii. **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.

iii. NPI (National Provider Identifier)/Atypical Number

Providers are required to submit billing with their NPI or Atypical Number on the electronic 837. The NPI/Atypical 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.

iv. Verification and Notification

Sandhills Center provides the following responses via electronic means to help ensure that electronic 837 billing is accepted into the Sandhills 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 State payer. Otherwise, the ASC X12 Implementation Guides are to be referenced. Summarized companion guides are available at: https://tp.sandhillscenter.org/claims-submissions-tp.

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.
Publishing of Rates - Refer to Sandhills Center website

c. Service Codes and Rates
d. Standard Codes for Claims Submission

6. CPT/HCPC/Revenue Codes
   See Sandhills Center website http://tp.sandhillscenter.org/claims-submissions-tp

   See Sandhills Center web page http://www.sandhillscenter.org/icd-10/

8. Place of Service Codes
   See Sandhills Center website http://tp.sandhillscenter.org/claims-submissions-tp

2. 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.

   a. 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 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.

   b. 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.

   c. 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 to obtain a response from the insurance company. However, it is important that providers not exceed 180-days 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.

3. **Fee Schedules**

   a. **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.

   b. **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.

4. **Response to Claims**

   a. **Remittance Advice**
The Remittance Advice is Sandhills Center’s way of communicating back to the provider community exactly how every service has been adjudicated. Sandhills Center provides the Remittance Advice in a downloadable file and can be accessed through Sandhills Software System.

b. **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.

c. **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.

5. **SNIP Editing**

Data Quality Checks: We will validate all encounter files for completeness and accuracy, and this includes subcontractor encounter files. This process includes claim count verification, HIPAA compliance validation to identify potential TA1 or 999 errors, and validation of all critical data elements. Using IBM ITXA tools, we will comply with Strategic National Implementation Process (SNIP) Levels 1-7 validations that make sure claim lines and dollar amounts are equal to the total claim amount as submitted by the provider and to validate specific situations described in HIPAA implementation guides. In addition, validation of required and situational fields confirms the accuracy of encounter transactions, reducing the potential for error. To ensure Level-7 validation, we will perform testing on Companion Guide Requirements and work with the Department to test Pre-processor response, Compliance checker response and Business Rules engine validation responses provided before submitting production files. Frequency: Multiple times per week.

6. **Clearinghouses**

- **Hardware/Software Requirements**

There are many different products that can be used to bill electronically. As long as you have the capability to send EDI claims to Change Healthcare, whether through direct submission or through another clearinghouse/vendor, you can submit claims electronically.

- **Contracting with Change Healthcare and Other Electronic Vendors**
If you are a provider interested in submitting claims electronically to the Plan but do not currently have Change Healthcare EDI capabilities, you can contact the Change Healthcare Provider Support Line at 1-800-845-6592. You may also choose to contract with another EDI clearinghouse or vendor who already has Change Healthcare capabilities.

- Contacting the EDI Technical Support Group Providers interested in sending claims electronically may contact the EDI Technical Support Group for information and assistance in beginning electronic submissions.
  - When ready to proceed:
    - Read over the instructions within this booklet carefully, with special attention to the 79 information on exclusions, limitations, and especially, the rejection notification reports.
    - Contact your EDI software vendor and/or Change Healthcare to inform them you wish to initiate electronic submissions to the Plan.
    - Be prepared to inform the vendor of the Plan’s electronic payer identification number.

Important: Change Healthcare is the largest clearinghouse for EDI Healthcare transactions in the world. It has the capability to accept electronic data from numerous providers in several standardized EDI formats and then forwards accepted information to carriers in an agreed upon format.

Contact EDI Technical Support by calling 1-833-885-2262 or by email at edi.acnc@amerihealthcaritasnc.com.

Providers using Change Healthcare or other clearinghouses and vendors are responsible for arranging to have rejection reports forwarded to the appropriate billing or open receivable departments.

J. Claims Investigations-Fraud and Abuse

a. Trends of Abuse and Potential Fraud

One of the primary responsibilities of Sandhills Center is to monitor the Provider Network for fraud and abuse. Sandhills Center’s Tailored Plan/Medicaid Direct/PIHP contract places responsibility on Sandhills Center for monitoring and conducting periodic audits to help ensure compliance with all Federal and State laws and in particular the Medicare/Medicaid fraud and abuse laws.

Specifically, Sandhills Center needs 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.

b. **Audit Process**

Sandhills Center has the responsibility to help 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.

c. **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.

d. **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://tp.sandhillscenter.org/claims-submissions-tp](https://tp.sandhillscenter.org/claims-submissions-tp), in the provider section under Finance Claim Forms. Sandhills Center will adjust the system and those adjustments will appear on the next Remittance Advice.

e. **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. **Cultural and Linguistic Competency and Accessibility Requirements**

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

b. Cultural Competency Plan (Attachment I)

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 Network Access Plan is posted on the Sandhills Center website at the following links:

- Cultural Competency Plan: [https://tp.sandhillscenter.org/for-providers/](https://tp.sandhillscenter.org/for-providers/)
- Network Access Plan: [https://tp.sandhillscenter.org/for-providers/](https://tp.sandhillscenter.org/for-providers/)

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. 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 helps ensure 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://tp.sandhillscenter.org/provider-training-materials-tp](https://tp.sandhillscenter.org/provider-training-materials-tp), click on “Cultural Competency Orientation” link.

c. 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 their 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 Statute 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://www2.ed.gov/about/offices/list/ocr/ellresources.html
- https://ncitlb.org/
- https://catiweb.org/

d. Cultural Competency Resource Booklet (see Sandhills Center Website)
https://tp.sandhillscenter.org/provider-training-materials-tp

9. Provider Orientation

Orientation procedures are as follows:

1. Sandhills Center informs potential providers of the orientation requirement during the contracting process.

2. 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.

3. Annual Orientation: In collaboration with Sandhills Center programs/departments, the Training Coordinator plans and facilitates the annual orientation events for any
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, but may be posted on the Sandhills Center website in lieu of face-to-face presentations or conducted virtually. 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.

4. Orientation agendas are planned to provide network providers with the information necessary to comply with 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 the website, including:
  1) Provider news and other updates
  2) The Provider Manual;
  3) Technical assistance such as the Provider Help Desk, Provider Support Portal and Department Directory
  4) Changes in fee schedules and contracting provisions.
  5) Information on how to obtain benefits, eligibility, formularies, grievance and appeals information.
  6) Provider Dispute Resolution Process;
  7) Provider Forms and Documents
  8) Claims and Reimbursement
  9) The Provider Training Calendar
  10) Other information that is part of the Sandhills Center Provider Communications Plan.

- 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;
• State and Federal Requirements;
• Cultural Competency;
• Credentialing and re-credentialing procedures with NC Tracks, and
• Sanctions, Disputes and Appeals.
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 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 informs providers of revisions to the manual at Quarterly Provider Forums.

L. Provider Appeals and Grievance Process

Overview
The Sandhills Center Provider Grievances and Appeals Policy has been developed to ensure that Providers escalating any dissatisfaction to the attention of Sandhills Center will be addressed in a timely manner with the upmost quality customer service response via the systematic receipt, documentation, evaluation, and resolution of the Grievance or Appeal.

Purpose
Sandhills Center BH I/DD Tailored Plan/Medicaid Direct/PIHP (the Plan) is committed to recognizing and addressing all Provider Grievances and Appeals and has developed a Grievance/Appeals-response system that encapsulates the following:
- Easy access to a respectful and time-sensitive response to Grievances and Appeals that is both consistent and fair;
- Provider-centered design that is focused on every facet of the Grievance and Appeals process including receiving, logging, responding to, tracking, and working towards a satisfactory disposition;
- Emphasis on transparency throughout the process to establish trust and maintain open communication with Provider:
- Capable staff and a thorough process able to review Provider Grievance and Appeal outcomes and identify trends and existing operational or clinical opportunities to improve the Provider experience.

Additionally, Sandhills Center’s Provider Grievances and Appeals Policy provides definitions of frequently used terms and establishes guidelines to meet all recommended standards as outlined for BH I/DD Tailored Plan and Medicaid Direct PIHP Providers by the North Carolina Department of Health and Human Services.

Definitions
GRIEVANCE—Complaint or expression of dissatisfaction by a Provider regarding any aspect of the operations, activities, or behavior related to the organization of Sandhills Center.

APPEAL—A formal procedure by which the submitting Provider can seek initial reconsideration of an adverse decision made by Sandhills Center or as a follow-up to a Grievance resolution that the provider chooses to dispute as part of that procedure process.

PROVIDER SUPPORT PORTAL—Online access platform by which Providers can access electronic versions of forms and processes as well as print those documents; additionally, providers can submit Appeals or Grievances via the secure Provider Support Portal to the appropriate Sandhills Center triage staff.

DEPARTMENT—The North Carolina Department of Health and Human Services and includes both the Division of Health Benefits (“DHB”) and the Division of Mental Health, Developmental Disabilities and Substance Abuse Services (“DMH”).

CONTRACT—An agreement between an insurer and a health care Provider for the provision of health care services by the Provider on a preferred or in-network basis.

PROVIDER—A person, firm, or corporation that provides behavioral health services, medical services, care or supplies to members enrolled in the Plan. Providers include but are not limited to Licensed Independent Practitioners (LIPs), agencies, physicians, hospitals, durable medical equipment and home care companies, and pharmacies.

IN-NETWORK PROVIDER—A Provider which maintains a full contract with Sandhills Center to provide services to various populations in the Sandhills catchment.

OUT-OF-NETWORK PROVIDER—A Provider which maintains a single-case agreement with Sandhills Center to serve a select member or members of the Sandhills catchment. This type of contract is limited to the duration of service being delivered to the designated member(s).

Policy

The Sandhills Provider Grievances and Appeals Policy is distinct from the process offered to Members and ensures that all Provider Appeals and Grievances are handled promptly, consistently, fairly, and in compliance with state and federal laws and Department requirements for BH I/DD Tailored Plan/Medicaid Direct/PIHP Providers. All Provider Grievances and Appeals submitted to Sandhills Center are directed to the appropriate department based on the nature and subject of the request and are required to be resolved within thirty (30) calendar days from receipt of the Grievance and/or Appeal. Additionally, Sandhills Center ensures that all Providers may file a Grievance and/or Appeal without fear of retaliation per the Nondiscriminatory Policy.
**Nondiscriminatory Policy**

Sandhills Center shall not discriminate against or retaliate against any Provider based on any action taken by the Provider under Provider Grievances and Appeals Section of the Contract (Section V.B.4.v., Section IV.H.5 Provider Grievances and Appeals) or under Member Grievances and Appeals Section of the Contract (Section V.B.1.vi., Section IV.E.6. Member Grievances and Appeals) taken on behalf of a member.

**Procedure**

**Provider Appeals**

Sandhills Center maintains a formal Provider Appeals Process by which Providers may dispute certain adverse actions and decisions made by Sandhills Center. It should be noted that Providers may appeal an adverse determination at any time and do not need to participate in the formal Grievance process first to initiate the Appeal process. Providers may request an Appeal for the following reasons:

<table>
<thead>
<tr>
<th>In-Network Providers</th>
<th>Out-of-Network Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Program Integrity related findings or activities</td>
<td>• An out-of-network payment arrangement</td>
</tr>
<tr>
<td>• Finding of fraud, waste, or abuse by Sandhills Center</td>
<td>• Finding of waste or abuse by the Plan</td>
</tr>
<tr>
<td>• Finding of or recovery of an overpayment by Sandhills Center</td>
<td>• Finding of or recovery of an overpayment by the Plan</td>
</tr>
<tr>
<td>• Withhold or suspension of a payment related to fraud, waste, or abuse concerns</td>
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<tr>
<td>• Termination of, or determination not to renew, an existing provider contract due to violation of terms between Sandhills Center and Provider</td>
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<tr>
<td>• Determination to de-certify an AMH+ or CMA (applicable to Medicaid Providers only)</td>
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In accordance with the guidelines set forth by the Department regarding BH/IDD Tailored Plan and Medicaid Direct/PIHP governance, all Sandhills Center Providers have the right to file a Provider Appeal for the reasons listed in the table above. Sandhills Center is committed to adhering to the following as it relates to Provider Appeals:

- Ensuring that Providers are notified in writing of their right to Appeal decisions made by Sandhills Center and given the appropriate instructions for completing the process.
• Arranging for Appeal investigation assignment based on the nature of the Appeal to be reviewed and resolved by qualified personnel from the relevant Sandhills Center department.
• Maintaining a Provider web portal to ensure that Providers can easily submit Appeals to Sandhills Center for review and resolution.
• Ensuring timely acceptance and response of Appeal requests from Providers and complying with Department-mandated timelines regarding responses and extensions.
• Maintaining an Appeal Review Committee to oversee Appeals decisions (see Appeal Review Committee).
• Offering the Provider an in person or virtual/telephone hearing as well as access to an attorney during the Appeals process for withholding or suspension of payment if requested (see In-Person or Virtual/Telephone Hearings).
• Providing notice to the Department of any Provider Appeal regarding certain issues as suspension/withholding of payment and issues of fraud, waste, and abuse.
• Ensuring that the Appeals process enables Sandhills Center Providers to challenge certain Sandhills Center actions/decisions as well as providing them information regarding access to a state level review through the North Carolina Office of Administrative Hearings.
• Informing Providers of limits regarding Appeals in cases of suspension or withhold of Provider payment to whether Sandhills Center had good cause to commence the withhold or suspension of Provider payment.

Appeal Timeframes and Submission Process
• Providers wishing to file an Appeal must do so within thirty (30) calendar days from the date on which:
  o The Provider received written notice from Sandhills Center of a decision giving rise to the right to the Appeal; or
  o Sandhills Center should have taken a required action but failed to take such actions.

• Provider Appeals can be submitted via the Provider Appeal Form found in the Provider Support Portal at the following web address: https://support.sandhillscenter.org/support/login
  o If the provider opts to fill out the form electronically, it will be submitted via the provider Support Portal.
  o If the Provider opts to print out the form, they may do so by accessing the form on the Provider Support Portal, by requesting it be sent to them via email through the Provider Support Portal, or by clicking here; once it has been filled out in writing by the Provider, it can be mailed to the following address:

  Provider Network Grievance and Appeals Coordinator
  3802 Robert Porcher Way
  Greensboro, NC  27410

  o The Provider may also Fax the form to the following Fax number:  910-673-6202

Receipt and Logging of Provider Appeals
For Provider Appeals submitted through Provider Support Portal:
  o The Appeal will be completed on the electronic web-based Provider Appeal Form found in the Provider Support Portal;
  o Receipt confirmation will automatically be sent to the Provider upon submission of the web-based Provider Appeal Form along with a generated Appeal number for future reference.
  o The Provider Grievance & Appeals Coordinator and IT have access to the Provider Web Portal. Information gathered includes:
    o Provider Data including Provider name, Provider number, Provider Contact Information, Date and time Appeal received.
    o Reason for Appeal
    o Member Information (if applicable)
    o Previous Grievance Number (if applicable)
    o Request for an In-Person or Virtual/Telephone Hearing If Desired
  o The Provider Grievance & Appeals Coordinator is responsible for tracking the Appeal through the system until final disposition. Even when triaged to another program or department, the Provider Grievance & Appeals Coordinator continues monitoring the tracking log for compliance with internal and external timeframes, activities, and documentation until final disposition. Documentation of the investigation includes any aspects of clinical care involved. Except for extensions of time granted for extensions (per the request of the Provider) Sandhill Center will resolve all Provider Appeals within thirty (30) calendar days.

For Provider Appeals submitted in writing:
  o The Appeal will be submitted on the printed version of the Provider Appeal Form and will be received by the Provider Grievance & Appeals Coordinator at the address or Fax number listed previously; Information gathered includes:
    o Provider Data including Provider name, Provider number, Provider Contact Information, Date and time Appeal received.
    o Reason for Appeal
    o Member Information (if applicable)
The Provider Grievance & Appeals Coordinator is responsible for tracking the Appeal through the system until final disposition. Even when triaged to another program or department, the Provider Grievance & Appeals Coordinator continues monitoring the tracking log for compliance with internal and external timeframes, activities and documentation until final disposition. Documentation of the investigation includes any aspects of clinical care involved. With the exception of extensions of time granted for extensions (per the request of the Provider) Sandhill Center will resolve all Provider Appeals within thirty (30) calendar days.

Appeal Decision Process
  o Once an Appeal has been received from a Provider either via the Provider Support Portal or via a written or Fax form, the Sandhills Center Provider Grievance & Appeals Coordinator will do the following:
    1. Notify Provider that the form has been received within five (5) calendar days of receipt of the request.
2. Ensure via written communication that the provider should anticipate a resolution date within thirty (30) calendar days.
3. Triage the Appeal request via the following actions:
   a) Ensure an Appeal identification number has been assigned to the Appeal request and follow-up with the Provider to confirm they are aware of the Appeal identification number.
   b) Notify the appropriate Sandhills Center department of the appeal based on the information given by the Provider.
   c) Notify the Appeals Review Committee (see Appeals Review Committee) of the new appeal request and send relevant appeal review documentation once the Appeals Review Committee has been scheduled to meet.
4. Track the Appeal request to ensure that it is being vetted and resolved within the expected timeline while ensuring that all pertinent facts will be investigated and considered. Sandhills Center’s policies and procedures will also be considered.

Resolution of Standard Appeals
- Once a decision has been reached by the Appeal Review Committee regarding the Appeal request, Sandhills Center will provide written notice of the decision to the Provider via the Provider Grievance & Appeals Coordinator.
- All Appeal requests will be resolved within thirty (30) calendar Days of receiving a complete Appeal request (the date on which all the evidence is submitted to the Sandhills Center);
- The timeline may be extended past the thirty (30) calendar days if an Appeal extension (see Appeal Extensions) is granted to the provider to submit additional evidence.
- At the time of notification, Providers will be given additional information regarding additional Appeal rights with the North Carolina Office of Administrative Hearings (oah.nc.gov);
- Notification of Appeal decision will be sent to the provider via the Provider Support Portal as well as via secure email and a letter sent certified mail.

Appeal Extensions
- Sandhills Center will extend the timeframe by thirty (30) calendar days for Providers to request an Appeal for good cause as determined by Sandhills Center. “Good cause” reasons may include, but are not limited to the following:
  1. The Provider representative or family member is seriously ill which prevents the representative from requesting a reconsideration in person, through another person, or in writing.
  2. There was a death or serious illness in a party's immediate family.
  3. Important records were accidentally destroyed or damaged by fire or other cause.
- An Appeal Extension Request may be submitted either via the Provider Support Portal or via written submission (see information above regarding accessing the form) via the Provider Appeal Extension Form before the initial thirty (30) calendar days have expired.
• The Appeal Extension Request will include the Good Cause rationale and any supporting documentation needed to support the request.
• An Appeal will only be extended once for each Appeal incident.
• If the timeframe is extended, the Provider will receive prompt oral notice. Within two (2) calendar days, the Provider will receive a written notification that the timeframe has been extended.

In-Home or Virtual/Telephone Hearings For Withholding or Suspension of Payment
• While all Provider Appeal requests are conducted via an Appeal Documentation Review per the Appeal Review Committee, Sandhills Center will offer the Provider an in-person meeting or virtual/telephone hearing if a provider so desires when a Provider is appealing an adverse decision made by Sandhills Center.
• If the provider requests an in-person meeting or telephone hearing, the meeting/hearing and decision will be conducted within fifteen (15) calendar days by appropriate Sandhills Center staff; the Provider must request the meeting/hearing either in writing or via the Provider Support Portal.
• Depending on the nature of the Appeal, Sandhills Center may also request or initiate an on-site meeting or virtual/telephone hearing with the Provider requesting the Appeal.

Appeal Review Committee
• Sandhills Center will maintain an Appeal Review Committee that is comprised of the following qualified personnel to review and provide guidance for Appeals:
  a) At least three (3) qualified individuals who were not involved in the original decision, action, or inaction giving rise to the right to Appeal.
  b) For State-Funded Provider Appeals, the committee will include an external peer reviewer when the issue on Appeal involves whether the Provider met Objective Quality Standards.
• The Appeal Review Committee will be scheduled to meet by the Provider Grievance & Appeals Coordinator upon receipt of an appeal and will process all requests in a timely manner in order to adhere to the thirty (30) calendar day timeline expectation for Appeal resolution.

Appeals of Suspension or Withhold of Provider Payment
• Sandhills Center will limit the issue on Appeals in cases of suspension or withhold of Provider payment to whether Sandhills Center had good cause to commence the withhold or suspension of provider payment.
• Sandhills Center will not address whether the Provider has or has not committed fraud or abuse.
• Sandhills Center will notify the Department within ten (10) Business Days of a suspension or withhold of provider payment.
• Sandhills Center will offer the provider an in-person, telephone, or virtual hearing when provider is appealing whether Sandhills Center has good cause to withhold or suspend payment to the provider.
• Sandhills Center will schedule the hearing and issue a written decision regarding whether Sandhills Center had good cause to suspend or withhold payment within fifteen (15) Business Days of receiving the provider’s appeal. Upon a finding that Sandhills Center did not have good cause to suspend or withhold payment, Sandhills Center shall reinstate any payments that were withheld or suspended within five (5) Business Days.
• Sandhills Center will pay interest and penalties for overturned denials, underpayment, or findings it did not have good cause to suspend or withhold payment from the original Date of Payment, suspension, withhold or denial.

Appeal Rights and Limitations
Sandhills Center will adhere to the following Provider Appeal rights and limitations:
• Inform and allow all Appealing Providers to be represented by an attorney during the Appeals Process.
• Limit the issue on Appeal in cases of suspension or withhold or Provider payment to whether Sandhills Center had good cause to commence the withhold or suspension of provider payment. Sandhills Center will not address whether the Provider has or has not committed fraud or abuse.
• Ensure all Providers are aware that they must exhaust Sandhill Center’s internal Appeals process before seeking recourse under any other process permitted by contract or law.
• Provide information and instructions for Providers to submit Appeals to challenge certain Sandhills Center decisions by accessing a state level review through the North Carolina Office of Administrative Hearings (oah.nc.gov) including a filing period of sixty (60) calendar days from the date of receipt of resolution

Provider Grievances
Sandhills Center will receive and resolve Grievances with Providers where remedial action is not requested. Grievances must be resolved in a timely manner. Additionally, Sandhills Center will accept and resolve all Provider Grievances regarding Sandhills Center that have been referred from the Department. Sandhills Center can receive Provider Grievances through at least two different avenues:
• Provider Grievances can be submitted via the Provider Grievance Form found in the Provider Support Portal at the following web address: https://support.sandhillscenter.org/support/login
  o If the provider opts to fill out the form electronically, it will be submitted via the provider Support Portal.
  o If the Provider opts to print out the form, they may do so by accessing the form on the Provider Support Portal or by requesting it be sent to them via email through the
Provider Support Portal; once it has been filled out in writing by the Provider, it can be mailed to the following address:

Provider Network Grievance and Appeals Coordinator
3802 Robert Porcher Way
Greensboro, NC  27410

- The Provider may also Fax the form to the following Fax number:  910-673-6202

If the Grievance is being submitted via the Provider Portal, receipt confirmation will automatically be sent to the Provider (see Receipt and Logging of Initial Grievance) along with a Provider Grievance Identification Number for future reference. All Provider Grievances are directed to the appropriate department through the Provider Grievance & Appeals Coordinator who is responsible for triaging the Grievance and determining which department it should be assigned to for review and resolution. The Provider Grievance & Appeals Coordinator has an extensive knowledge of the therapeutic service array and has valued experience needed to make determinations regarding the review and assignment of Grievances to various internal departments. Additionally, the representatives in the receiving departments (see Triage of Grievances) have the skill set and/or clinical background required to address issues related to both the Grievance and Appeal outcomes. Should the Grievance inquiry and/or investigation result in sanctions for the contracted Provider, there is an Appeals process available as previously outlined.

- Once the Grievance has been assigned to the appropriate department for processing, Providers are notified in writing that they can expect resolution within thirty (30) calendar days from receipt of the Grievance. In each potential department, Sandhills Center has identified a process to and staff capable of reviewing Provider Grievance and Appeal outcomes to identify trends and existing operational or clinical opportunities to improve the Provider experience. After the resolution has been determined and given to the Provider in writing, Providers will be informed of their Appeal rights and a timeline will be issued regarding their response if they choose to pursue the Appeals process. The Appeal will be conducted utilizing the formal and objective guidelines (outlined in the previous section regarding Appeals). It should be noted, however, that a Provider can directly file an Appeal regarding an adverse action that they wish to dispute and do not have to go through the Grievance Process to submit an Appeal.

Receipt and Logging of Initial Grievance

- For Provider Grievances submitted through Provider Support Portal:
  - The Grievance will be completed on the electronic web-based Provider Grievance Form found in the Provider Support Portal.
  - The Provider Grievance & Appeals Coordinator and IT have access to the Provider Web Portal. Information gathered includes:
    - Provider Data including Provider name, Provider number, Provider Contact Information, Date and time Grievance was received.

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- Date and Nature of the Grievance
- Member Information (if applicable)
- Identification of the Sandhills Center department and/or employee involved in the Grievance

  - The Provider Grievance & Appeals Coordinator is responsible for tracking the Grievance through the system until final disposition. Even when triaged to another program or department, the Provider Grievance & Appeals Coordinator continues monitoring the tracking log for compliance with internal and external timeframes, activities, and documentation until final disposition. Documentation of the investigation includes any aspects of clinical care involved. With the exception of extensions of time granted for extensions per the request of the Provider (see **Time Extension for all Grievances**), Sandhill Center will resolve all Provider Grievances within thirty (30) calendar days.

For Provider Grievances submitted in writing:

  - The Grievance will be submitted on the printed version of the Provider Grievance Form and will be received by the Provider Grievance and Appeal Coordinator at the address or Fax number listed previously; Information gathered includes:
    - Provider Data including Provider name, Provider number, Provider Contact Information, Date, and time Grievance was received.
    - Date and Nature of the Grievance
    - Member Information (if applicable)
    - Identification of the Sandhills Center department and/or employee involved in the Grievance

  - The Provider Grievance & Appeals Coordinator is responsible for tracking the Grievance through the system until final disposition. Even when triaged to another program or department, Provider Grievance & Appeals Coordinator continues monitoring the tracking log for compliance with internal and external timeframes, activities, and documentation until final disposition. Documentation of the investigation includes any aspects of clinical care involved. With the exception of extensions of time granted for extensions per the request of the Provider (see **Time Extension for all Grievances**), Sandhill Center will resolve all Provider Grievances within thirty (30) calendar days.

**Grievance Inquiry and/or Investigation**

- Grievances are categorized as either requiring desk top reviews or onsite investigation, depending on the nature and severity of the Grievance. Network Operations staff utilizes the Sandhills Center High Risk Criteria document to categorize Grievances.
- Within five (5) calendar days of receipt of a Grievance, the Provider Grievance & Appeals Coordinator contacts the Provider, in writing, stating the Grievance has been received and will be investigated.

**Standard (Low Risk) Grievances**
Grievances that are categorized as standard meet internal low risk criteria and are generally conducted through desktop reviews.
   - Within five (5) calendar days of receipt of the Grievance, the Provider Grievance & Appeals Coordinator will notify the Provider that the Grievance will be investigated.
   - The Network Operations department will complete the review within thirty (30) calendar days of the receipt of the Grievance.
   - If, during the review, issues are identified that indicate a need for further investigation, the process begins either internally, or is referred to the appropriate State or local government agency and must be completed within the designated timeframes. The Grievance is not closed until all internal investigation is complete and the letter is mailed to the Provider. Exception: If the Grievance is referred internally to the Program Integrity Section, the Network Operations department closes their investigation within the thirty (30) calendar day timeline. The timeline begins when the Grievance was received and is considered closed once Program Integrity accepts the referral.

**Expedited (High Risk) Grievances**

An onsite investigation occurs for Grievances that are categorized as expedited; these types of grievances can include allegations of health and safety issues, member abuse/exploitation/neglect, lack of qualified staff, poor quality of service provisions, and Provider fraud and generally meet internal high-risk criteria. Allegations of Provider fraud are initially reviewed by Network Provider Monitoring to determine accuracy of the Grievance prior to referral to the Program Integrity Section.

1. Within five (5) calendar days of receipt of the Grievances, the Provider Grievance & Appeals Coordinator contacts the Provider stating the Grievance will be investigated.
2. An onsite review is often required for expedited Grievances. Network monitoring staff is assigned to complete onsite reviews as needed.
3. An onsite review is scheduled, and a report is completed within thirty (30) calendar days of the receipt of the Grievance.
4. If, upon completing the Grievance allegation review, it is noted that other deficiencies are present that do not pertain to the Grievance allegations, Sandhills Center staff may include those deficiencies in the Report of Findings.

**Resolution of Provider Grievance:**

- Once a decision has been reached regarding the Grievance request, Sandhills Center will provide written notice of the decision to the Provider via the Provider Grievance & Appeals Coordinator.
- All Grievance requests will be resolved within thirty (30) calendar Days of receiving a complete Grievance request (the date on which all the evidence is submitted to the Sandhills Center);
The timeline may be extended past the thirty (30) calendar days if an extension (see Grievance Extensions) is granted to the provider to submit additional evidence.

At the time of notification, Providers will be given additional information regarding additional Appeal rights with the North Carolina Office of Administrative Hearings (oah.nc.gov) including a filing period of sixty (60) calendar days from the date of receipt of resolution.

Notification of Grievance decision will be sent to the provider via the Provider Support Portal as well as via secure email and a letter sent certified mail. This letter will include:
- All actions taken to resolve the Grievance.
- Results of review (substantiated, partially substantiated, not substantiated).
- Referral to outside agency if appropriate with contact information.
- Referral to another internal department if appropriate.
- Information regarding notification given to the Department (see Notification of Action to the Department)
- Information regarding the Provider Appeal process and Appeal rights and Limitations.

**Time Extension for Grievances:**

- Sandhills Center will extend the timeframe by thirty (30) calendar days for Providers to request a Grievance for good cause as determined by Sandhills Center. “Good cause” reasons may include, but are not limited to the following:
  1. The Provider representative or family member is seriously ill which prevents the representative from requesting a reconsideration in person, through another person, or in writing.
  2. There was a death or serious illness in a party's immediate family.
  3. Important records were accidentally destroyed or damaged by fire or other cause.
- A Grievance Extension Request may be submitted either via the Provider Support Portal or via written submission (see information above regarding accessing the form) via the Provider Grievance and Appeal Extension Form before the initial thirty (30) calendar days have expired.
- The Grievance Extension Request will include the Good Cause rationale and any supporting documentation needed to support the request.
- A Grievance will only be extended once for each Grievance incident; it can also be extended once for each Appeal request if the Provider so requests an Appeal.
- If the timeframe is extended, the Provider will receive prompt oral notice. Within two (2) calendar days, the Provider will receive a written notification that the timeframe has been extended.

**Appeal Process for Grievance Resolution**

- Providers wishing to file an Appeal must do so within thirty (30) calendar days from the date on which the Provider received written notice from Sandhills Center of a decision giving rise to the right to the Appeal.
- Please note that a Provider can directly file an Appeal regarding an adverse action that they wish to dispute and do not have to go through the Grievance Process to submit an
Appeals (however, Appeals are available for filing if a provider does wish to dispute the results of a Grievance)

- The Provider will follow the process found in the previous Appeals section regarding submitting a formal Provider Appeal either via the Provider Support Portal or in writing.

Notification of Action to the Department

- Sandhills Center will provide information to the Department regarding all Provider Grievances and Appeals to the Department upon request and any of the following:
  - Submitting the Provider Grievances and Appeals Policy to the Department for review one hundred twenty (120) days after the BH I/DD Tailored Plan/Medicaid Direct/PIHP Contract Award; additionally, Sandhills Center shall submit any significant policy changes to the Department for review at least sixty (60) Calendar Days before implementing the changes.
  - Provider Appeals regarding the suspension or withhold of payment, finding or recovery of an overpayment by Sandhills Center, or any action related to a finding of fraud, waste, or abuse. Such notice must be provided within five (5) Business Days of the Appeal.
  - Suspension or withhold of Provider payment within ten (10) Business Days.
  - If a provider has sued Sandhills Center in any administrative or general court of justice for actions related to Medicaid Managed Care. Such notice must be provided within five (5) Business Days of being served.
A. BH/I/DD TP/PIHP 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 60 days of receipt of the decision.

If the Provider is not satisfied, an appeal to NC Division of MH/DD/SAS may be made.

Dispute resolved or not contested / case closed.

**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 calendar days of receipt of request & responds in writing within 7 days (Medicaid), 30 days.

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 decision.

Sandhills Center decides within 14 calendar days of receipt of request & respondents in writing within 7 (Medicaid), 30 (State) calendar days.

Sandhills Center convenes a 2nd Level Panel, reviews information and decides.

Dispute resolved or not contested / case closed.

State: If the Provider is not satisfied, an appeal to NC Division of MH/DD/SAS may be made.
M. Complaint or Grievance Investigation and Resolution Procedures

1. 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 and 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.

2. Grievances

Sandhills Center may receive grievances from providers, stakeholders, members, families, or legal guardians regarding Sandhills Center’s Provider Network, the Tailored Plan/Medicaid Direct/PIHP and/or a specific provider’s services or staff. Any Sandhills Center staff can take a grievance.

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 Center, 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 requests an extension or Sandhills Center 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 the grievances and resolutions are recorded.

Sandhills Center’s Customer Services Department maintains the documentation for 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.

Provider Ombudsman

- For provider inquiries, concerns, and complaints regarding health plans, please contact Provider Ombudsman
  - Email: Medicaid.ProviderOmbudsman@dhhs.nc.gov
  - Phone: 866-304-7062

N. Performance Improvement Procedures

1. 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.

2. Quality Improvement
To help 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 and for 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 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 help 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 regarding 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 helps ensure 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
- Network Participation Committee
- 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 require 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.

3. Performance Measurements

a. 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, to assure compliance with DMH & DHB contract requirements.

b. Performance Improvement

Sandhills Center will complete Performance Improvement Projects (PIPs) as indicated in the Tailored Plan/Medicaid Direct/PIHP contract and URAC Standards. These Performance Improvement Projects will consist of both clinical and non-clinical studies and may require provider participation.

c. 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 because of a grievance or incident report or quality of care.

4. Performance Monitoring

An important part of Sandhills Center’s role as a Tailored Plan/Medicaid Direct/PIHP 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:

a. Provider Preventable Conditions
Provider Preventable Conditions (PPCs) are conditions that meet the definition of a “health care-acquired condition” or an “other provider preventable condition” as defined by the Centers for Medicare & Medicaid Services (CMS) in federal regulations at 42 CFR.447.26(b).

Sandhills Network Providers will ensure that the service provision of a safe environment for delivery of Mental Health, Substance Abuse, and Intellectual/Developmental Disability services to Sandhills Center members is delivered in a manner that minimizes preventable events from occurring.

Sandhills Center systematically monitors and evaluates all reportable incidents in accordance with Federal regulations and state law that requires service providers report all provider-preventable conditions (PPCs) associated with claims for Sandhills Center beneficiaries that did not exist prior to the provider initiating treatment.

Sandhills Center complies with State law that prohibits reimbursement for services to treat the PPC.

To aid in providing a safe environment for delivery of Mental Health, Substance Abuse and Intellectual/Developmental Disability services to Sandhills Center members that minimizes preventable events from occurring, SHC systematically monitors and evaluates all reportable incidents in accordance with Federal regulations and state law that requires service providers report all provider-preventable conditions (PPCs) associated with claims for Sandhills Center beneficiaries that did not exist prior to the provider initiating treatment.

Sandhills Center complies with State law that prohibits reimbursement for services to treat the PPC.

Provider Preventable Conditions (PPCs) are conditions that meet the definition of a “health care-acquired condition” or an “other provider preventable condition” as defined by the Centers for Medicare & Medicaid Services (CMS) in federal regulations at 42 CFR.447.26(b).

b. 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 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.

b. **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 Tailored
Plan/Medicaid Direct/PIHPs 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.ncdhhs.gov/default.aspx](https://iris.ncdhhs.gov/default.aspx)

Sandhills Center Critical Incident Support Specialists review 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 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 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 Customer Services) 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.

c. 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 and 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 reported incidents and determined 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 member grievances utilizing independent psychiatric review, as needed, for clinical concerns.
d. 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.

5. Corporate Compliance

Sandhills Center expects 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.

a. 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. 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.
b. **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.

6. **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.

7. **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

a. Contents of a Full Clinical Service Records

A full clinical service record is one that is used to document the provision of much of the mental health, intellectual or developmental disabilities, and substance use services discussed in this manual and contains the elements inherent in a complete clinical service record. All services, unless otherwise specified, must be documented in a full clinical service record.

All information developed or received by the provider agency about the individual during 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 if 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)].
  - Informed written consent for planned use of restrictive intervention [10A NCAC 27D .0303(b)].
  - Written consent granting permission to seek emergency care from a hospital or physician.
  - Informed written consent for participation in research projects.
  - Written consent to release information [10A NCAC 26B .0202 and .0203].

- **Demographic Information / In Case of Emergency / Advance Directives**
  - Individual’s name [must be on all pages in the service record that were generated by the agency].
  - 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.

- 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.
- 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.
- Advance directives.
- Health history, risk factors.
- 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.
  - Documentation of medications, dosages, medication administration, medication errors, and a Medication Administration Record [MAR], per 10A NCAC 27G.0209.
  - Medication orders.
  - When applicable, orders for, and copies of, lab tests.

- Notification of Rights.
  - 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.
  - Documentation that the individual’s rights were explained to the individual/legally responsible person.

- Restrictive Interventions.
  - 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.
  - Inclusion of any planned restrictive interventions in the individual’s service plan according to 10A NCAC 27E .0104(f), whenever used.
  - 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.
  o Clinical level of functioning measurement tools.
  o Screening, which shall include documentation of an assessment of the individual’s presenting problems/needs, and disposition, including recommendations and referrals.
  o 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)];
  o 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.
  o Identification of other team members.
  o Documentation of coordination with the rest of the individual’s team.
  o Treatment decision-making process, including thought processes and the issues considered.

• Service Plan‡
  o PCP [must include Medicaid ID number for Medicaid-eligible individuals].
  o Service plan / treatment plan / individual support plan when a PCP is not required.
  o 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.
  o 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 Sandhills Center 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 help 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 monitor medical record documentation to help ensure that standards are met.

10. 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://tp.sandhillscenter.org/corporate-compliance
11. 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/

12. 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 Services Department 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
4. Contact the Attorney General’s Medicaid Investigation Division at (919) 881-2320

i. Recipient/Member Satisfaction Surveys
Sandhills Center uses the annual surveys below to identify opportunities for improving member/recipient experiences, and provider satisfaction.

- Experience of Care and Health Outcomes (ECHO)
  - The most comprehensive tool available for assessing member/recipient health care experiences related to their counseling and treatment.

- Consumer Satisfaction Survey
  - This annual survey is administered to satisfy a Substance Abuse and Mental Health Services Administration (SAMHSA) reporting requirement for the Community Mental Health Services Block Grant.
  - Assesses consumer satisfaction and perceptions of quality and outcomes of publicly funded Mental Health and Substance Use services.

Survey Analysis

Sandhills Center uses a 5% variance of the state average as a baseline.
• If the Sandhills Center Average is greater than 5% of the State Average, it is identified as an area Sandhills Center excels in.

• If the Sandhills Center Average is more than 5% below the State Average, it is identified as an area for potential improvement.

**Survey Results**

Survey results are used by Sandhills Center for practical decision making:

• Identify strengths and weaknesses in Quality of Care and Services

• Assess where resources can best be allocated to improve weaknesses

• Track the effects of efforts to improve over time

Survey Results are:

• Posted on Sandhills Center website
• Presented to Sandhills Center internal committees
• Presented to Providers
• Used by workgroups to review areas needing improvement
• Considered a foundation of improved performance

### ii. Clinical Studies

Sandhills Center Quality Management (QM) and Quality Management Committee (QMC) objectively and systematically monitor and evaluate the quality, appropriateness, accessibility, efficiency, and availability of safe and equitable delivery of medical and behavioral health care and services. The application of data analytics and evidenced based practices, best practices and clinical studies are used to identify strategies, activities, and implementations in response to findings in need of improvement. The QM and QMC addresses the quality of clinical care and nonclinical aspects of service with a focus on key area that include, but are not limited to:

• Quantitative and qualitative improvement in Member outcomes

• Coordination and continuity of care across health care settings/services

• Quality of care/service

• Complaints/grievances

• Cultural competency

• Network adequacy

• Appropriate service utilization

• Member and Provider satisfaction
iii. Outcomes Requirements

Healthcare Effectiveness Data and Information Set

The Healthcare Effectiveness Data and Information Set (HEDIS®) is a tool used by more than 90 percent of health plans to measure performance on important dimensions of care and service. Annual HEDIS reporting is required by the state Medicaid programs and the health plan accreditation agencies. The tool comprises a wide variety of measures across 6 domains of care, including:

1. Effectiveness of care
2. Access/availability of care
3. Experience of care
4. Utilization and risk adjusted utilization
5. Health plan descriptive information
6. Measures collected using electronic clinical data systems

A key element in our partnership is the evaluation of the quality of care and services delivered to Members. One of the most important ways we measure that quality is through the HEDIS; the quality measures are based on the specifications developed by the National Committee for Quality Assurance (NCQA) and other state-defined measures.

All HEDIS data reported is audited and certified by an NCQA-designated auditing firm as required by accreditation bodies, our state partners, and the Centers for Medicare & Medicaid Services (CMS).
This HEDIS audit is a standard part of the NCQA HEDIS data collection process and NCQA accreditation standards.

As part of the HEDIS audit, we may contact providers for patient records to review according to HEDIS clinical documentation standards. In compliance with the HEDIS standards, we request medical records annually for certain measures to collect information that typically cannot be found in a claim or an encounter. Sandhills Center will contract with provider’s office to schedule medical record collection for member charts because we have identified that you are either the assigned or previous PCP of the member or have submitted a claim or encounter that relates to a HEDIS measure.

The requirement of an audit is also part of your provider contract with Sandhills Center, which requires that you submit needed records at no charge within 3 business days of the request or as otherwise stated. Please refer to your contract for more information.

O. Compensation and Claims Processing Requirements

Information required to submit claims and receive reimbursement is included in this portion of the provider manual. This is an overview of enrollment, authorizations, and claims submission. More detailed information will be available in Sandhills Claims Submission Guide.

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 through the Sandhills Center Managed Care Software System. Assistance can be found on Sandhills Center’s Managed Care Software System using the current version of Sandhills Center Enrollment documentation. Please contact the Member Enrollment and Eligibility section of the Customer Services Department at (800) 256-2452 with questions.

**Providers should assist members that may be eligible for Medicaid funding in applying for Medicaid through the county Department of Social Services.**

**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/for-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-State Funded**

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 for a claim to be accepted. 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.

6. **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 can 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 State Funded 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)/Atypical Number

Providers will submit billing on the electronic 837 with their NPI or Atypical Number. The NPI/Atypical 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 help ensure that electronic 837 billing is accepted into the Sandhills 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,
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 State payer. Otherwise, the ASC X12 Implementation Guides are to be referenced. Summarized companion guides are available at: https://tp.sandhillscenter.org/claims-submissions-tp

7. 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.

C. Service Codes and Rates

Contract Provisions

Provider contracts include a listing of services, which they are eligible to provide. 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, Sandhills will pay the DHHS published rate for rate floor services regardless of the billed amount unless Sandhills and the provider have a mutually agreed upon alternative payment method. 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://tp.sandhillscenter.org/claims-submissions-tp

D. Standard Codes for Claims Submission

11. CPT/HCPC/Revenue Codes
   See Sandhills Center web page [http://www.sandhillscenter.org/icd-10/](http://www.sandhillscenter.org/icd-10/)

13. **Place of Service Codes**
    See Sandhills Center website [https://tp.sandhillscenter.org/claims-submissions-tp](https://tp.sandhillscenter.org/claims-submissions-tp)

E. **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.

F. **Coordination of Benefits**

   In most instances, 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 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 180-days 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.

G. **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 Potential State Funded 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.

H. **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 Sandhills Software System.

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.

I. Claims Investigations

PIHP

1. Audit Process

Sandhills Center has the responsibility to help 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.

2. 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.

3. 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://tp.sandhillscenter.org/claims-submissions-tp, 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.

4. 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.

i. Requirement Electronic Formats

1. 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)/Atypical Number

Providers are required to submit billing their NPI/Atypical Number on the electronic 837. The NPI/Atypical 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 help ensure that electronic 837 billing is accepted into the Sandhills 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 State payer. Otherwise, the ASC X12 Implementation Guides are to be referenced. Summarized companion guides are available at: https://tp.sandhillscenter.org/claims-submissions-tp.

ii. Mandated Timelines

1. Timeframes for Submission of Claims

All claims must be submitted within 365 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 **180 days** from the service date. Claim corrections submitted past 180 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://tp.sandhillscenter.org/claims-submissions-tp](https://tp.sandhillscenter.org/claims-submissions-tp), 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.

### iii. Transition of Care Obligations

**AMH+, CMA, and Other Partner Oversight**

a. Oversight Responsibilities

   i. Sandhills Center will create separate departments for UM and Care Management, overseen by separate leadership.

      1. As part of its UM process, Sandhills Center will review the utilization patterns of all members receiving Tailored Care Management (whether from Sandhills Center, an AMH+ practice or a CMA).

      2. This UM review must assess whether any patterns exist that suggest that care managers have steered members toward or away from particular providers (e.g., toward the organization that employs the care manager or away from a competitor).

      3. As part of its standard UM responsibilities, Sandhills Center will assess whether members are receiving the appropriate level of care corresponding to their clinical information.

   ii. Sandhills Center will ensure that no care managers (whether employed by Sandhills Center, an AMH+ practice, or a CMA) are related by blood or marriage or financially responsible for any of the members to whom they are assigned or have any legal power to make financial or health-related decisions for any of their assigned members.

   iii. For Innovations and TBI waiver members engaged in Tailored Care Management, Sandhills will ensure compliance with federal requirements for conflict-free case management for members enrolled in a 1915(c) waiver as described further Policy BCM03-TP CM Policies PP-Conflict Free Care Management.
iv. Sandhills Center will ensure that a member does not receive duplicative care management services, as described further in Policy BCM03-TP CM Policies Preventing Duplication of Care Management.

v. Sandhills Center will hold each AMH+ and CMA accountable to all elements of the Tailored Care Management model contained within the Program Contract and associated guidance, by ensuring that all details are reflected in the contract with each AMH+ and CMA.

vi. Contract templates governing contracts between Sandhills Center and AMH+ practices and CMAs (or CINs or Other Partners on their behalf), including all sections and attachments of such contracts, will be submitted to the Department for approval.

vii. Sandhills will monitor AMH+ practices and CMAs’ performance against requirements contained in this contract as reflected in their contracts with AMH+ practices and CMAs. Any contract terms additional to the requirement in this contract that Sandhills Center seeks to offer to AMH+ practices and CMAs must be approved by the Department as part of contract review.

viii. Should Sandhills Center contract directly with a CIN or Other Partner that is acting on behalf of an AMH+ practice or CMA, Sandhills Center will monitor the CIN or Other Partner directly.

ix. During Contract Year 1, Sandhills Center will not require an AMH+ practice, CMA, or CIN or Other Partner to undergo a pre-delegation audit for the purposes of NCQA accreditation, although a delegation arrangement may be entered by mutual agreement.

x. Sandhills Center will ensure that in conducting oversight of AMH+ practices, CMAs and CINs or Other Partners that are delegates for NCQA plan-level functions, it is monitoring not only in terms of NCQA requirements, but also Tailored Care Management-specific requirements contained in the Tailored Care Management Provider Manual.

xi. To promote AMH+ practices and CMAs’ ability to make informed decisions about CIN or Other Partner affiliations, Sandhills Center will do the following:

   1. Send direct notification to each AMH+ practice or CMA practice describing the CIN or Other Partner oversight process, within ninety (90) days of contracting with the AMH+ practice or CMA.

xii. Send direct notification to each AMH+ practice or CMA practice affiliated with a CIN or Other Partner the results of CIN or Other Partner level audits, including CAPs or similar processes as described below, within sixty (60) days of the audit.

b. Corrective Action Plans

i. In the event of underperformance by an AMH+ practice, CMA or CIN or Other Partner relative to the requirements for Tailored Care Management, Sandhills Center will provide the following oversight support:

   1. Send a notice of underperformance to the AMH+ practice/CMA within fourteen (14) days of identifying the underperformance, with a copy to the Department.

   2. Provide the AMH+ practice, CMA or CIN or Other Partner with the
opportunity to remediate any identified issues through a Corrective Action Plan (CAP), and a copy of the CAP shall be sent to the Department.

3. Ensure that a minimum of thirty (30) Calendar Days is provided for remediation of the identified underperformance addressed by the CAP, although the parties may establish longer remediation periods by mutual agreement.

ii. Sandhills Center Network Operations, in collaboration with NCDHHS/DHB, retain the right to initiate a delegate corrective action plan (dCAP) and/or delegate warning letter (dWL) to the CM Delegates (AMH+, CMA, and other Partners) who fail to meet the standards applicable to the particular Delegation arrangement, which may include but not limited to those standards set forth by ACNC, NCDHHS/DHB, federal or other state regulatory authorities, or NCQA.

1. Care Management Delegation arrangements are governed by a written agreement between the CM Delegate and Sandhills Center that outlines the scope of delegated activities; reporting responsibilities; the responsibilities of Sandhills Center; the CM Delegate performance monitoring process; and the remedies available, such as revocation of delegation if the CM Delegate fails to meet its obligations or the imposition of sanctions if the CM Delegate’s performance is inadequate.

2. Sandhills Center Network Operations conducts a pre-Delegation assessment and a formal annual audit of each CM Delegate’s performance and compliance against the responsibilities outlined in the written agreement.

3. Network Operations is responsible for coordinating internal and external approvals as may be necessary for the initiation and continuation of a delegated relationship, through the governing internal committee structure and any required external approval process, including but not limited to approval from the Sandhills Center Care Management Delegation Oversight Committee (CMDOC) and NCDHHS/DHB.

iii. Performance measures will be monitored per reporting requirements. A dWL will be issued to the CM Delegate with a copy to NCDHHS/DHB when it is determined that performance or metric deficiencies can reasonably be remedied within thirty (30) calendar days from the date of remediation workplan approval and/or where it has been determined that there has been minimal or no member or provider impact.

iv. If a dWL extends beyond the thirty (30) calendar day period, the dWL shall be closed and a dCAP issued. A dCAP will be required for performance/reporting measures under the following circumstances:

1. the deficiency is anticipated to require longer than thirty (30) calendar days to remedy.

2. if the deficiency can be remediated in less than thirty (30) calendar
days, the deficiency has been assessed to have member or provider
impact(s) which will require additional oversight and monitoring; or
3. if a dWL has been issued twice within ninety (90) days for the same
deficiency.
v. Network Operations, External Care Management, and/or appropriate
Sandhills Center Department representatives shall provide consultation to
the CM Delegate to help the CM Delegate complete any outstanding items on
the dCAP.
vi. The Network Operations Department is responsible for ensuring that
appropriate updates are prepared as necessary for the CMDOC, ACNC
Compliance and/or Corporate Compliance, governing bodies and
NCDHHS/DHB and other regulatory authorities.
vii. Upon satisfactory completion of the outstanding items in the dCAP, the
Network Operations Department prepares the CM Delegate’s information for
presentation to internal/external committees as information only. Once
reviewed by internal Plan specific committees, dCAP closure approval is
sought from Sandhills Compliance and/or Corporate Compliance and
applicable external reviewers, such as regulatory authorities where review
and approval of the Delegation relationship is required.
ix. If performance deficiencies remain unresolved in accordance with the
timeframes set forth in the delegate corrective action plan (dCAP), Sandhills
Center, NCDHHS/DHB, exercises its right to revoke Delegation consistent with
the terms of the Delegation Agreement. Delegates of Sandhills Center are not
permitted to sub-delegate any functions being delegated to them unless such
sub-Delegation is prior approved in writing by Sandhills Center.
c. Payments/ Continued Underperformance
i. In the event of continued underperformance by an AMH+ practice, a CMA or
a CIN or Other Partner that is not corrected after the time limit set forth on
the CAP, and Sandhills Center terminates its contract with the AMH+ practice,
CMA, CIN, or other entity, Sandhills Center will notify the Department within
seven (7) days that it will no longer be contracting with the AMH+ practice,
CMA or CIN or Other Partner for Tailored Care Management. The Department
reserves the right to specify the timing and format of this notification.
ii. Should the CMDOC decide that the CM Delegate/ other Partner should be
terminated and/or the AMH+ status downgraded in accordance with
applicable Addendum terms based on the presentation of audit results and
outstanding items on the dCAP, the Network Operations Department or
designee will notify NCDHHS/DHB.
iii. Sandhills Center will stop paying the Care Management Fee payment as
applicable and notify the Delegate in writing of the termination/downgrade
in the Tier status to include the appeals rights.
iv. The Network Operations is responsible for working with the Legal Affairs
Department to prepare the correspondence in accordance with applicable
requirements. At a minimum, the letter will include the reason(s) for
termination of the CM Delegate/ other Partner, notice of nonpayment for
required payments (as applicable) and the procedure(s) the CM Delegate must follow to return the delegated function(s) back to Sandhills to avoid gaps in care management functions.

v. In the case of recission of delegation of Care Management where an LHD is the delegate, written notification will be provided to NCDHHS/DHB, and upon approval, Sandhills Center will notify LHD of recission decision and will include language to revoke the delegation along with appeals rights. Sandhills Center, in collaboration with DHB, will seek to contract with another LHD to provide local care management.

d. Reassigning Members in the Event of a Termination

i. Sandhills Center shall notify each member who, at a minimum, received his or her primary care from, or was seen in the previous twelve (12) months by a terminated provider, of the provider’s termination from the Network V.B.4.ii.(x).(f).(1).

ii. Sandhills Center shall make a good faith effort to provide written notice to members within fifteen (15) Calendar Days after receipt of a notice of termination by the Department or issuance of termination notice to the provider by the Sandhills Center V.B.4.ii.(x).(f).(1).i

iii. In the provider termination notice, Sandhills Center shall include information about selecting or being auto-assigned a new PCP, if the provider was a PCP, describe the efforts to support transition of care for the member to the new provider, and if the terminated provider was a specialist, assist impacted members with transition of care V.B.4.ii.(x).(f).(1).ii-iv.

iv. Sandhills Center will not terminate its contract with an AMH+, CMA or CIN or Other Partner under this provision until at least ninety (90) days after BH I/DD Tailored Plan/Medicaid Direct/PIHP launch.

e. Supporting AMH+/CMAs to Continue Providing Services

i. In the event of underperformance by an AMH+ practice, a CMA or a CIN or Other Partner for Tailored Care Management, Sandhills Center will ensure that there are no gaps in care management functions for members assigned to the AMH+ practice or CMA. Sandhills Center shall provide written notice by certified mail and/or secure email to AMH+/CMA providers affected by the termination of a CIN or Other Partner within fifteen (15) Calendar Days after receipt of a notice of termination by the Department or issuance of termination notice to the provider by the Sandhills Center.

ii. Notification will include date of termination of CIN or Other Partner.

1. A list of alternative CINs and Other Partners.
2. Instructions on contracting directly with Sandhills Center.
3. Sandhills Centers Network Operations Director or their designee will follow-up with affected providers within five (5) business days of sending out the notification to provide technical assistance if required, and to confirm the AMH+/CMA’s decision.
4. AMH+/CMA providers must complete transition to a currently contracted CIN or Other Partner, or contract directly with Sandhills Center no less than ten (10) days prior to the termination date.
5. Sandhills Center shall notify each member who, at a minimum, received his or her primary care from, or was seen in the previous twelve (12) months by a terminated provider, of the provider’s termination from the Network V.B.4.ii.(x).(f).(1).

6. Sandhills Center shall make a good faith effort to provide written notice to members within fifteen (15) Calendar Days after receipt of a notice of termination by the Department or issuance of termination notice to the provider by the Sandhills Center V.B.4.ii.(x).(f).(1).i

7. In the provider termination notice, Sandhills Center shall include information about selecting or being auto-assigned a new PCP, if the provider was a PCP, describe the efforts to support transition of care for the member to the new provider, and if the terminated provider was a specialist, assist impacted members with transition of care V.B.4.ii.(x).(f).(1).ii-iv.

Member Notification of Provider Termination

- In instances in which a provider is terminated or leaves the Sandhills Center network for expiration or nonrenewal of the contract and the member is in an ongoing course of treatment or has an ongoing special condition, Sandhills Center will enter into a Client-Specific Agreement to permit the member to continue seeing their provider, regardless of the provider’s network status. In instances in which a provider is terminated or leaves the Sandhills Center network for reasons related to quality of care or Program Integrity, the Sandhills Center shall notify the member and assist the member in transitioning to an in-network provider that can meet the member’s needs.

- Within fifteen (15) Calendar Days of providing notice of termination to the provider, Sandhills Center shall provide written notice of termination of a network provider to all members who have received services within the twelve (12) month period immediately preceding the date of notice of termination or are scheduled to receive services consistent with Section VII. Attachment G. Required Standard Provisions for BH I/DD Tailored Plan, and Section VI. Attachment F. Required Standard Provisions for Medicaid Direct/PIHP and Provider Contracts from the terminated provider within the sixty (60) Calendar Days, except if a terminated provider is a primary care provider (PCP), Advanced Medical Home Plus (AMH+) or care management agency (CMA) for a member. 42 C.F.R. §438.10(f)(1).

- If a terminated provider is a PCP, AMH+ or CMA for a Member, Sandhills Center shall notify the Member by the later of thirty (30) Calendar Days prior to the effective date of termination or fifteen (15) Calendar Days after the receipt or issuance of a provider termination notice of the following:
  - Procedures for selecting an alternative PCP, AMH+ or CMA.
  - That the member will be assigned to a PCP, AMH+ or CMA if they do not actively select one within thirty (30) Calendar Days.
  - If a terminated provider is a PCP, AMH+ or CMA for a member, the BH I/DD Tailored Plan/Medicaid Direct/PIHP shall ensure that the member selects or is assigned to a new PCP, AMH+ or CMA within thirty (30) Calendar Days of the date of notice to the member and notify the member of the procedures for continuing to receive care.
from the terminated provider and the limitations of the extension.

- Sandhills Center shall use a member notice consistent with the Department-developed model member notice for the notification required by this Section. 42C.F.R. § 438.10(c)(4)(ii).
- Sandhills Center shall hold the member harmless for any costs associated with the transition between providers, including copying medical records or treatment plans.
- Sandhills Center shall establish a Provider Transition of Care Policy that is consistent with the Department’s Transition of Care Policy and this Contract.
- The Provider Transition of Care Policy shall include processes and procedures for coordinating care for members who:
  - Have an ongoing special condition as defined in N.C. Gen. Stat. § 58-67-88(a)(1);
  - Are discharged from a residential or institutional setting.
  - Are obtaining services from a provider that leaves Sandhills Center’s network.
  - Must select a new PCP after a provider termination; and
  - Other requirements as identified by the Department.
- Sandhills Center shall submit the Provider Transition of Care Policy to the Department for review and approval upon request but no sooner than one hundred eighty (180) Calendar Days after the Contract Execution.

1. Coordination of Services Requirements (See page

In most instances, 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.

Exceptions to Payer of last resort rule:
Medical Support Enforcement: The Tailored Plan/Medicaid Direct/PIHP will pay and chase, If the claim is for a service provided to a Member on whose behalf the child support enforcement his being carried out of:
- The third-party coverage is through an absent parent; and
• The provider certifies that, the provider has billed a third party, the provider has waited one hundred (100) Calendar days form the date of service without receiving payment before billing the Health Plan.

Preventive Pediatric Services: The Tailored Plan/Medicaid Direct/PIHP will pay and chase for preventive pediatric services (including EPSDT). These services will be identified using Modifier EP for Medicaid members.

List of Programs/Services that are exceptions to the payer of last resort rule:

<table>
<thead>
<tr>
<th>Program or Service</th>
<th>Federal</th>
<th>State</th>
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<tbody>
<tr>
<td>Crime Victims Compensation Fund</td>
<td>X</td>
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<tr>
<td>Part B and C of Individuals with Disabilities Education Act (IDEA)</td>
<td>X</td>
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<td>Ryan White Program</td>
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<td>Indian Health Services</td>
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<td>Veteran’s Benefits for state nursing home per diem payments</td>
<td>X</td>
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<tr>
<td>Veteran’s Benefits for emergency treatment provided to certain veterans in a non-VA facility</td>
<td>X</td>
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<tr>
<td>Women, Infants and Children Program</td>
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<td>Older American Act Programs</td>
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<tr>
<td>World Trade Center Health Program</td>
<td>X</td>
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<tr>
<td>Grantees under Title V of the Social Security Act</td>
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<td>X</td>
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<tr>
<td>Division of Service for the Blind</td>
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<td>X</td>
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<tr>
<td>Division of Public Health “Purchase of Care” Program</td>
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<td>X</td>
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<tr>
<td>Vocational Rehabilitation Services</td>
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<td>X</td>
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<tr>
<td>Early and Periodic Screening, Diagnostic and Treatment (EPSDT)</td>
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2. 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.

3. 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.

P. Interest and Penalty Provisions for Late or Under-payment by the BH I/DD Tailored Plan/Medicaid Direct/PIHP

The Finance Department is responsible for ensuring compliance with prompt pay requirements as delineated in the BH I/DD Tailored Plan/Medicaid Direct/PIHP contract.

Within 18 calendar days after receipt of a Provider medical claim and 14 calendar days for Pharmacy, the LME/MCO shall either:

a. approve payment of the invoice/claim;
b. deny payment of the claim; or
c. determine that additional information is required for making an approval or denial.

If payment is approved, the claim shall be paid within 30 calendar days after it is approved.

Payment due on a claim that is not made within the period specified shall bear interest at the annual percentage rate of 18% beginning on the first date following the day on which the payment should have been made. A payment considered made on the date upon which a check, draft, or other valid negotiable instrument is placed in the United States Mail, first class postage prepaid, properly addressed to the Provider, or if not mailed, on the date of the electronic fund transfer, or other actual delivery, of the payment to the Provider. In addition to the interest on late payments, the BH I/DD Tailored Plan/Medicaid Direct/PIHP will pay the provider, a penalty equal to one percent (1%) of the claim for each calendar day following the date that the claim should have been paid as specified in the Contract.

Q. Recipient/Member Rights and Responsibilities

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 provide 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 must 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 rights have been violated, they may contact the Sandhills Center 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. Members can also directly access a Call Center Licensed Clinician by calling the Behavioral Health Crisis Line at 1 (833) 600-2054 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://tp.sandhillscenter.org/for-medicaid-members](https://tp.sandhillscenter.org/for-medicaid-members)

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 Tailored Plan/Medicaid Direct/PIHP 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://tp.sandhillscenter.org/for-medicaid-members

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 help 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 help
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 sign it.

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 their right to participate in decisions regarding their healthcare, including the right to refuse treatment, and to express preferences about future treatment decisions.

F. Psychiatric Advanced Directive (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 Directive 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 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 the Advance Directive, they 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 themself 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><strong>Medical Care Decisions &amp; Advance Directives Brochure</strong></td>
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<tr>
<td><strong>DHB website page for Advance Directives</strong></td>
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<tr>
<td><a href="https://medicaid.ncdhhs.gov/medicaid/your-rights">https://medicaid.ncdhhs.gov/medicaid/your-rights</a></td>
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<tr>
<td><strong>NC General Statutes web link for Advance Directives G.S. 122C-71 through 77 (Article 3, Part 2)</strong></td>
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<tr>
<td><a href="https://www.ncleg.gov/EnactedLegislation/Statutes/PDF/ByChapter/Chapter_122C.pdf">https://www.ncleg.gov/EnactedLegislation/Statutes/PDF/ByChapter/Chapter_122C.pdf</a></td>
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<tr>
<td><strong>CFR 42 431.20 Advance Directives Basis &amp; Purpose</strong></td>
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<tr>
<td><strong>CFR 42 422.128 Information on advance directives</strong></td>
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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 their 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 utilize 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

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 Utilization Management.

- **Denial:** A denial could occur if the criteria are not met to support a new authorization request for a service. The member/legal guardian will receive a letter by U.S. Mail explaining this decision and how to request a reconsideration (i.e., appeal). During this time, Sandhills Center will not provide the requested service in dispute.

- **Reduction, Suspension, or Termination:** Services that are already authorized may be reduced, suspended, or terminated based on several different factors including: the failure of the provider to follow clinical guidelines; member no longer meets medical necessity for the frequency, amount, or duration of a service; and evidence of fraudulent activity. 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/legal guardian requests a reconsideration by the deadline stated in the letter, the services may continue through the end of your original authorization.

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 with the member’s written consent. If you would like to discuss the case with the Sandhills Center UM Director or designee, please call 1 (800) 256-2452.

I. Appeals Process

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
- Limited Authorizations, including the type or level of service
- Reductions
- Suspensions
- Terminations of previously authorized services
- Denial, in whole or part, of payment for service
- Failure to provide services in a timely manner, as defined by NC DHHS
- Failure of Sandhills Center to act within the required review or appeal timeframes.

Appeals are the right of the member/legal guardian. The provider or another representative may file an appeal with written consent from the member or legal guardian.

Sandhills Center has two levels of appeal:
1. An internal appeal called a **reconsideration**
   - These appeals are reviewed by Sandhills Center contracted clinicians who have appropriate clinical expertise in treating the member’s condition(s).
   - The reviewing clinician is not the clinician who made the original adverse determination and is not a subordinate of the clinician who made the original adverse decision.

2. An external appeal called a **State Fair Hearing (SFH)**
   - These appeals are a legal proceeding overseen by an administrative law judge at the NC Office of Administrative Hearings (OAH).
   - Members will be offered participation in a mediation prior to the SFH. Members do not need to accept participation in a SFH.

Under North Carolina Medicaid rules, members must first exhaust the reconsideration process before proceeding to a State Fair Hearing. If the initial adverse decision is overturned at any point during the appeal process, Sandhills Center will authorize the disputed service or procedure within 72 hours of being informed of the appeal outcome.

**Standard Reconsiderations:** Most reconsideration requests are for standard reconsiderations. In these cases, there is no immediate jeopardy to the member’s health or safety. It can take up to **30 days** for the reconsideration decision and notification to be made. Standard reconsiderations give the member more time to gather and submit additional information they think will be useful in the appeal.

**Expedited Reconsiderations:** Expedited reconsiderations are granted when the standard resolution timeframe of 30 days could jeopardize the member’s health and safety. It can take up to **72 hours** for the reconsideration decision and notification to be made. Members will receive verbal notification of the reconsideration outcome within 72 hours of submitting the reconsideration request.

**Extensions:** For either a standard or expedited reconsideration, 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 and they do not agree with the extension.

1. **Filing a Reconsideration Request**

Reconsiderations can be requested verbally or in writing. Members or their representative have **60 days** from the *mailing* date of the adverse determination letter to make a request for a reconsideration. The adverse determination letter is called a Notice of Adverse Benefit Determination (NABD). The NABD will have very detailed instructions on how to file an appeal. The NABD will also have an appeal request form. The member may use this form to request an appeal and assign a representative, but the member is not required to use this form.

As a provider you can help the member read and understand the NABD and the appeal process.
To file a reconsideration request:

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<tr>
<th><strong>By Phone:</strong></th>
<th><strong>In Person</strong></th>
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<tbody>
<tr>
<td>1-800-241-1073</td>
<td></td>
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<tr>
<td><strong>By Fax:</strong></td>
<td></td>
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<tr>
<td>(336) 389-6543</td>
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<tr>
<td><strong>By Mail:</strong></td>
<td></td>
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<tr>
<td>Sandhills Center Appeals Coordinator</td>
<td></td>
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<tr>
<td>P.O. Box 9</td>
<td></td>
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<tr>
<td>West End, NC 27376</td>
<td></td>
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<tr>
<td>3802 Robert Porcher Way</td>
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<tr>
<td>Greensboro, NC 27410-2190</td>
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<tr>
<td>or</td>
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<tr>
<td>185 Grant Street</td>
<td></td>
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<tr>
<td>West End, NC 27376</td>
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Members have the right to review any information, including decision criteria that was used during the initial review or during the reconsideration process. They may also submit any additional information they believe will support the reconsideration request. To request or submit information, the member can call a Sandhills Center UM Appeals Coordinator at 1-800-241-1073.

2. **Filing a State Fair Hearing Appeal**

If a member disagrees with the reconsideration decision, they may submit an appeal to the NC Office of Administrative Hearings (OAH) 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 decide 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, they 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 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 Members: 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 Tailored Plan/Medicaid Direct/PIHP 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 the member receives or with the Tailored Plan/Medicaid Direct/PIHP;
- The failure of a provider or Tailored Plan/Medicaid Direct/PIHP to respect a person's rights, privacy or confidentiality;
- A provider or employee of a provider, or Tailored Plan/Medicaid Direct/PIHP 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://tp.sandhillscenter.org/file-a-grievance-tp](https://tp.sandhillscenter.org/file-a-grievance-tp). You can also make a grievance in person at Sandhills Center located at 185 Grant Street, West End NC 27376. Our staff provide assistance as needed in regard to your grievance.

For Providers: A grievance can be made when:
• You have a disagreement with Sandhills Center Tailored Plan/Medicaid Direct/PIHP (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:

Sandhills Center 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. Where the grievance is investigated by Sandhills Center, the timeframe for grievance completion may be extended the timeframe by fourteen (14) days if: the member requests the extension; or Sandhills Center 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 will 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 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.

Client Rights Regulations are in NCGS 122C-51-67 and APSM 95-2 and APSM 30-1 and NCAC 10A 27G.0504, 10A NCAC 27G.0103 and DMH Communication Bulletin #30.

L. Consumer and Family Advisory Committee (CFAC)

State law requires each of North Carolina’s behavioral health managed care organizations – including Sandhills Center – to support and collaborate with an advisory group made up of individuals (consumers) and/or family members. These groups are called Consumer and Family Advisory Committees, or CFACs. Each local CFAC is a self-governing and self-directed organization. The CFAC assists Sandhills Center in the planning of behavioral healthcare in its nine-county service region.

The CFAC consists of individuals who benefit from Sandhills Center-funded mental health, substance use disorder and intellectual/developmental disabilities (I/DD) services. Members are selected based on their disability, experience with Sandhills Center and geographic representation. Employees of Sandhills Center, or agencies that have a contract or Memorandum of Agreement with Sandhills Center, cannot serve on the CFAC.

The CFAC supports and facilitates the contributions of consumers to the Sandhills Center service system. Members advocate for improvements in quality care, and they identify barriers, service gaps and needs, as they arise. CFAC also recommends possible solutions. Members of the CFAC serve as a bridge between Sandhills Center and their communities. They also:

- Give voice to families and individuals who use behavioral health and/or I/DD services.
- Work to ensure that the development and delivery of services remain responsive to the well-being of individuals who are served.
- Have representation on the Sandhills Center Board of Directors, ensuring that the public’s needs are met.

The Sandhills Center CFAC meets monthly throughout the year, except in July and December when meetings are not held. 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.

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.

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 Tailored Plan/Medicaid Direct/PIHP area and interaction with staff from across Sandhills Center is instructive for both staff and CFAC members. Members of the CFAC serve as a bridge between Sandhills Center and their communities.

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 and 1 (833) 600-2054 Behavioral Health Crisis Line. 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 Sandhills Center’s sponsored opportunities for member training.
4. Facilitate adequate random sampling on State and Sandhills Center 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 ongoing knowledge of changes to statutes, laws, and regulations.
6. Provide information to the member about their 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.
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 while 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://www2.ed.gov/about/offices/list/ocr/ellresources.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://www.hhs.gov/civil-rights/for-individuals/special-topics/limited-english-proficiency/index.html)
- [https://ncitlb.org/](https://ncitlb.org/)
- [https://catiweb.org/](https://catiweb.org/)

R. Recipient/Member Cost Share Requirements

Members who have their services paid for in whole or in part by Sandhills Center must be enrolled in the Sandhills Center system. 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, Davidson, Guilford, Harnett, Hoke, Lee, Montgomery, Moore, Randolph, Richmond, and Rockingham 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 Sandhills Center.

S. Provider Program Integrity Requirements

NOTE: Program Integrity has not yet begun discussions on the TP/PIHP with ACNC.

The Program Integrity Team began operating in January 2013. The team works under the supervision of the Chief 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 Sandhills Center and various other violations of State 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 Tailored Plan/Medicaid Direct/PIHPs.

   c) The PI staff participates in a monthly PI forum to discuss procedures and standardization between Tailored Plan/Medicaid Direct/PIHPs, participates in a quarterly meeting with DHB and MID to discuss specific cases and issues that affect Tailored Plan/Medicaid Direct/PIHPs.

2. **Team Composition**

   The team consists of five positions – the Director, Investigator, Clinical Analysts 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 Analysts work 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 Chief 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 Analysts review consumer records for evidence of medical necessity.

f) The findings are compiled into a written report to be reviewed by the Chief 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 Sandhills Center Tailored Plan/Medicaid Direct/PIHP 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 Sandhills Center.

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.

Referral or internally generated leads are 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. Referrals or internally generated leads are 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 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 to help 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 associated documentation and evidence is referred to the Division of Health Benefits (DHB) within twenty-four (24) hours of completing the investigation, and Sandhills Center coordinates 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, Sandhills Center may proceed with administrative sanctions including but not limited to:

   a. Recoupment of improper billing paid by Sandhills Center
   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 the 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 per the Tailored Plan/Medicaid Direct/PIHP Contract. Sandhills Center will report, and promptly return overpayments within sixty (60) calendar days of identifying the overpayment.

12. Sandhills Center maintains electronic copies of case records.
i. How to Report Suspected Fraud

PIHP
Call Sandhills Center 24 hours a day, seven days a week - 1-800-256-2452.
Call the Sandhills Center Program Integrity department directly - 336-389-6236.
Use this confidential online grievance form.
Contact the Attorney General’s Medicaid Investigation Division - 919-881-2320.

ii. Waste and Abuse

1. Trends of Abuse and Potential Fraud

One of the primary responsibilities of Sandhills Center is to monitor the Provider Network for fraud and abuse. Sandhills Center’s Tailored Plan/Medicaid Direct/PIHP contract places responsibility on Sandhills Center for monitoring and conducting periodic audits to help ensure compliance with all Federal and State laws and in particular the Medicare/Medicaid fraud and abuse laws.

Specifically, Sandhills Center needs 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 help 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://tp.sandhillscenter.org/claims-submissions-tp](https://tp.sandhillscenter.org/claims-submissions-tp), in the provider section under Finance Claim Forms. Sandhills Center will adjust 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.

iii. **Compliance with Other State and Federal Requirements**

1. **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://tp.sandhillscenter.org/corporate-compliance](https://tp.sandhillscenter.org/corporate-compliance)
- [https://www.hhs.gov/hipaa/index.html](https://www.hhs.gov/hipaa/index.html)

2. **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/

T. Sections for Medicaid Providers
   i. Clinical Practice Standards

   1. Your Responsibility as a Provider

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

   2. Network Leadership Council (NLC)

   The overall purpose of the Network Leadership Council is to help 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 and practitioners, 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 and practitioners serving on the Council are expected to represent other providers and practitioners delivering the same or similar services and not their own individual agency/practices. Provider and practitioner representation 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 includes the following:

a. Recommend new service initiatives to address service needs/gaps and participate in provider recruitment and retention activities to build and maintain network sufficiency.

b. Provide input regarding the Sandhills Center Network Adequacy & Accessibility Analysis and Network Access Plan.

c. Offer information and make recommendations for the use of emerging best practices.

d. Provide input regarding the Annual Provider Training Plan.

e. Assist in the development, approval, and annual review of the Sandhills Center Cultural Competency Plan.

f. Review provider and practitioner Satisfaction Survey results and make recommendations to address areas of concern.

g. Review and make recommendations for the Provider Communications Plan annually.

h. Review and make recommendations for the Provider manual and web site.

i. Review reports and data on provider and practitioner related performance and quality management activities and provide input/recommendations.

j. Review and approval of the Provider Code of Ethics.

k. Conduct an annual self-assessment process and evaluation.

l. Offer recommendations for provider monitoring and quality indicators.

m. Receive regular updates regarding on-going projects, and the latest information on pending changes from state and local organizations.

n. Review provider and practitioner network performance against stated goals.

o. Provide feedback and recommendations for staff education and training needs.

p. 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.

q. Provide feedback on network data management processes related to access to member information, treatment authorization, claims adjudication, and payment.

r. Provide opportunity for feedback and recommendations regarding provider contracting, contractual responsibilities, rate setting and provider payment to the extent allowed by Sandhills Center clients - NC DHHS and NC DHB;
s. Help ensure that any changes in provider and/or practitioner contracts, contractual requirements, rates, and administrative requirements are discussed in detail with providers and practitioners and that providers are given an advanced 30-day notice of these and other changes unless specifically prohibited by law and statute or contractual requirements.

ii. Authorization, Utilization Review, and Care Management Requirements

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 Center maintains 24-hour 7 days a week telephone access line (800) 256-2452. Incoming calls are answered by a live person within 30 seconds. Customer Service Representatives answer the access lines and 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. Members can also directly access a Call Center Licensed Clinician by call the Behavioral Health Crisis Line at 1 (833) 600-2054, 24 Hours a Day/7 Days a Week.

Based on the caller’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.

When calls are warm transferred to the Call Center, the Call Center Licensed Clinician will complete screening, triage and referral for services.

   a. Access to Services

      1. Routine Services:

Members who present a clinical level of need at the routine level for substance abuse needs are given an appointment for services within forty-eight (48) hours. Members who present a clinical level of need at the routine level for mental health needs are given an appointment for services within fourteen (14) calendar days. 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 that needs a quick response.
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.

The Customer Services access line (1 800-256-2452) is staffed by:

- Customer Service Representatives
- Licensed Clinicians
The Behavioral Health Crisis line (1-833-600-2054) is staffed by:

- Call Center Licensed Clinicians

**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.

**Call Center Licensed Clinicians**

The role of the Call Center Licensed Clinician in the Customer Services 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.

**Member Eligibility and Enrollment Specialists**

The Member 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.

**Grievances and Incidents Reports Specialists**

The grievance and incident reports section of the Customer Services department’s primary function is to review, mediate and/or investigate grievances received and review critical incidents that occur within the network. Allegations of abuse, neglect, and/or exploitation are referred to the appropriate Department of Social Services.

b. **Registry of Unmet Needs**

Registry of Unmet Needs (Not applicable to Medicaid-funded services except for NC Innovations funding):
Sandhills Center works to ensure 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 Services Department 1 (800) 256-2452. Referrals will then be transferred to the IDD Care Coordination Department with 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 Tailored Plan/Medicaid Direct/PIHP 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, Davidson, Guilford, Harnett, Hoke, Lee, Montgomery, Moore, Randolph, Rockingham, 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 providerssupport@sandhillscenter.org and request the login information specific to your provider.

When a provider wishes to enroll a member into Sandhills Center Tailored Plan/Medicaid Direct/PIHP, the following steps should be followed:

a. Utilize Patient Search to verify whether 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. Utilization Management Department Description

The UM Program is managed on a day-to-day basis by the UM Department and is an integral part of the ongoing clinical operations of Sandhills Center. The Sandhills Center UM Program is nationally accredited, and operations, policies, procedures, and practice are designed and monitored to help ensure the highest standards of performance and compliance to DHB, accrediting body, federal and state regulations, and contractual obligations and to be reflective of the mission and vision of Sandhills Center.

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, 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. UM staff are available to receive and respond to inquiries regarding 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 UM department correspondence.

Most of the contact between providers and 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 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.

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 UM staff will return voice mail messages by the next business day for non-emergency UM calls.

UM staff responds to general inquiries regarding 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 UM Department has full time staff to include Sandhills Center Chief Medical Officer/Chief Clinical Officer, UM Director, UM Manager and Master’s 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 UM Department and is available daily 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 UM policies and procedures, protocols, criteria, and decision support tools and provides formal weekly supervision to UM staff.

The 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 subcommittees support and oversee the functions and responsibilities of the UM Department including the internal Clinical Leadership Team, the external Clinical Advisory Committee, the UM Committee, and the Quality Management Committee.

The role of these committees is to oversee and monitor the Utilization Management structure, process and related activities to help ensure members have prompt access to 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 UM Committee monitors and evaluates to help ensure members receive culturally competent, relevant medically necessary services that are aligned with evidence-based and best practice guidelines.

UM Department is an integral part of Sandhills Center clinical operations and as such interfaces with core and support departments and programs.

UM Department works in synchronization primarily with Care Coordination/Management Department as well as the other accredited departments, Customer Services, Network Operations and Quality Management to help ensure the fulfillment of Sandhills Center’s mission of effectively serving members that are foremost in our culture.

Emphasis is levied to collaborate with the Care Coordination Department to help ensure members are appropriately and promptly identified for care coordination services when needed. The UM and Care Coordination/Management 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 support barriers to care and service, and affirms the following:

1. 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 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 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 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*

UM initial reviewers are master’s 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 the 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, UM initial reviewers initiate the first or initial clinical review. The initial reviewer reviews the Service Authorization Request (SAR), the SAR data elements and 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**

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**

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 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**
2. **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 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 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 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 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.

4. 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 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. Determinations and related actions will be recorded in the Sandhills Managed Care Software System.

5. 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 UM Department electronically as a Service Authorization Request (SAR). Additional documentation should also be submitted as deemed necessary on the UM Master Grid that is located on the Sandhills Center website at https://tp.sandhillscenter.org/for-providers/ and click on “Sandhills Center UM Services Grid” under Utilization Management.

b. UM Department staff will review the submitted request for completion and medical necessity.

c. 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 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. 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 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 UM Care Manager will review the information.
d. Based on a review of the information provided, the 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 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 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. Determinations and related actions will be recorded in Sandhills Center 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 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 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 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 UM Care Manager will review the information.

d. Based on a review of the information provided, the 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 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 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. 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 Chief Medical Officer/Chief Clinical Officer. The Chief Medical Officer/Chief Clinical Officer makes a recommendation to the Tailored Plan/Medicaid Direct/PIHP 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. 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 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.

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) the 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 North Carolina 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, they 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 must 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 they feel 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 themselves 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 principal 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 the 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 Utilization Management Care Manager in assisting with Discharge Planning Efforts.

PROCESS:

1. The 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 Utilization Management Care Manager addresses the relevant issues with the provider.

M. Utilization Review

The primary function of the UM Department is to monitor the utilization of services and review utilization data to evaluate and help 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.

ii. Over-Utilization of Services – Example: members who continue to access crisis services with no engagement in other services.

iii. Services infrequently utilized – Example: an available practice that is not being used.

iv. 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 help 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.

iii. Care Coordination and Discharge Planning Requirements

1. I/DD Care Coordination/Management

The Sandhills Center I/DD Care Coordination/Management Department provides care coordination/management 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/Management activities are focused on the member and help ensure that each individual receives the services they need.
I/DD Care Coordinators/Care Managers 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/Care Manager provides the following activities:

1. Education about available MH/DD/SA services and supports, as well as education about the 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 other appropriate service and support providers.
4. Coordinate services to help ensure members have access to the care that they need.
5. Monitoring of the ISP to help ensure that services and supports is received and help 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:
2. **BH/SUD Care Coordination/Management**

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

a. Monitor service provision based on Person-Centered Planning and sound clinical guidelines;

b. Help ensure that eligible members are receiving the right amount of the most appropriate services at a given point in time;

c. Collaboration to transition members from more restrictive services/supports to more natural ones in the community;

d. Determine need and eligibility for Care Coordination/Management interventions;

e. Make referrals to the Tailored Plan/Medicaid Direct/PIHP’s Child System of Care coordination/management services;

f. Assist in connecting members with supports needed as transition between services occur;

g. Make referrals and assist with support services such as housing, transportation, interpretation services, and jail diversion;

h. 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;

i. Work closely with Community Care of North Carolina (CCNC) and providers of services to help ensure that members receive integrated care;

j. Assist in the reduction of inappropriate use of crisis services.

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

a. Work collaboratively with the Care Coordinator/Care Manager;

b. Provide information pertinent to the development of an Individual Service Plan (Person Centered Plan) or directly participate in the planning process;

c. 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;

d. Collaborate with member’s, family members, and the Tailored Plan/Medicaid Direct/PIHP to help assure continuity of care and that there is no disruption of service;
e. Comply with North Carolina Continuity of Care statute (GS 122C-63) which requires sixty (60) day notice by the provider to the Tailored Plan/Medicaid Direct/PIHP of intent to close a facility or discharge a member who may be in need of continuing care as determined by the Tailored Plan/Medicaid Direct/PIHP;
f. Allow designated Tailored Plan/Medicaid Direct/PIHP staff to participate in any treatment team and discharge planning meetings regarding members served.
g. Allow Tailored Plan/Medicaid Direct/PIHP staff to review documentation related to the provision of member services;
h. Allow Tailored Plan/Medicaid Direct/PIHP staff immediate direct access to any Tailored Plan/Medicaid Direct/PIHP referred or funded member or member served;
i. If requested, provide at least twenty-four (24) hours prior notice to the Tailored Plan/Medicaid Direct/PIHP 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 Tailored Plan/Medicaid Direct/PIHPs and Standard Prepaid Health Plans (PHPs), North Carolina Community Care Networks, and the providers of behavioral health services in North Carolina to help 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 help 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/Management responsibilities for identified members;
- A care coordination/management 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/management 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 help ensure that the people we support have access to and receive integrated care.

4. Assurance of Confidentiality

Sandhills Center Care Coordination/Management 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 safeguarded 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 Tailored Plan/Medicaid Direct/PIHPs, 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 priority 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 priority population about community-based mental health services and supported housing options.
6. **Case Management Program**

Sandhills Center began a program to help children who have complex care needs. Children who have received or may benefit from out of home services may need more support to make sure they are getting the best treatment. A Sandhills Center Case Manager will work with qualifying children and their caregivers to solve problems, find community resources, and help with communication between behavioral health and medical providers. This Case Management Program is at no cost to your member. The program does not replace any of your member’s current medical or behavioral healthcare services. Through participation in this program, a Sandhills Center Case Manager will work with your member to develop a personalized Care Plan and will provide support to help your member achieve the goals in the Care Plan.

Some of the goals of the Case Management Program are to:

- Provide participants with information and support;
- Educate participants about their health issues and help them receive the best treatment available;
- Work with participants to solve problems and find community resources;
- Coordinate with participants and their healthcare providers to help with communication about problems and needs.

If you have a member that may qualify and benefit from this program, and would like to refer them for this program, please contact the Customer Services department at 1-800-256-2452.

7. **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.

U. **Sections for State-Funded Providers**

1. **Case Management and Discharge Planning Requirements**

*Case Management Program*
Sandhills Center began a program to help children who have complex care needs. Children who have received or may benefit from out of home services may need more support to make sure they are getting the best treatment. A Sandhills Center Case Manager will work with qualifying children and their caregivers to solve problems, find community resources, and help with communication between behavioral health and medical providers. This Case Management Program is at no cost to your member. The program does not replace any of your member’s current medical or behavioral healthcare services. Through participation in this program, a Sandhills Center Case Manager will work with your member to develop a personalized Care Plan and will provide support to help your member achieve the goals in the Care Plan.

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If you have a member that may qualify and benefit from this program, and would like to refer them for this program, please contact the Customer Services department at 1-800-256-2452.

V. Provider Obligations

1. Your Responsibility as a Provider
   a. Ensure member eligibility and request services using the correct funding source (Medicaid or State-funded).
   b. Submit authorization requests timely; 14 days prior to the requested start date is recommended (non-urgent requests only).
   c. Submitting authorization requests timely will ensure that members have access to needed services without delay.
   d. Provide additional clinical information as requested within the required time frames
   e. Participate in peer reviews.
   f. Work collaboratively with Sandhills Center UM staff.
   g. Retain patient records for the mandated period.
   h. Ensure that all documentation regarding services provided is timely, accurate, and complete.
   i. Notify members of service approvals within 72 hours of receiving the notification through the Sandhills Center managed care software system.
   j. Sandhills Center does not notify members when services are approved. Sandhills Center will notify members of any denial or partial denial.
2. Fiscal Responsibility and Integrity

Providers shall demonstrate that they have in place accounting systems sufficient to ensure fiscal responsibility and integrity.

W. List of Revisions

Sandhills Center is committed to transparency regarding revisions to this provider manual and will do the following:

- Review and update the provider manual annually, with submission due on July 1st, or upon request of the Department to reflect changes to applicable federal and state laws, rules and regulations, Department or MD PIHP policies, procedures, bulletins, guidelines or manuals, or MD PIHP business processes as necessary.

- Correct errors in the electronic version of the Provider Manual or make revisions as requested by the Department within fifteen (15) Calendar Days of notification or request by Department. Corrections or revisions to the printed version must be included in the next printing.

- Sandhills MD PIHP may update the provider manual once per quarter in the event of substantive updates or revisions that impact providers or PIHP business. Unless directed by the Department, the Sandhills MD PIHP shall not update the provider manual more than once per quarter during the Contract Year. Submissions of the provider manual to the Department by the PIHP during the Contract Year shall not replace or eliminate the requirement to annually review and update the provider manual in accordance with this section.

- Sandhills Center MD PIHP shall have fifteen (15) Calendar Days to return an updated version of the provider manual if any revisions are requested by the Department during the review and approval process. Sandhills Center MD PIHP shall make the provider manual available, within five (5) Calendar Days of approval from the Department, in an electronic version accessible via a website or the provider web portal, and in writing upon request of a contracted provider.

- When seeking review and approval of the provider manual, Sandhills Center shall submit the provider manual to the Department for approval within fifteen (15) Calendar Days of making substantive updates. Sandhills Center shall not post, print, or enforce the updates until the PIHP has received approval from the Department.
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<th>Details</th>
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<td>11/30/22</td>
<td>Voluntary Repayment of Claims – paragraph updated</td>
<td>209</td>
<td>Due to revision of claims process to align with new process.</td>
<td>T. Hobgood, Claims Manager K. Kern, Network Operations Director</td>
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<td>1/10/23</td>
<td>Information on NC Child &amp; Family Improvement Initiative</td>
<td>66-68</td>
<td>Per NCCFII/Cansler</td>
<td>A. Gainey, Care Management Director K. Kern, Network Operations Director</td>
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<td></td>
<td>Provider Ombudsman contact information added</td>
<td>138</td>
<td>Per The Department</td>
<td>K. Kern, Network Operations Director</td>
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<td></td>
<td>Clinical Studies – description added</td>
<td>157</td>
<td>Per The Department</td>
<td>T. Coleman, QM Director, T. Walker, Population Health Director K. Kern, Network Operations Director</td>
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<td>Outcomes Requirements – description added</td>
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<td>Per The Department</td>
<td>T. Coleman, QM Director, T. Walker, Population Health Director K. Kern, Network Operations Director</td>
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<td>Compensation and Claims Processing Requirements – description added</td>
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<td>Revisions to the claims process</td>
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<td>To reflect the Department’s Decision to delay the MCD launch</td>
<td>K. Kern, Network Operations Director K. Kern, Network Operations Director</td>
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<td>2/1/23</td>
<td>Summary of Revisions List Added</td>
<td>244-250</td>
<td>Per The Department</td>
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<td>Statement regarding criteria #36 added</td>
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<td></td>
<td>Removed (as going away) and State-Funded providers, they are not credentialed by NC Medicaid or on the PEF</td>
<td>68</td>
<td>Per The Department</td>
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<td>Statement regarding criteria #34 removed from cover sheet and added</td>
<td>226</td>
<td>Per The Department</td>
<td>K. Kern, Network Operations Director</td>
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<td>Deleted references to credentialing and re-credentialing</td>
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<td>Per The Department</td>
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<tr>
<td>Deleted all references to NC Health Choice</td>
<td>Throughout</td>
<td>Per The Department</td>
<td>K. Kern, Network Operations Director</td>
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<td>Replaced Credentialing and Recredentialing information to reflect all related processes are completed by the Dept. Sandhills Center utilizes the Provider Enrollment File (PEF) generated through this process to make contracting decisions regarding provider participation eligibility in the Sandhills Center Network.</td>
<td>77</td>
<td>Per the Department</td>
<td>K. Kern, Network Operations Director</td>
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<td>Adjusted page numbers on table of contents to address issue #5</td>
<td>Throughout</td>
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<td>Launch date changed to 10/1/23</td>
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<td>To reflect dela The Department’s Decision to delay the MCD launch</td>
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<td>Again Adjusted page numbers on table of contents to address issue #5</td>
<td>Throughout</td>
<td>Per the Department</td>
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<td>Added additional Medicaid Direct information</td>
<td>Throughout</td>
<td>Per the Department</td>
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<td>Revised ACNC information to notate that they are a physical health subcontractor</td>
<td>8</td>
<td>Clarification</td>
<td>K. Kern, Network Operations Director</td>
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<td>Added statement regarding physical health reimbursement for out of network providers at 90%</td>
<td>18</td>
<td>Clarification</td>
<td>K. Kern, Network Operations Director</td>
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<td>Chart revised for to illustrate differences between TP and MCD</td>
<td>34-50</td>
<td>Per the Department</td>
<td>K. Kern, Network Operations Director</td>
<td>K. Kern, Network Operations Director</td>
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<td>Added, “Through DHHS Centralized Credentialing Process” to the Credentialing and Recredentialing Section Headers</td>
<td>77</td>
<td>Per the Department</td>
<td>K. Kern, Network Operations Director</td>
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<td>Removed reference to Credentialing/Re-Credentialing</td>
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<td>Per the Department</td>
<td>K. Kern, Network Operations Director</td>
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<td>Launch date changed to 10/2023</td>
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<td>Per the Department</td>
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<td>Deleted Cultural Competency information from page due to duplication</td>
<td>74</td>
<td>Per the Department</td>
<td>K. Kern, Network Operations Director</td>
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<tr>
<td>Removed “Nursing homes licensed under 10A”</td>
<td>83</td>
<td>Per the Department</td>
<td>K. Kern, Network Operations Director</td>
<td>K. Kern, Network Operations Director</td>
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<td>Removed point “e.” per the content of this section</td>
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<td>Per the Department</td>
<td>K. Kern, Network Operations Director</td>
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<td>Added PIHP to the purpose section</td>
<td>114</td>
<td>Per the Department</td>
<td>K. Kern, Network Operations Director</td>
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<td>Added link to Provider Appeal Form</td>
<td>117</td>
<td>Per the Department</td>
<td>K. Kern, Network Operations Director</td>
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<td>Corrected number of days for replacement claims from 365 to 180 days</td>
<td>97</td>
<td>Correction</td>
<td>K. Kern, Network Operations Director</td>
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<td>Deleted duplicate Coordination of Benefits section</td>
<td>100-101</td>
<td>Duplicated information</td>
<td>K. Kern, Network Operations Director</td>
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<td>Deleted Incident Reporting from section</td>
<td>111-114, 152-155, and 201-205</td>
<td>Duplicated information</td>
<td>K. Kern, Network Operations Director</td>
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<td>Added, “Member” to grievances Customer Services reviews</td>
<td>136</td>
<td>To distinguish member grievances from Provider grievances</td>
<td>K. Kern, Network Operations Director</td>
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<td>Deleted Program Integrity information under Corporate Compliance</td>
<td>138-142</td>
<td>Duplicate information</td>
<td>K. Kern, Network Operations Director</td>
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<td>Corrected information regarding “Member Notification of Provider Termination”</td>
<td>173-174</td>
<td>Correction</td>
<td>K. Kern, Network Operations Director</td>
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<td>Added information regarding Reporting Fraud, Waste, and Abuse</td>
<td>199</td>
<td>Duplication</td>
<td>K. Kern, Network Operations Director</td>
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<tr>
<td>Header changed to “Transitions to Community Living” to better reflect section content</td>
<td>56</td>
<td>Correction</td>
<td>K. Kern, Network Operations Director</td>
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<td>PIHP citations added</td>
<td>116</td>
<td>Per the Department</td>
<td>K. Kern, Network Operations Director</td>
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<td>Attachment F reference added per PIHP contract</td>
<td>172</td>
<td>Per the Department</td>
<td>K. Kern, Network Operations Director</td>
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<td>Corrected flow chart title to reflect content</td>
<td>127</td>
<td>Per the Department</td>
<td>K. Kern, Network Operations Director</td>
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<td>Noted time differences in the time and distance</td>
<td>93</td>
<td>Per the Department</td>
<td>K. Kern, Network Operations Director</td>
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4/12/23
<p>| Added Disaster and Emergency planning and response information | 15-16 | Per the Department | K. Kern, Network Operations Director | K. Kern, Network Operations Director |
| Added Provider Selection Criteria | 83-84 | Per the Department | K. Kern, Network Operations Director | K. Kern, Network Operations Director |
| Section v. Revised to reflect the end of the transition period for credentialing and re-credentialing | 84 | Clarification of timeline for re-credentialing | K. Kern, Network Operations Director | K. Kern, Network Operations Director |
| Combined Credentialing and Recredentialing sections | 84 | Eliminate redundancies | K. Kern, Network Operations Director | K. Kern, Network Operations Director |
| Added that the TBI Waiver is through the BH/IDD Tailored Plan for everyone except for individuals who are in the tribal option who have opted out of managed care. | 39 | Per the Department | K. Kern, Network Operations Director | K. Kern, Network Operations Director |
| Updated link to TCM Provider Manual | 35 | Per the Department | K. Kern, Network Operations Director | K. Kern, Network Operations Director |
| Updated link to Benefit Plan Eligibility Criteria | 25 | Per the Department | K. Kern, Network Operations Director | K. Kern, Network Operations Director |
| Updated Benefit Plan List | 26 | Per the Department | K. Kern, Network Operations Director | K. Kern, Network Operations Director |
| Criteria taken out of contents | 3-4 | Per the Department | K. Kern, Network Operations Director | K. Kern, Network Operations Director |
| Clarified that EPSDT is covered by Medicaid Direct | 39 | Per the Department | K. Kern, Network Operations Director | K. Kern, Network Operations Director |
| Revised Member Disenrollment language for clarification | 27-28 | Per the Department | K. Kern, Network | K. Kern, Network |</p>
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<tr>
<td>Updated and revised county transportation links</td>
<td>57-58</td>
<td>Per the Department</td>
<td>K. Kern, Network Operations Director</td>
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<td>Added, “Ensure that all documentation regarding services provided is timely, accurate, and complete” to Provider Obligations</td>
<td>214</td>
<td>Per the Department</td>
<td>K. Kern, Network Operations Director</td>
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<tr>
<td>Added, “Sandhills Center shall not post, print, or enforce the updates until the PIHP has received approval from the Department.”</td>
<td>215</td>
<td>Per the Department</td>
<td>K. Kern, Network Operations Director</td>
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<td>Updated the newest link for pharmacy newsletters</td>
<td>46</td>
<td>Per the Department</td>
<td>K. Kern, Network Operations Director</td>
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<td>Revised to show TP launch on 10/1/23 and MD launch on 4/1/23</td>
<td>7, 60</td>
<td>Per the Department</td>
<td>K. Kern, Network Operations Director</td>
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<tr>
<td>Revised to clarify that PH providers can contract directly with Sandhills Center TP</td>
<td>8</td>
<td>Clarification purposes</td>
<td>K. Kern, Network Operations Director</td>
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<td>Revised to reflect that providers have 180 days to resubmit replacement or voided claims</td>
<td>95</td>
<td>Per the Department</td>
<td>K. Kern, Network Operations Director</td>
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<td>Added, “Medicaid Direct PHIP” to sentence to reflect both plans</td>
<td>108</td>
<td>Per the Department</td>
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<td>6/2/2023 Clarified member disenrollment pertains to BH/IDD TP, SFS, and PHIP</td>
<td>21</td>
<td>Per the Department</td>
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<td>Corrected Rockingham Country Transportation link</td>
<td>52</td>
<td>Per the Department</td>
<td>K. Kern, Network Operations Director</td>
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<td>Added a column for Medicaid Direct to</td>
<td>34-51</td>
<td>Per the Department</td>
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<td>Differentiate between Medicaid Direct and Medicaid Direct PIHP</td>
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<td>Deleted all references to Provider Affiliation Form as well as clarified that all contracting decision are made utilizing the Department’s Centralized Credentialing process</td>
<td>79-81</td>
<td>Per the Department</td>
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<td>6/16/23 Corrected links to Rockingham County Public Transportation</td>
<td>54</td>
<td>Per the Department</td>
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<td>Clarified Member Disenrollment information</td>
<td>22-23</td>
<td>Per the Department</td>
<td>J. Islam, Customer Services Director</td>
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