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ADDENDUM
Section I: INTRODUCTION AND OVERVIEW

A Message from Cardinal Innovations Healthcare

Welcome to the Cardinal Innovations Healthcare Provider Network. We value strong providers that are committed to the principles of delivering care with dignity, quality, inclusion and self-determination. We look forward to working with those that share our vision of an elite provider network that observes the latest, evidence-based, and person-centered practices to improve the health and wellness of our members.

We will honor our relationship with respect, support, appreciation, transparency and trust. We ask for your reciprocity, and in turn, we will support you in your efforts to serve our state’s most vulnerable individuals. This is our joint responsibility, and together we will all succeed and thrive.

As an LME/MCO, the role of Cardinal Innovations is to facilitate and oversee the delivery of services for people with mental health, intellectual/developmental disabilities and substance use conditions. We have many members, families and stakeholders that depend on us, and we believe that extends beyond our provider network to identify and leverage specialized supports and community services on behalf of people with behavioral health conditions. Our philosophy is based on the widely recognized best practice that individuals thrive when they are integrated into their communities and are treated in the least restrictive settings possible.

While the future of healthcare delivery in North Carolina is ever-evolving, there will always be a place at Cardinal Innovations for providers that offer person-centered, evidence-based and outcome-oriented services. We welcome you to our network.
Section II: GOVERNANCE AND ADMINISTRATION

The Board of Directors of Cardinal Innovations Healthcare is responsible for overseeing the business and affairs of the Cardinal Innovations. Consistent with § 122C-118.1 of the General Statutes, the Board is composed of directors that have certain professional experience and expertise, including, without limitation, healthcare and social services, finance, law, insurance, healthcare administration and other related fields. The Board is required to meet at least six times per year. The Board has several standing committees, including an Executive Committee, a Finance and Audit Committee, a Performance, Evaluation and Compensation Committee, and a Governance Committee. The Board, among other things, is responsible for providing financial oversight and approving the organization’s annual budget.

A. Network Management

The Network Management Department is responsible for the development and maintenance of the Cardinal Innovations Provider Network in order to meet the needs of members by ensuring availability of high-quality providers and access to behavioral health service choices. Network Management closely monitors provider enrollment, credentialing/re-credentialing, practitioner-related demographics, and other data to ensure the availability of adequate numbers and types of providers to meet member demand. The following resource link to the provider page of the Cardinal Innovations website is provided for further guidance:

https://www.cardinalinnovations.org/Providers

Additionally, you may wish to reference our Provider Orientation Companion here.

Your responsibilities as a Cardinal Innovations Contracted Provider are to:

- Enroll as a Medicaid provider with the state of North Carolina through its NCTracks system and maintain that enrollment in good standing at all times
- Provide services for which you are qualified, credentialed and enrolled to provide
- Be responsive to the cultural and linguistic needs of the members whom you serve
- Provide services only at endorsed service sites as outlined in your contract
- Obtain authorizations as required for contracted services
- Adhere to all performance guidelines in your contract, and work to meet the needs of members through best-practice approaches to treatment and supports
- Be knowledgeable about and implement any deliverables associated with grants and special funding allocated to you under a Designated Funding Authorization issued by Cardinal Innovations
Cardinal Innovations Healthcare Provider Manual

SECTION II: GOVERNANCE AND ADMINISTRATION

• Work in a solution-focused, collaborative manner with Cardinal Innovations
• Work with Cardinal Innovations to mediate problems and concerns
• Work in collaboration with other providers, members and their families
• Stay abreast of all relevant changes and updates that are disseminated to you through any of the communication methods used by Cardinal Innovations

Cardinal Innovations’ responsibilities to Providers are to:

• Actively recruit high quality providers that share Cardinal Innovations’ mission, vision and core values
• Credential and re-credential practitioners who meet Cardinal Innovations’ requirements for obtaining credentialing privileges
• Identify gaps in services or capacity within the Provider Network and develop strategies to address those issues through existing providers and/or the enrollment of new providers
• Identify and respond to the identified training needs of providers and, if possible, facilitate or provide the training
• Support the development of best practices or emerging best practices
• Respond to requests for enrollment in the Provider Network according to the demonstrated needs for additional provider capacity

Cardinal Innovations website, its Communications Bulletins and/or its InfoSource Newsletter
• Update the Cardinal Innovations Provider Manual as necessary to reflect material changes and communicate these changes to the Provider Network

B. Clinical Operations

The Clinical Operations Department includes the Access Call Center, Clinical Support Unit, and Utilization Management Unit. The Clinical Operations Department conducts authorization and care management functions, performs utilization management and utilization review activities, maintains telephonic access for providers and members, and coordinates the crisis response system. Clinical Operations defines review dates, completes preservice, concurrent and retrospective reviews and responds to appeals. Additionally, the department researches utilization trends, identifies areas for further study and reviews/develops clinical guidelines and written protocols. This unit supports the Clinical Advisory Committee. The Chief Medical Officer oversees all clinical activities performed in the Clinical Operations Department.

C. Utilization Management Functions

The Utilization Management Unit determines whether a member meets and continues to meet medical necessity criteria and target population requirements for the frequency, intensity and duration of requested services. Our goal is to ensure that members receive the right service, at the right time and at the right level – creating the most effective and efficient treatment possible. This work is accomplished through consistent and uniform application of medical necessity, Clinical
Coverage Policies, evidence-based practices, and state and federal waivers. Authorization decisions are made according to each member’s individual clinical needs for the appropriate type of care, service, frequency and intensity of services in the appropriate clinical setting. Utilization Management Care Managers assist the provider in managing a member’s care needs and identification of appropriate services.

- **Utilization Management**
  The primary function of Utilization Management (UM) is to make authorization decisions by conducting reviews of services based on medical necessity criteria for the frequency, intensity and duration of the service request. UM is the process of evaluating the necessity, appropriateness and efficiency of behavioral health care services against established guidelines and criteria. UM includes activities such as ongoing evaluation of timeliness to care, as well as analysis of utilization patterns to monitor for both under- and over-utilization, gaps in care and unnecessary use of restrictive service models.

- **Utilization Review**
  The primary function of Utilization Review (UR) is to monitor the utilization of services and review service notes and treatment plans to evaluate and ensure (1) that services are being provided appropriately in accordance with treatment plans, service definitions, waiver compliance, established benchmarks and clinical guidelines; (2) that services are consistent with the authorization and approved Person-Centered Plan (PCP), Individual Support Plan (ISP) or other service plan and (3) that services continue to meet the needs of the member. UR is an audit process that involves closely looking at a sample of services that have been provided. Relevant information from the member’s record (assessment information, treatment plan and progress notes) is evaluated against all applicable criteria. This audit is completed during re-authorization or after the service has been provided. The outcome of this review can indicate whether provided services did not meet medical necessity, identify situations where the member did not receive the correct service(s) or needed care, and help determine the overall quality of care provided. UR of a case can be a random, routine review or a targeted, focused review. A targeted review could result if UM has data that indicates a high utilization of service(s) and/or frequent hospital admissions. Indicators will be identified to select cases for review, such as high utilization of service or frequent hospital admissions, as well as random sampling.
  - **Focused Reviews** target specific clinical concerns that are identified as having the potential to be outside the norm according to utilization data and use of emergency services. Samples of focused reviews may include the following.
    - High-risk members. Examples may include, but are not limited to, members who have been hospitalized more than once in a 30-day period; members with intellectual and developmental disabilities who are identified as having community safety risks; children and youth who are involved with law enforcement; or pregnant females actively using substances.
— 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.

— Over-utilization of services. Samples include members who continue to access crisis services with no engagement in other services.

— Services infrequently utilized. Samples include an available practice that is not being used.

— High-cost treatment. Samples include members in the top 10% of claims for a particular service.

○ **Routine Utilization Reviews** focus on the efficacy of the clinical processes in cases as they relate to reaching the goals in the member’s PCP/ISP. Cardinal Innovations also reviews the appropriateness and accuracy of the service provision in relation to the authorizations. All providers contracted with Cardinal Innovations who are currently serving Cardinal Innovations members are subject to utilization reviews to ensure that clinical standards of care and medical necessity are being met.

The criteria used in the UR processes are based on the most current approved guidelines and service manuals utilized under the NC MH/DD/SAS Health Plan and NC Innovations Waivers and processes for NC state services. These documents include, but are not limited to, the following:

- Current NC Medicaid State Plan clinical coverage policies with admission, continuation and discharge criteria
- NC Innovations Clinical Coverage Policy
- Integrated Payment and Reporting System (IPRS) Service Definitions
- Cardinal Innovations’ Medicaid 1915(b) Waiver Plan
- Current approved NC MH/DD/SAS service records documentation rules
- Cardinal Innovations approved Clinical Practice Guidelines which are located on the website in the Resource Library at: [https://www.cardinalinnovations.org/Resources/Resource-Library](https://www.cardinalinnovations.org/Resources/Resource-Library)

D. **Quality Management**

The Quality Management (QM) Department has oversight for quality assurance and improvement activities throughout the Cardinal Innovations system. QM supports a Global Continuous Quality Improvement (GCQI) system that includes a representative sample of volunteers from the Provider Network. QM provides technical assistance to providers on standards, requirements, quality improvement, indicators and targets, client rights, health/safety and other critical areas of performance as needed. QM provides monitoring information to the Client Rights and Consumer and Family Advisory Committees (CFACs), as well as the Regional Health Councils, and tracks, evaluates and investigates incidents. QM also implements a system of review, monitoring and investigation. QM utilizes the NC DHHS Monitoring Process for providers as part of review activities. In addition to the NC DHHS Monitoring Process, QM completes Home and Community Based Services (HCBS) reviews and targeted monitoring of quality initiatives for provider performance, which
includes, but is not limited to, Clinical Quality Reviews, Focused Reviews and investigations into concerns and grievances. More information can be found in the Resource Library at https://www.cardinalinnovations.org/Resources/Resource-Library and searching Quality Management.

Your responsibilities as a Cardinal Innovations Contracted Provider are to:

- Cooperate fully with any review, investigation, grievance, complaint, concern inquiry, follow-up and/or audit; and provide to Cardinal Innovations requested records and documentation needed to resolve issues
  - All requested information should be provided within the timeframe specified (the timeframe will vary based upon the circumstances)
- When requested by Cardinal Innovations staff, provide immediate on-site access to hard copy records/documentation or access to electronic files (i.e., progress notes, goal documentation, etc.)
- Respond to correspondence from Cardinal Innovations staff in a timely manner. Correspondence includes, but is not limited to, phone calls/voicemails, emails and mail. Providers are expected to check their mail on a consistent basis to prevent the return of certified mail from Cardinal Innovations. In addition, providers should check and respond to emails and voice mail messages within three (3) business days
- Maintain systems, procedures and documentation that demonstrates compliance with all applicable federal, state and local rules, laws and practices, including:
  - Conducting self-monitoring activities for compliance
  - Developing and implementing, within given timelines, plans of corrections and/or making paybacks with any area found out of compliance during Cardinal Innovations monitoring activities
- Maintain internal systems, procedures and documentation that demonstrate compliance with Cardinal Innovations requirements as outlined in the contract and this Manual
- Conduct self-monitoring activities for compliance and develop/implement plans of correction for any identified area of non-compliance
- Self-initiate paybacks for services billed in error or without supporting documentation
- Comply with North Carolina state rules for service records, confidentiality and record retention
- Ensure all billing submitted for payment is supported by documentation that meets all requirements
- Notify Cardinal Innovations of any concerns you have in regards to our actions
- Collaborate with Cardinal Innovations on the development of solutions to issues
- Participate in ongoing training opportunities as applicable
- Provide opportunities for direct care staff to participate in Person-Centered Thinking training every two years and, thereafter, utilize Person-Centered Thinking tools in service delivery (ex., relationship map, learning log, matching, communication chart, 4+1, etc.)
- Maintain services at an optimal level to meet member needs by providing services
in accordance with Cardinal Innovations Practice Guidelines and Quality Initiatives

- Render services in accordance with best practice and Practice Guidelines.
- Develop and implement a system of continuous quality improvement which includes – at a minimum – the development of systems to self-evaluate services, systems to evaluate collected data and identify needed areas of improvement, implement strategies to address areas of improvement and continual evaluation/refinement of processes
- Develop/implement systems to assess services to ensure members are benefiting from the services provided
- Submit documentation for all grievances and/or incidents, including requested follow-up documentation, as defined by state rules, to Cardinal Innovations within given timelines set by the organization and cooperate fully with needed follow up from Cardinal Innovations
- Notify Cardinal Innovations within the time limitations identified in Article II of the General Conditions of the Procurement Contract of any Type A or Type B citations, violations or sanctions received from the Division of Health Services Regulation. This includes for contracted and non-contracted sites
- Post copies of current licenses from the NC Division of Health Service Regulation (DHSR) at all sites at all times
- Maintain current and signed copies of the following documents on-site where services are provided:
  1. The Individual Support Plan (ISP, Person-Centered Plan (PCP) and/or Treatment Plan
  2. The Task Analysis (TA)
  3. The Behavior Support Plan (BSP)
  4. Seizure Logs (if applicable)
  5. Service grids for the current month
  6. Medication Administration Records (MARs) for the current month

Additionally, all staff providing services must be informed and trained on each of the above documents, including understanding the purpose of the documents.

- Maintain the following documentation standards to include, but not limited to:
  1. Member documentation must include the correct Cardinal Innovations’ member ID number, Medicaid ID number and MCO name
  2. Service documentation must include the full and correct service name of the service being rendered (including the level of service – i.e., documentation should reflect Residential Supports AFL – Level 3 as opposed to RS)
  3. Service grids must be completed for each date of service within seven days of the provision of the service (the data on service grids should be recorded daily for each date of service)
  4. Service grids must include short-term goals and service frequency that are consistent with the short-term goals and service frequency as listed on the TA
  5. Service grids must include every day of the month (if the service grid template is printed on both sides of the page, both sides must be included in the member record)
  6. Signature pages from previous or expired documentation shall never be used as a signature page for current/revised/updated
documentation. New signature pages are required for all new documents.

7. Services or medication administration shall not be documented prior to the provision of services/administration of medication (future-dating service grids/MARs or competing service grids/MARs in advance is not permissible).

8. TAs must be written to include clear, functional steps on how to implement each goal as stated in the ISP. All staff providing services must understand the TA and be able to implement the steps in the TA as written with the member/family.

9. TAs must be updated/revised along with the ISP (effective dates must match the ISP’s effective dates).

10. Target dates on TAs must be current and consistent with the target dates on the ISP.

11. Short-term goals/steps listed in the TA must be consistent with the goals listed on the Service Grid.

12. TAs must include all short-range goals, steps on how to manage those goals, who is responsible for the goals, service frequency, and signatures from both the legally responsible person and the QP who developed the TA.

- Maintain the following Medication Administration Standards (unless there is an exception for “F” designated facilities as outlined in 27G. 5600) to include, but not limited to:

1. Staff may only administer over-the-counter medications that are included on standing orders. Otherwise, a prescription will be required.

2. Medications must be administered in a timely manner after the date prescribed. It is not acceptable and best practice to wait several days to fill the prescription.

3. MARs must be fully completed for the month, for each medication and for each time the medication is administered. The reason for any blanks on the MAR must be documented on the MAR.

4. Medications must be stored securely. If medications must be refrigerated, those medications must be stored in a locked container, separate from other non-refrigerated medications and from food items.

5. MARs for PRN medications (medications prescribed on an as-needed basis) must not designate specific administration times.

6. MARs must be initialed and signed by the staff who has administered the medication to the member.

7. There may only be one copy of the monthly MAR for each member (there may not be multiple copies of the same MAR for the same month/member at one location).

8. Only a physician may approve the discontinuation of medications that have been prescribed and documentation of this discontinuation should be obtained (provider staff may not choose, without physician advisement, to not refill a medication).

9. Physician’s orders/medication labels must be consistent with medications documented on MAR.

10. Staff must indicate that medications have been administered by writing their initials on the corresponding medication name/time on the MAR. Slash marks or code letters that are not included on the MAR key may not be used.
• Provide services at the frequency and location specified in the ISP
• Follow the below expectations when providing Day Supports to include, but not limited to:
  1. Day Support staff must be with the member at all times during the provision of Day Supports
  2. The location of all members must be reported/known at all times during the provision of Day Supports
  3. Day Supports may not be provided in the home of the member or the staff and members may not be taken to their homes or the homes of the staff or others at any time during the provision of Day Supports
  4. Members must be engaged in activities at all times during the provision of Day Supports
• Not exceed the number of units provided/billed for services allotted per week as authorized by Cardinal Innovations, as applicable
• Follow the specifications in the Member Specific Agreement. Member Specific Agreements are member and site-specific; therefore, members cannot be moved to other sites or services without the prior notification to and approval by Cardinal Innovations
• Provide supervision of staff and monitoring of services on site where and when services are being provided

Cardinal Innovations’ responsibilities to Providers are to:
• Evaluate new applicants for enrollment in the Cardinal Innovations Provider Network and determine the prospective provider’s qualifications for enrollment
• Conduct on-site monitoring (if applicable) of providers to ensure appropriate implementation of services, member health and safety, member satisfaction, positive outcomes for members and compliance with provisions of the Procurement Contract
• Conduct routine auditing of provider documentation in relation to appropriateness and accuracy of information submitted for authorizations and payment
• Ensure provider and licensed practitioner compliance with treatment record standards and confidentiality practices and to follow up on any areas of concern or out of compliance
• Implement the Cardinal Innovations Compliance Plan and activities related to ensuring Cardinal Innovations staff complies with rules, laws and regulations
• Monitor, on an on-going basis, systems within Cardinal Innovations and the provider network at large to check for fraud and abuse
• Coordinate a system of continuous quality improvement for Cardinal Innovations and the provider network that includes ongoing evaluation and planning in relation to needed areas of improvement in the service delivery system
• Review, mediate and/or investigate grievances or concerns received regarding the quality of services provided by any provider; ensure appropriate corrections are implemented as needed
• Review critical incidents that occur within the provider network; ensure that all appropriate follow up is completed and that the rights of members have been protected
• Monitor critical incident data from across the Network and evaluate for trends and patterns
• Ensure publication and availability of the review and monitoring standards for any monitoring process used by Cardinal Innovations, including the NC DHHS Monitoring Process

• Review any Type A or Type B citations/violations/sanctions a provider may receive from the Division of Health Service Regulation, and determine the impact of the citation/violation/sanction on the members served by that provider
  o The Cardinal Innovations Network Management Cross-Departmental Managerial Workgroup (NMCDMW) will make determinations regarding the provider’s eligibility for continued participation in the Cardinal Innovations Provider Network

• Review any violation/sanction a practitioner may receive from a licensing board and determine the impact of that violation/sanction on members served by that practitioner
  o The Cardinal Innovations Credentialing Committee and the NMCDMW will make determinations regarding the practitioner’s eligibility for continued service delivery to Cardinal Innovations members

E. **Program Integrity/Special Investigations Unit**

Program Integrity, otherwise known as the Special Investigations Unit (SIU), is part of the Office of General Counsel and is comprised of Clinical and Special Investigators and Data Analysts whose primary purpose is to investigate allegations of healthcare fraud, waste and abuse.

If a complaint is received by the SIU that involves a provider, an investigation may or may not be conducted with prior notice to the provider. Contracted providers shall cooperate fully with all investigations. The provider may be provided a written summary of any findings resulting from an investigation. For further detail on this issue, please see the General Conditions of the Procurement Contract.

The SIU does not rely on any one source to aide in the detection of fraud, waste or abuse. Anyone may provide a tip to the SIU team and every person is crucial in preventing and detecting fraud, waste and abuse.

Medicaid fraud typically includes any of the following:

• Knowingly submitting, or causing to be submitted, false claims or making misrepresentations of fact to obtain a federal health care payment for which no entitlement would otherwise exist
• Knowingly soliciting, receiving, offering, and/or paying remuneration to induce or reward referrals for items or services reimbursed by federal health care programs
• Making prohibited referrals for certain designated health services

Here are some examples of Medicaid fraud:

• Billing Medicaid for appointments the member failed to keep
• Knowingly billing for services at a level of complexity higher than services actually provided or documented in the file
• Knowingly billing for services not furnished, supplies not provided, or both, including falsifying records to show delivery of such items
• Paying for referrals of Federal health care program beneficiaries

Providers and others may contact Cardinal Innovations via any of the following methods to report suspected fraud, waste or abuse:
Call our toll-free Fraud and Abuse Line to leave a confidential voicemail at 1.800.357.9084

- Complete our Online Suspected Fraud and Abuse Reporting Form; the link to this form can be found at: https://www.cardinalinnovations.org/report-fraud-and-abuse
- Write to us at: Cardinal Innovations Healthcare Attention: Program Integrity Unit 550 South Caldwell St., Suite 1500 Charlotte, North Carolina 28202

When fraud is substantiated, the appropriate administrative action is taken by the SIU.

These actions may include:

- Requesting paybacks
- Requesting a plan of correction for out of compliance items
- Making a referral to other internal or external entities for possible sanctioning

Your responsibilities as a Cardinal Innovations Contracted Provider are to:

- Cooperate fully with any investigation conducted by the SIU and provide records and documentation as requested
- Provide all requested information within the timeframe specified (the timeframe will vary based upon the circumstances)
- Maintain systems, procedures and documentation that demonstrates compliance with all applicable federal, state and local rules, laws and practices, including:
  - Complete Provider Self Reports when fraudulent, wasteful or abusive practices are discovered within your own organizations; providers are obligated to contact the SIU
  - Report discovered billing errors to the Cardinal Innovations Service Center
  - Develop and implement, within given timelines, plans of corrections and/or make paybacks, as requested, for any area identified to be out-of-compliance during SIU investigations
- Maintain internal systems, procedures and documentation that demonstrate compliance with Cardinal Innovations’ requirements as outlined in the contract and this manual
- Notify Cardinal Innovations of any concerns you have regarding our findings/actions by following the guidelines for requesting reconsideration of those actions (see Section XII for information concerning the Reconsideration process)

Cardinal Innovations’ responsibilities to Providers and Members are to:

- Conduct investigation on any received allegation, no matter the source, in order to ensure that state, federal and Medicaid guidelines were implemented, and determine the appropriate course of action
- Review provider documentation in relation to appropriateness and accuracy of information submitted for payment/reimbursement
- Ensure provider and licensed practitioner compliance with treatment record standards and follow up on any areas of concern that are found to be out-of-compliance
- Implement the Cardinal Innovations Compliance Plan and activities related to ensuring Cardinal Innovations’ staff compliance with rules, laws and regulations
• Use Data Analytics to monitor, on an ongoing basis, systems within the provider network at large to check for fraud, waste and abuse
• Review outcomes of investigations, determine the impact of items found to be out-of-compliance on the members served by that provider and, when appropriate, make referrals for possible sanctioning

F. Finance

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

Your responsibilities as a Cardinal Innovations Contracted Provider are to:

• Verify member insurance coverage at the time of referral, admission or each appointment and on a quarterly basis
• Determine the member’s ability to pay using the Sliding Fee Schedule for all designated non-Medicaid services based on your agency’s contract requirements
• Bill all first and third party payers prior to submitting claims to Cardinal Innovations
• Report all first party required fees and third party payments and denials on the claim you submit to Cardinal Innovations
• Submit Clean Claims electronically within 90 days of the date of service unless otherwise stated in your contract
• Report all billing errors to your Cardinal Innovations Claims Specialist

Cardinal Innovations’ responsibilities to Providers are to:

• Manage your Accounts Receivable to prevent unnecessary rebilling of services paid
• Submit all documentation required for federal, state, or grant reporting requirements including, but not limited to, required member enrollment demographics that must be reported to the state of North Carolina by Cardinal Innovations

G. Service Center

The Cardinal Innovations Service Center brings together all functions involved in the claims process, including provider enrollment, contracting, member eligibility and claims processing. Our model is designed to employ
highly integrated state-of-the-art technology to support business processes.

As a cross-functional department, the Service Center delivers increased efficiencies that result in lower administrative costs to Cardinal Innovations’ providers across the state. Through the standardization of operating procedures, structured communication through our management system and dedicated professionals who perform these functions, customer service is significantly enhanced. Together these efforts support Cardinal Innovations’ mission to provide access to quality services with members always in mind.

Your responsibilities as a Cardinal Innovations Contracted Provider are to:

- Verify member insurance coverage at the time of referral, admission or each appointment and on a quarterly basis
- Determine the member’s ability to pay using the Sliding Fee Schedule for all designated non-Medicaid services based on your agency’s contract requirements
- Bill all first and third party payers prior to submitting claims to Cardinal Innovations
- Report all first party required fees and third party payments and denials on the claim you submit to Cardinal Innovations
- Professional providers: Submit clean claims electronically within 90 days of the date of service unless otherwise stated in your contract
- Hospital providers: Submit clean claims electronically within 180 days of the date of service
- Submit clean Coordination of Benefit claims electronically within 180 days of the date of service
- Notify the Service Center of any billing errors in a timely manner
- Manage your Accounts Receivable by utilizing the reconciliation tools available to you (Remittance Advice, 835s and Claim Status Report on Provider Direct) which will help to prevent unnecessary rebilling of services paid

Cardinal Innovations’ responsibilities to Providers are to:

- Monitor retroactive Medicaid eligibility and recovery of funds
- Proactively manage claims processing to achieve timely adjudication and payment to providers
- Closely work with other Cardinal Innovations internal departments (Network and Quality Management) to timely resolve issues affecting providers
- Audit providers for Coordination of Benefits (COB)
- Pay Clean Claims within Prompt Pay Guidelines

H. Information Technology (IT)

The Cardinal Innovations Provider Direct application is available to help providers manage the various activities they must perform related to Cardinal Innovations members. Some of these activities include, but are not limited to: enroll new members, update clinical documentation, create treatment authorization requests, submit claims, view client information, and view claims status. If your provider agency wishes to access Provider Direct and your agency has not been granted a system administrator login credential, you must complete a System Administration Designee Request Form.

Each provider must have at least one system administrator designated for their organization who will be responsible for managing user account credentials.
The System Administrator for Provider Direct is required to submit one contact for the company to create and disable Provider Direct System Logins via the System Administrator Designee Request Form (ITPD-SYSADM). Provider Direct is the web based system used to request/complete enrollments, authorizations and billing. Employees at the company will need to request user accounts from the designated Provider Direct System Administrator. The System Administrator will be responsible for creating user accounts in Provider Direct. The company may also name a backup System Administrator. If the System Administrator or back up leaves the company, the signatory of the System Administrator Designee Request Form is responsible for immediately notifying Cardinal Innovations at pdsystemadmin@sp.cardinalinnovations.org so that the permissions may be terminated. A new System Administrator Designee Request Form must be completed to designate a new System Administrator. The System Administrator must be a direct employee of the organization and have an email address that is not shared.

The System Administrator(s) identified on the System Administrator Designee Request Form must complete a web-based System Administrator Rules and Regulations training before they will be assigned login credentials. The System Administrator will receive the training link information once the System Administrator Designee Request Form is approved. The System Administrator should be familiar with the Tasks Required to Obtain a Provider Direct Login document to understand the tasks that must be completed to obtain a Provider Direct login. It is mandatory that Provider Direct system user accounts are managed at every company by a System Administrator. When users leave the organization or no longer have a need to use Provider Direct, the System Administrator is responsible for disabling user logins within two business days of the last day of use. Quarterly audits will be conducted by Cardinal Innovations to validate active users.

In an effort to assist providers with managing user access to Provider Direct, the following communications are sent to System Administrators throughout the year:

90 Day Notifications – These alerts are sent via email on the first Monday of every month.

Requirements for providers who receive 90-day alerts:

- Alerts are sent to System Administrators via email. A list of users who have not logged into Provider Direct in the past 90 days is included in the email alert.
- Providers are asked to conduct a self-audit of their Provider Direct user accounts to determine if active users continue to need access to Provider Direct. If users on the list continue to need access, the System Administrator should notify the users identified in the alert and have them log into Provider Direct. They also should ask the user to log in at least once every 90 days to eliminate the 90-day notifications.
- If user(s) no longer requires access to Provider Direct, the System Administrator should go into Provider Direct and deactivate the user by referring to the System Administrator User Management Guide under the training tab in Provider Direct.
- Providers must take action within (2) two business days of the date the alert was sent to ensure that the member’s
protected health information (PHI) remains secure.

180 Day Deactivations – The second Monday of every month applicable providers receive these alerts.

Requirements for providers who receive 180-day alerts:

- Users who appear on this email alert have appeared on the 90-day notifications list for at least three (3) consecutive months. When no login action has been taken after 180 days by a user, they are systematically deactivated.
- No action is required of the System Administrator or the back-up System Administrator if the users on the list no longer require access to the Provider Direct system.

Quarterly Provider Direct Audits

Each provider with Provider Direct access will be audited once per year. Quarterly one-fourth of the provider network is audited.

Required response to an audit:

The audit notification is sent to System Administrators via their email address located in Provider Direct and includes a list of all active users in Provider Direct. The System Administrator(s) is required to comply with the following audit requests:

1. Review the list and confirm which users require access to Provider Direct as well as the users that no longer require access
2. Reply to audit email within five (5) business days
3. In your email reply, indicate the deactivation date for users that no longer require access
4. Go into Provider Direct and deactivate all users that no longer require access (refer to the System Administrator User Management Guide under the training tab in Provider Direct for instructions to deactivate users)

The organization must comply with audits conducted by Cardinal Innovations to validate active Provider Direct logins for System Administrators and users. Failure to comply with audit requests will result in logins associated with the company being disabled; which will impact enrollments, authorizations and billing.

Providers may elect to submit their claims using the HIPAA Standard Electronic Transaction Sets (837’s). Providers may elect to submit their 837 files by uploading within Provider Direct, submitting to a secure File Transfer Protocol (FTP) with Cardinal Innovations or submitting the file(s) using an approved clearing house. To submit 837 files directly to Cardinal Innovations, either through an FTP site or uploading within Provider Direct, the provider must first submit a test file by sending a zipped, password-protected 837 file attached to an email directed to EDISupport@cardinalinnovations.org. You must also send a separate email to EDISupport@cardinalinnovations.org with your password for the encrypted 837 file. If you wish to request an FTP account with Cardinal Innovations, you must submit a completed FTP Access Change Request Form (https://www.cardinalinnovations.org/Cardinal.Innovations/media/Documents/Resource%20Library/Form/ftp-access-change-form.pdf) to EDISupport@cardinalinnovations.org.

If you would like to use a clearing house to submit your 837 files, you may contact Change Healthcare, formerly Emdeon, the only organization that Cardinal Innovations has approved for providers to use for payment cycle solution services of this type.
To establish an account with Change Healthcare, you may contact [http://www.changehealthcare.com](http://www.changehealthcare.com). If you elect to send your claims files through Change Healthcare, you will not be required to submit a test file to Cardinal Innovations.

Provider Direct users can review training material located on the Training link in Provider Direct to learn how to perform various functions within Provider Direct. Cardinal Innovations Healthcare is committed to continuing to increase the functionality and usability of its product for provider use. If you have suggestions on how we can improve Provider Direct, please select the feedback button in Provider Direct and share your suggestion(s).

Technical assistance for Provider Direct can be obtained by selecting the feedback button in Provider Direct or by calling 855.270.3327 and selecting Option 3. When requesting technical assistance using the feedback button, provide as much detail related to the issue as possible and include the specific record ID that was saved (when applicable).

Minimum software/hardware requirements for the user of Provider Direct are located in the table below:

<table>
<thead>
<tr>
<th>Internet Connection:</th>
<th>High-speed, broadband or better</th>
</tr>
</thead>
<tbody>
<tr>
<td>Operating System:</td>
<td>Windows 7 or higher</td>
</tr>
<tr>
<td>Web Browser:</td>
<td>IE10 or IE11</td>
</tr>
<tr>
<td></td>
<td>Google Chrome – current version</td>
</tr>
<tr>
<td></td>
<td>Firefox – current version</td>
</tr>
<tr>
<td></td>
<td>Safari – current version</td>
</tr>
</tbody>
</table>

Cardinal Innovations continues to develop our systems to refine and enhance its capabilities to support our changing business operations. For up-to-date information on system enhancements to Provider Direct, refer to the training videos within Provider Direct.

Complete and accurate data are critical for Cardinal Innovations reporting to the state; therefore, Cardinal Innovations is dependent upon our providers to collect and report this data to us. The following resource links are provided for further guidance:

Provider Direct Login: [https://providerdirect.cardinalinnovations.org](https://providerdirect.cardinalinnovations.org)


Submit a System Administrator Login Form: pdsystemadmin@sp.cardinalinnovations.org.

**Your responsibilities as a Cardinal Innovations Contracted Provider are to:**

- Maintain connectivity requirements noted below
- Always provide complete and accurate data in all submissions to Cardinal Innovations
- Follow technical support procedures as identified by Cardinal Innovations
- Ensure your Provider Direct System Administrators maintain active users; promptly disable users as necessary
- Comply with audits conducted by Cardinal Innovations to validate active Provider Direct logins for System Administrators and users
Cardinal Innovations’ responsibilities to Providers are to:

- Maintain the server that provides interface for Provider Direct functions
- Provide Software Support technical assistance to support provider interface
  - Support Hours Monday through Friday, 8:30 a.m. to 5 p.m.
  - claims@cardinalinnovations.org
  - Support can be reached by telephone at 855.270.3327, Option 3
- Provide regular training for new providers on Provider Direct via training webinars

I. Care Coordination Department

The Cardinal Innovations Care Coordination Department provides a number of supports for specialty populations with our most high-need, high-risk members. Care Coordination is a managed care tool that is designed to proactively intervene and ensure optimal care for individuals. Staff members coordinate and monitor care across the continuum of healthcare providers and across various care settings. Coordinators also work in conjunction with the individual, providers and others to improve outcomes for the member and to make the best use of healthcare dollars. This is both a risk management and a quality management function that has a significant impact on the management of resources and the quality of care for an individual. The goal of Care Coordination is to assist individuals, in collaboration with existing enhanced behavioral health providers, in achieving optimum health and functional capability, in the right setting and in a cost-effective manner.

Cardinal Innovations prioritizes and assigns a Care Coordinator for members within special healthcare needs populations. High-risk individuals are assigned a Care Coordinator when indicated based on our state contract and waiver requirements. Members receiving Care Coordination intervention are those who require extensive use of resources and need assistance navigating the system to facilitate appropriate delivery of care and services. Examples of members who receive Care Coordination include, but are not limited to, the following:

- Members with history of failed community transition following discharge from behavioral health inpatient treatment or Emergency Department behavioral health treatment
- Members authorized for Child Residential or Psychiatric Residential Treatment Facility (PRTF)
- Adults with severe mental illness (SMI) living in or at risk of admission to Adult Care Homes
- Members currently in detention with anticipated release within the next 30 days (or who have been released within the last 30 days) and do not have an enhanced behavioral health provider
- Members in need of residential transition assistance due to imminent risk
- Members enrolled in the NC Innovations Waiver

Members receiving direct Care Coordination intervention often have existing behavioral health providers. Care Coordination is a supplement to the role of providers, not a replacement. Care Coordinators work in partnership with the member and involved providers to address needs and barriers to treatment engagement.
Your responsibilities as a Cardinal Innovations Contracted Provider for people receiving Care Coordination are to:

- Actively participate in the PCP/ISP process with others serving the individual to develop or enhance a comprehensive treatment plan
- Development of treatment and/or rehabilitative programs in accordance with the PCP/ISP
- Communicate and collaborate with Care Coordinators about the needs of individuals that you support
- Notify Care Coordinators of any changes, incidents and other information of significance related to the members that you serve

Cardinal Innovations’ responsibility to Providers is to conduct the following activities for members who are receiving Care Coordination:

- **Assessment**
  - IDD Care Coordinators will complete or arrange for needed assessments to identify support needs and to facilitate person-centered planning processes
  - MH/SUD Care Coordinators will complete or arrange for needed clinical assessments for individuals in order to identify any ongoing special conditions that require treatment or monitoring

- **Ensuring the Development of an Individualized PCP/ISP**
  - IDD Care Coordinators will develop the ISP for NC Innovations Waiver participants in collaboration with the individual and his/her support team. For other individuals, the IDD Care Coordinator will ensure that an ISP is developed
  - MH/SUD Care Coordinators will ensure that a Person-Centered Plan is developed by the Behavioral Health Clinical Home, in collaboration with the individual, legally responsible person, and other members of the treatment team. Person-Centered Plans should be completed by the designated provider of an enhanced service. In some situations, the MH/SUD Care Coordinator develops the Person-Centered Plan while at the same time working on linkage to an enhanced behavioral health provider (e.g., child or adolescent current receiving Outpatient treatment who needs child Residential Level III)

- **Treatment Planning Care Coordination**
  - Both IDD and MH/SUD Care Coordinators will coordinate services for individuals who have been identified as needing assistance accessing the care that they need; activities will involve working across the Cardinal Innovations Network and with other systems of care, including Primary Care

- **Monitoring**
  - IDD Care Coordinators will complete on site visits for NC Innovations Waiver participants to monitor the health and safety of the individual, to assess the satisfaction of individuals served and to monitor implementation of the Person-Centered Plan
  - MH/SUD Care Coordinators will complete on-site and/or telephonic monitoring to ensure engagement of the individual and provider, to monitor implementation of the Person-Centered Plan and to ensure
J. Community Operations

The Community Operations Department engages community advisory boards, county leaders, elected officials and other key stakeholders to ensure Cardinal Innovations is involved and present within the communities we serve. The Community Operations staff educates members and their families on the resources available through Cardinal Innovations and within their communities, and assists in the navigation of those systems and supports. In addition to members, families and elected officials, the staff strategically engages key community stakeholders such as representatives from schools, social services, the legal system, and law enforcement.

Community Operations is comprised of three distinct units: Community Relations, Community Engagement and Member Engagement.

Community Relations, through our Regional Executives (formerly Senior Community Executives), provides an executive-level link between Cardinal Innovations and local leaders, elected officials and other key stakeholders who represent the interests of the communities we serve.

Community Engagement engages key community partners, such as law enforcement agencies, school systems and non-profit organizations, through outreach, education and training to promote awareness of Cardinal Innovations, the special populations we serve and their unique needs.

Member Engagement assists Cardinal Innovations’ members and their families in navigating Medicaid benefits, Cardinal Innovations, and community resources and supports. Member Engagement Specialists respond to concerns and questions from individuals and family members. They serve as liaisons for Consumer and Family Advisory Committees, and coordinate Client Rights Committee meetings. This unit also provides education and programming designed to promote self-advocacy, health awareness and wellness among members and their families.

These staff members provide numerous community stakeholder trainings including (but not limited to) the following topics and evidence-based programs:

- Cardinal Innovations Overview of services available for members and stakeholders
- Disabilities Overview; Intellectual and Developmental Disabilities
- Guardianship and Alternatives for IDD and MH
- Mental Health First Aid (for Adults, Youth, Veterans)
- Person-Centered Thinking/Planning
- Stigma
- Suicide Prevention Training (QPR – Question, Persuade, and Refer)
- Trauma
- Whole Health Action Management (WHAM) self-management of chronic physical health conditions, mental illnesses and addictions
- Wellness Recovery Action Planning (WRAP)

Community Operations’ staff are located throughout our geographic coverage areas and demonstrate the commitment and partnership between Cardinal Innovations and the communities we serve. Cardinal Innovations’ Community Operations team
strives to achieve optimal customer satisfaction from the community at large.

**Your responsibilities as a Cardinal Innovations Contracted Provider are to:**

- Actively participate in community collaborative efforts to support prevention, education and outreach programs
- Participate in the education of community stakeholders on system access and available services
- Publicize and support Cardinal Innovations-sponsored opportunities for member training
- Facilitate adequate random sampling on state- and Cardinal Innovations-generated member satisfaction surveys
- Respond to inquiries about member issues and concerns

**Cardinal Innovations’ responsibilities to Providers are to:**

- Develop comprehensive prevention, education and outreach programs
- Participate and/or facilitate in community collaborative efforts to assess community capacity, need and gaps in services
- Develop and disseminate educational material to providers and community stakeholders relative to accessing services
- Foster effective communication through its Communications and Marketing Department by maintaining the Cardinal Innovations website, [www.cardinalInnovations.org](http://www.cardinalInnovations.org), which contains information about Cardinal Innovations for members, providers, key stakeholders and the general public
- Serve as liaison with local and state organizations to promote member rights and integration into the community
- Address stigma and discrimination associated with mental illness, intellectual/developmental disabilities and/or a substance use diagnosis
- Serve as a resource for development of peer support
- Provide information for members to make complaints and grievances
- Ensure that member interests are always represented on executive management teams, committees and councils
- Be a resource for evidenced-based best practices and emerging best practices with the goal of improving positive outcomes in the member’s self-determination, quality of life and progress toward recovery

Information and assistance for members and families may be accessed by the following link:
[https://www.cardinalinnovations.org/Members](https://www.cardinalinnovations.org/Members).

**K. Medical Department**

Cardinal Innovations employs a full-time Chief Medical Officer and a full-time Vice President of Medical Services. Both of these key leadership positions are based in Charlotte, NC with the ability to travel to all of our regions when needed. Both the Chief Medical Officer and the Vice President of Medical Services are Board Certified Psychiatrists with extensive clinical and business expertise. Our organization also employs experienced and dedicated Peer Advisors. Peer Advisors are NC licensed physicians, doctoral level psychologists, and pharmacists who support the workforce in all of our clinical departments, such as Utilization Management, Care Coordination, and Quality Management. Our team is supported by dedicated administrative support.
professionals, an experienced project manager, and a seasoned licensed therapist who work collaboratively on internal and external initiatives.

Our team works in collaboration with our behavioral health providers, primary care providers in the community, and stakeholders at State and community hospitals to ensure that they are receiving what they need from our organization in order to support them as they care for our members. Members of the medical team ensure adherence to State and national guidelines during the authorization process, provide guidance and oversight to our quality and credentialing teams, and promote and follow evidence-based practices in service to our members. The team assists in the development of preventive health projects, provides leadership for several quality improvement projects, and leads several clinical initiatives, such as metabolic monitoring, medication reconciliation, medication adherence, and Crisis Intervention Team training. Our medical team provides clinical subject matter expertise to a variety of population health innovations that are customized for our population.

L. **Stakeholder Involvement in Cardinal Innovations System Management**

Cardinal Innovations has a comprehensive system of operational forums to ensure engagement of our members, family members, advocates, providers and community agencies. This system involves a number of operational committees that bring Cardinal Innovations staff, members/family members, providers and stakeholders together to address concerns, provide important feedback to Cardinal Innovations regarding its performance, and to assist in pro-active planning. Examples of this involvement include participation on the Innovations Waiver Stakehold Workgoup, Community Advisory Committees, Global Quality Improvement Committees, Network Councils, Consumer and Family Advisory Committees (CFACs) and Cardinal Innovations’ Client Rights Committee.

M. **Community Advisory Council Meetings**

Community Advisory Council Meetings are held in each of the regions in Cardinal Innovations’ service area to ensure that the unique needs and concerns of those counties are highly visible to Cardinal Innovations. Membership is open to community stakeholders and generally includes the following:

- Local Departments of Social Services (DSS)
- School Systems
- Juvenile Justice agencies
- Partnership for Children
- Law Enforcement
- Advocacy Organizations
- Comprehensive Community Provider Representation
- Consumer and Family Advisory Committee Representation

As in the past, these forums continue to serve the critical purposes of helping Cardinal Innovations understand problems and community priorities, and of informing the community about Cardinal Innovations initiatives and activities.

N. **Community Governance Committees**

Cardinal Innovations has relied on Community Governance Committees to bring together Cardinal Innovations, members/family members, providers and the community to exchange ideas, address
problems and plan collaboratively. These committees have helped Cardinal Innovations to remain aware of community needs and to understand the impact of our activities. Participation has given members of these committees opportunities to better understand and assist with community-facing activities and challenges as they arise.

These activities allow Cardinal Innovations to continually improve and strengthen its performance as an MCO. It is expected that these groups will continue to grow in their collective ability to impact Cardinal Innovations operations and management in a positive manner. The types of committees vary according to the unique needs of our local communities.
Section III: PROVIDER NETWORK

A. **The Cardinal Innovations Provider Network**

The Cardinal Innovations Provider Network is comprised of contracted behavioral health service providers that are located within and outside of the 20-county Cardinal Innovations service area.

Cardinal Innovations operates a closed provider network. Therefore, Cardinal Innovations contracts with only as many providers as necessary to ensure member choice and positive outcomes, and to promote overall network efficiency. Cardinal Innovations strives to maintain a network which includes providers with particularized expertise in evidence-based practices in order to better meet the needs of the members whom Cardinal Innovations serves.

Each network provider is required to have a fully executed Cardinal Innovations Procurement Contract that lists its approved services and sites prior to delivery of services to Cardinal Innovations members. The Cardinal Innovations Procurement Contract’s General Conditions, the Cardinal Innovations Provider Manual and the Cardinal Innovations Communications Bulletins are all incorporated into Cardinal Innovations’ Procurement Contracts by reference.

Your responsibilities as a Contacted Provider are to:

- Review your Procurement Contract for accuracy and fully complete any paperwork required by that contract within the required timeframe(s)
- Obtain a fully executed Cardinal Innovations Contract Amendment for any material change to the original contract, such as a change in services or sites, prior to implementation of the proposed change
- Understand and comply with all terms of the contract, including the obligations set forth in Cardinal Innovations’ Provider Manual and Cardinal Innovations Communications Bulletins
- Be knowledgeable concerning and implement any deliverables associated with grants and special funding allocated to you under a Designated Funding Authorization issued by Cardinal Innovations
- Carefully plan and monitor service delivery with regard to the amount of state funding provided to avoid exceeding or underutilizing the allocation
- Maintain good standing (as defined in this Manual) in the Provider Network, which includes being current with the submission of all reports or data elements as required in the contract
- Enroll as a Medicaid provider with the state of North Carolina through its NCTracks system and maintain that enrollment in good standing at all times:
To help maintain data integrity, providers must report the same information to Cardinal Innovations as they have reported to NCTracks. When providers make updates to their information in the NCTracks system, they must request that Cardinal Innovations make the same updates to their information.

- Attempt to first resolve any disputes with other network providers or Cardinal Innovations through direct contact or mediation.
- Notify Cardinal Innovations in advance of any mergers or changes in ownership.
- Notify Cardinal Innovations of any adverse actions imposed by another entity, such as an LME/MCO or DMA.
- With specific respect to insurance requirements, the following information reflects providers’ responsibilities as required by the Procurement Contract:

### The False Claims Act

The False Claims Act (31 U.S.C. §§ 3729-3733) is a federal law that imposes liability on persons or companies who defraud government programs such as Medicaid by presenting, or causing to be presented, a false or fraudulent claim for payment or approval. The State of North Carolina also has a False Claims Act statute (N.C. Gen. Stat. Article 51 § 1-607) that closely mirrors the federal False Claims Act. It is important for providers to educate themselves and be aware of what constitutes fraud, waste, and abuse. Anyone who has a concern regarding fraud, waste and abuse can report their concerns without fear of retaliation through any of the following options:

- **Cardinal Innovations’ Fraud and Abuse line at 1.800.357.9084**
- **Online: Complete our Suspected Fraud and Abuse Reporting Form at https://www.cardinalinnovations.org/Contact/Report-fraud-abuse**
- **Email: fraud-abuse@cardinalinnovations.org**
- **Mail to: Cardinal Innovations Healthcare, Attention: Program Integrity Unit, 550 South Caldwell St., Suite 1500 Charlotte, NC 28202**
- **DHHS Customer Service Center at 800.662.7030**
- **Medicaid Tip-Line at 877.DMA.TIP1**
- **OIG Fraud Line at 800.HHS.TIPS**
- **To access Centers for Medicare and Medicaid Services’ (CMS) Fraud Prevention Toolkit, go to https://www.cms.gov/outreach-and-education/outreach/partnerships/fraudpreventionToolkit.html**

Cardinal Innovations’ provider contracts require that each network provider carry specific insurance coverage types and amounts. Cardinal Innovations is required to maintain a copy of each of the provider’s Certificates of Insurance (COI), and related attestations, in its files that show current coverage is in place or excused because the insurance is not applicable. See Agency General Conditions at Article II, Section 14; LIP General Conditions, Article II, Section 13.

Cardinal Innovations maintains a Provider Resource Library regarding the COI Requirements on its website to assist Providers with the COI compliance process. You can access these resources at Certificate of Insurance Provider Resource Library. If additional assistance is needed, questions can be submitted to providerinsurance@cardinalinnovations.org.
B. Cultural Competency of the Network

The demographics of the Cardinal Innovations service area continue to experience rapid change and growth. It is imperative that Cardinal Innovations is able to adequately meet the needs of people from all cultures within its service area. Cardinal Innovations acknowledges that becoming culturally competent is both a developmental and dynamic process. Cardinal Innovations is committed to incorporating cultural competence as one of the foundational principles of our system, and strives to make it an integral part of care and services. This foundational principle plays an essential part in reaching the goal of helping individuals achieve their own potential, independence and recovery.

The Cardinal Innovations Provider Network has demonstrated extensive leadership and commitment to cultural competence. By partnering with providers, Cardinal Innovations continues to expand cultural competence to all of the counties that it serves. Furthermore, through education and training, network providers are being equipped with the tools to provide culturally appropriate and responsive services to the members they serve.

The following resource links are provided for further guidance on the topic of cultural competence:

Your responsibilities as a Cardinal Innovations Contracted Provider are to:

- Earnestly participate in initiatives, trainings, and other informative opportunities designed to promote cultural competence
- Strive to provide services in a culturally appropriate, responsive, and sensitive manner to all members

Cardinal Innovations’ responsibilities to Providers are to:

- Develop and maintain a cultural competence plan in partnership with the provider network
- Develop and disseminate educational material to providers and members relative to cultural competence
- Provide support to providers in developing culturally appropriate services

C. Types of Network Providers

1. Agency

An agency is a provider entity that has been incorporated, established as a limited partnership/limited liability company or operates under a Certificate of Authority issued by the Corporations Division of the North Carolina Department of the Secretary of State. The source of authority for an agency is established by charter, constitution, by-laws and/or articles of incorporation.

Agency providers render one or more enhanced clinical, therapeutic, rehabilitative and/or habilitative services to members with mental health, intellectual/developmental disabilities and/or substance use disorders/conditions. Agency providers bill and submit claims under a Tax ID number issued by the Internal Revenue Service.
Critical Access Behavioral Health Agency (CABHA) is a state-designated status for agency providers who meet certain specified criteria and are equipped to deliver a comprehensive array of mental health and substance abuse services. However, per the state’s Joint Communication Bulletin # J248, issued May 16, 2017, the Division of Mental Health, Developmental Disabilities and Substance Use Services will sunset the requirements and designation for CABHAs. In its stead, the state’s bulletin announced its plan to revise the policy and state plan for the four services offered by CABHAs – Community Support Team, Intensive In-Home, Child and Adolescent Day Treatment, and Mental Health and Substance Abuse Targeted Case Management – to ensure strong medical and clinical oversight of the services.

a. **Comprehensive Community Clinic (CCC)** is a designation given to a limited number of agency providers by Cardinal Innovations, consistent with the model Cardinal Innovations developed to better meet the needs of the people within its service area. CCCs are required to provide Cardinal Innovations members increased access to Medicaid and IPRS (state-funded) safety-net services, which include basic therapy and medication management services for both children and adults in the treatment of substance use and mental health conditions. CCCs are established by county, providing services in the county in which the designation is granted. In counties where the population cannot support a full CCC site, CCCs in neighboring counties will be identified to provide services at satellite sites for a limited number of hours per week, as volume demands.

In addition to providing robust basic services, CCCs are expected to meet the following clinical standards:

- Provide high quality assessments
- Provide outpatient treatment
- Offer prescriber services no less than 24 hours per week
- Primarily utilize on-site prescribers with psychiatric specialty certification
- Provide flexible and open-access scheduling
- Provide access to services within 48 hours for urgent needs and 14 days for routine needs
- Meet quality standards for member engagement in services to achieve low member utilization of crisis system resources
- Provide timely around-the-clock crisis response to members served
- Have psychiatrists who provide the agency with medical leadership and oversight
- Demonstrate a willingness to help address system, service and access gaps
- Provide Multi-Disciplinary Evaluations (MDEs) and Forensic Evaluations as requested
- Have staff training in Disaster Response Management

Additionally, CCC agencies are expected to utilize injectable antipsychotics, Clozapine and/or Suboxone when medically indicated; provide medication management to underserved or difficult-to-serve
populations; accept members on outpatient commitment; bill for services rendered to non-Medicaid payers (including Medicare); and maintain effective and efficient interactions with Cardinal Innovations regarding treatment authorization requests and claims processing.

b. **Clinical Home for Members** The state Medicaid service definitions that were implemented in 2006 included the designation of a clinical home for members. The role of the clinical home is further reinforced by the development of the CABHAs and the CCC models. CABHAs and CCCs are designed to serve as clinical homes for members by providing core clinical services to ensure members receive the continuity of services that they need.

c. **Expected Outcomes for Agency CCCs functioning as Clinical Homes for members:**

- Single point of responsibility to plan, link and coordinate clinical and support services for members
- Clinical accountability
- Clearly identified first responder responsibility
- Development of Crisis Plans or Advance Directives
- Use a team approach to planning and monitoring care. Team includes (as appropriate) psychiatrists, nurses, licensed professionals and peer specialists, as well as staff from other provider agencies serving the member
- Development of Person-Centered Plans that reflect all member needs
- Communication between the behavioral health and with primary healthcare providers

d. **Alternative Family Living Providers (AFLs).** AFL services must be provided by providers that have been incorporated as businesses, and not by individuals. Cardinal Innovations requires the following of its AFL providers:

- Documentation of training and background checks for both primary and backup staff
- Maintenance of personnel files for all employees, including
  - Documentation for service provision that meets the requirements of APSM 45-2, APSM 45-1
  - Any governing HIPAA regulations
  - All relevant service requirements
- Readily available documentation for review purposes
- Maintenance of the AFL site as the primary residence of the AFL caregiver who receives reimbursement for cost of care (this includes couples or single people)
- Employment by the provider of all people who offer services within the scope of the AFL compensation and/or requirements
- Maintenance of a license issued from the DHSR by all AFL providers that either serve more than one
individual or serve individuals under the age of 18
- Maintenance of backup staffing plans and backup staff employed by the provider
- Completion of Health and Safety Reviews completed by Cardinal Innovations’ Quality Management Department in accordance with that Department’s performance profiles and Waiver requirements
- Adherence to prohibition against providing services to more than one adult member at unlicensed AFL sites
- Maintenance of all required property and automobile insurance coverage by AFL providers on AFL sites and automobiles used for service purposes

Paybacks may be required if an AFL provider moves a member to a non-contracted site without prior approval for that move from Cardinal Innovations.

e. **Intensive In-Home Service Providers (IIH).** On July 1, 2019, Cardinal Innovations implemented a mandatory pay-for-performance program for providers of this service. The program requires IIH providers to conduct quarterly self-audits for members identified by Cardinal Innovations in order to demonstrate fidelity to the provider’s identified evidence-based practice(s). The program includes a validation process created by Cardinal Innovations. Using data from providers’ initial self-audits, Cardinal Innovations has established baseline performance expectations, and providers are required to meet or exceed the established expectations on quarterly bases to receive reimbursement at the enhanced rates for this service. A provider’s inability to demonstrate fidelity to the governing evidence-based practice will result in reimbursement at the lower Medicaid approved rate for the service.

2. **Hospital**

Hospitals are facility-based providers that are licensed by the DHSR and accredited by the Joint Commission. Hospitals enrolled in the Cardinal Innovations’ Provider Network may provide outpatient, inpatient and/or emergency department-based behavioral health services.

3. **Licensed Independent Practitioners (LIPs) and LIP Groups**

This category of providers renders important access to outpatient care for members, such as conducting assessments and providing outpatient therapies. Often the care that these providers render is more specialized than is available in the CCCs. LIPs and LIP Groups are required to maintain after-hours, on-call coverage to respond to the needs of their client(s)/patient(s), and to assure continuity of care. These types of providers can be comprised of, among other practitioners:
- Medical Doctors (MD)
- Practicing Psychologists (PhD and PsyD)
- Licensed Psychological Associates (LPA-Master’s Level Psychologists)
• Master’s Level Social Workers (LCSW)
• Licensed Marriage and Family Therapists (LMFT)
• Licensed Professional Counselors (LPC)
• Licensed Clinical Addiction Specialists (LCAS)
• Advanced Practice Psychiatric Clinical Nurse Specialists
• Psychiatric Nurse Practitioners
• Licensed Physician Assistants (PA)
• Board Certified Behavior Analysts

LIPs can bill and submit claims under their own licenses using their Social Security numbers as their Tax ID numbers. LIP Groups must bill and submit claims under a Tax ID number issued by the Internal Revenue Service (IRS).

The enrollment process for such practices includes background and reference checks, license verification and evaluation of other specific criteria to make certain the practitioner meets Cardinal Innovations’ and National Committee for Quality Assurance (NCQA) criteria and State and federal laws and regulations. In addition, the practitioners associated with these types of practices must be credentialed by Cardinal Innovations. Such credentialing processes include background checks for people with ownership or controlling interests in the provider entity. The terms ownership and controlling interest are defined by Title 42 Code of Federal Regulation, Part 455, Section 101.

4. Specialty Providers

These are providers that specialize in a particular type of service (such as vocational or residential), serve a specific disability area, or both. Specialty providers are important components of the provider network because they can focus their efforts on the best clinical practice strategies that have been developed and approved by Cardinal Innovations for use with the specific populations that they serve. The majority of Cardinal Innovations’ providers are specialty providers.

5. Provisionally Licensed Practitioners

Practitioners who are provisionally licensed by the relevant NC licensing board may render outpatient services to Cardinal Innovations’ members as an employee of an agency, hospital or group practice that is fully contracted with Cardinal Innovations for outpatient services. A provisionally licensed practitioner also may complete the credentialing process and directly enroll as an LIP provider with Cardinal Innovations under his or her own provider contract, so long as the practitioner submits proof of his or her professional clinical supervision, as evidenced by a current supervision contract that includes the name and contact information of the clinical supervisor. Upon approval by the Cardinal Innovations Credentialing Committee, the provisionally licensed practitioner will be able to provide outpatient services to Cardinal Innovations members; and to submit claims for those services in accordance with the Cardinal Innovations Procurement Contract, the practitioner’s licensing body, and/or limitations established by Cardinal Innovations Credentialing Committee.
D. **Quality of Care**

In conjunction with other Cardinal Innovations departments, including Utilization Management and Quality Management, Network Management works to assure the quality of services available from the Provider Network. Cardinal Innovations is accountable to the Division of MH/DD/SAS and the Division of Medical Assistance in the management of both state- and Medicaid-funded services.

As part of the continuous quality improvement (CQI) process, Cardinal Innovations operates a Global Continuous Quality Improvement (GCQI) Committee, which includes Cardinal Innovations’ providers, members, and staff. The purpose of the committees is to ensure that all relevant stakeholders are working together to achieve system improvements and to monitor the overall quality of services. This partnership is critical for success. The Cardinal Innovations CQI Committee develops a single Quality Improvement Plan for the Cardinal Innovations Provider Network with input and feedback from the GCQI Committees and other stakeholders. The plan identifies strengths, weaknesses and areas of improvement; and it includes a program description, work plan and annual report. Annually, Cardinal Innovations makes available information about its CQI performance to members of the Provider Network and stakeholders on the Cardinal Innovations website. A printed copy of the information is provided upon direct request to Cardinal Innovations.

Therefore, Cardinal Innovations expects its providers to demonstrate high levels of proficiency and/or skill in numerous areas, including:

- Health and safety of members
- Member rights protection
- Provider qualifications
- Member satisfaction
- Management of grievances
- Incident investigation, monitoring and reporting
- Assessment of outcomes to determine efficacy of care
- Management of care for Special Needs Populations
- Preventive health initiatives
- Clinical best practices

**Your responsibilities as a Cardinal Innovations Contracted Provider are to:**

- Provide services in accordance with all applicable state and federal laws
- Comply with all applicable service definitions and practice guidelines
- Provide medically necessary covered services to members in accordance with their PCP/ISP/Service Plan and the terms of your Procurement Contract
- Adhere to the access standards set forth in your Procurement Contract, chiefly identified in the General Conditions
- Adhere to a “no rejection of referrals” policy for members who have been determined to meet medical necessity for your services
- Ensure that members have input into their treatment plans, including having members and/or their legally responsible persons (LRP) sign and date the plans whenever they are developed, reviewed or revised
- Ensure that discharge planning takes place early in treatment, with the expectation that the member will continue to improve and, as a result,
require less restrictive services as time passes

- Strive to achieve best practices in every area of service
- Develop a cultural competency plan and comply with cultural competency requirements
- Provide culturally competent services and ensure the cultural sensitivity of staff members
- Provide interpreter services for members who require them
- Demonstrate member-friendly attitudes when interacting with members, their family members, other providers and Cardinal Innovations staff
- Ensure a system that promotes and maintains good communication with members and families
- Ensure, as a provider of enhanced services, that you fully comply with additional first-responder duties outlined in state policies and service definitions
- Ensure a smooth transition for any member desiring to change providers and for any member being discharged because your agency or practice cannot meet his/her special needs, and to provide timely notice of all such events to Cardinal Innovations
- Document all services provided in accordance with the applicable Medicaid or NC Waiver requirements and state rules
- Agree to cooperate and participate with all Cardinal Innovations’ procedures related to contracting, credentialing/recredentialing, utilization and quality management and/or review, appeal and grievance activities as derived from any source, including the Cardinal Innovations Procurement Contract, the Cardinal Innovations Provider Manual and Cardinal Innovations’ Communications Bulletins
- Participate in the various surveys, clinical studies and questionnaires issued by or about Cardinal Innovations
- Comply with all requirements related to incident reporting and outcome requirements as requested
- Comply with member records requirements as set forth in any Cardinal Innovations document, policy or procedure
- Provide Cardinal Innovations with updated contact and personnel information whenever you experience these or other material changes

With specific respect to crises and emergencies, providers are required to have a clinical backup system in place to provide around-the-clock responses to all crises/emergencies for members receiving services. The clinical backup system will contain information and directions on how to seek assistance in a crisis/emergency, including coverage for posted office hours, weekends, evenings and holidays for all members you serve or identification of your first responder as outlined in the service definition of your contract. In addition, part of this clinical function is to develop crisis plans that are available to clinicians in your office, members, their natural supports and Cardinal Innovations’ Access Department.

Likewise, providers must make available for members around-the-clock telephonic access to a clinician or qualified professional in the case of an MH/DD/SA crisis or emergency. This contact may not be 911. This contact also may not be a hospital or mobile crisis team unless that is the service being provided under contract with Cardinal Innovations, or unless you have subcontracted with and pay
such providers directly for emergency backup services. The backup contact person must:

- Have the qualifications, training and capacity to navigate the range of MH/DD/SA crisis scenarios a member may experience;
- Advise the member and assist in the coordination of care during the crisis;
- Be available telephonically and assist in-person if the situation requires; and
- Have immediate access to crisis plans for members who have them.

Cardinal Innovations’ responsibilities to Network Providers are to:

- Assist you with understanding and complying with relevant Cardinal Innovations’ policies/procedures, applicable policies/procedures of the NC Department of Health and Human Services and the policies/procedures of governing federal agencies, including the Centers for Medicare and Medicaid Services
- Assist you with understanding the requirements of Cardinal Innovations’ accrediting bodies including, but not limited to, the National Committee for Quality Assurance (NCQA)
- Provide technical assistance, as appropriate, related to Cardinal Innovations’ contract requirements, the development of appropriate clinical services, adherence to applicable grantor requirements associated to federal or state funding, quality improvement initiatives, and the identification of additional sources for technical assistance
- Provide training opportunities that support providers’ efforts to attain or maintain the skills necessary to render high quality services for members

E. Provider Communication

Cardinal Innovations maintains ongoing communication with its providers through a variety of means in order to keep providers well informed of important information, such as changes in state or federal law or policies, relevant contract-related updates, and opportunities for trainings and other collaborative efforts. Therefore, Cardinal Innovations maintains a list with contact information for all contracted providers. One vital use made of this list is the dissemination of emails and other communication materials. **This is why it is imperative that providers ensure all contact information on record with Cardinal Innovations is accurate and up-to-date at all times.**

In addition, Cardinal Innovations uses the provider section of the Cardinal Innovations website to communicate with providers. Cardinal Innovations also disseminates critical and time-sensitive information through Communication Bulletins, which can be sent directly to providers; published in the weekly electronic newsletter, InfoSource; or both.

For access to those resources, please go to: [https://www.cardinalinnovations.org/Providers/Communication-bulletins](https://www.cardinalinnovations.org/Providers/Communication-bulletins)

Cardinal Innovations also takes advantage of several collaborative activities with providers in order to obtain feedback designed to improve the efficiency and effectiveness of its management activities. Some of these collaborative activities include:

- The Cardinal Innovations Provider Partners Council and the Regional Provider Partners Council
- The Clinical Advisory Committee
- The Global CQI Committees
- Regular provider meetings
• Ad hoc committees and work groups

Your responsibilities regarding communications as a Cardinal Innovations Provider are to:

• Keep apprised of current information through the communications offered, and adhere to any new requirements presented therein
• Attend and participate in provider meetings and trainings
• Work in conjunction with personnel at your local Community Offices or at Cardinal Innovations Corporate Office for technical assistance as shown below
• Regularly review Cardinal Innovations’ various communication sources for information, including updates and changes
• Regularly review the following state-operated websites for additional sources of important information
  o https://dma.ncdhhs.gov
  o https://www2.ncdhhs.gov/dhsr
  o www.cms.gov

Cardinal Innovations’ responsibilities to Providers are to:

• Assign a Network Relation’s Staff who will strive to develop a professional relationship with each provider and to serve as a resource for addressing individual provider concerns
  For Access to Provider Assignments, please go to: https://www.cardinalinnovations.org/Providers/Provider-Network
• Promptly respond to provider inquiries and provide feedback as needed
• Regularly facilitate provider meetings as noted on the Cardinal Innovations website
• Promptly update information maintained on the provider webpage
• Post official Network Communications on the website
• Send written correspondence to providers as needed

F. Network Councils

Cardinal Innovations hosts Provider Partners Councils with provider members which serve as fair and impartial representatives of the service providers within their respective service areas within the Provider Network. Provider Partners Councils facilitate open exchanges of ideas; they promote collaboration and mutual accountability among providers. Provider Partners Councils strive to achieve best practices to empower members within our communities to achieve their personal goals.

G. Changes in Status

Cardinal Innovations maintains a database with current practice-related information for its providers and practitioners as submitted by them. The collection of all practice-related information supports Cardinal Innovations’ ongoing commitment to maintain a high-quality network of providers. Because this data is also used for referral purposes, it is imperative that Cardinal Innovations receives and maintains up-to-date information regarding its providers’ areas of practice. Providers should submit notice of all changes in status within the time frames required by the governing Procurement Contract. Such changes include: changes in licensure and/or privilege status with other accrediting organizations, pending citations, pending malpractice claims, changes in ownership or management, proposed changes in facility location, changes in capacity, termination of
participation by DMA or pending investigations conducted by DMA or its contractors, and changes in certifications held by clinician members.

If a provider wishes to acquire, merge with or otherwise assume the business operations of another provider, the provider shall notify Cardinal Innovations in advance of completing that change in status. Continued network participation following a business combination, including the sale of a business, is subject to the final approval of Cardinal Innovations. Business combinations and transactions may not be used to circumvent any of Cardinal Innovations’ rules concerning its closed provider network. Additionally, Cardinal Innovations may request periodic updates on the status of changes in business operations in advance of their becoming final; providers should promptly respond to all such requests.

Cardinal Innovations’ responsibilities to Providers is to:

- Update providers’ files and its provider network database in a timely manner to reflect all newly submitted information
- Notify providers in writing if their changes in status will adversely impact their eligibility to maintain enrollment in the provider network

H. Practitioner Credentialing and Recredentialing

Practitioners must be credentialed by Cardinal Innovations in order to be reimbursed for services rendered to their client(s)/patient(s). Practitioners must also enroll as Medicaid providers with the state of North Carolina through its NCTracks system, and maintain that enrollment in good standing at all times. To initiate credentialing, practitioners should carefully review all of the information provided at the link below. Once credentialed by Cardinal Innovations, practitioners are required to have their credentials reviewed, verified and reapproved at a minimum of every 36 months from the date of the last credentialing review. Cardinal Innovations starts notifying practitioners by electronic mail six months in advance of a credentialing expiration of the need for recredentialing; however, responsibility for timely recredentialing remains with the practitioner.

Additional information regarding credentialing and recredentialing may be obtained at: https://www.cardinalinnovations.org/Resources/Resource-Library and searching Forms.

Your responsibilities as a Cardinal Innovations Contracted Provider are to:

- Promptly respond to communications from Cardinal Innovations regarding the need to provide or update your records
- Maintain current and accurate contact information on file with Cardinal Innovations to include electronic mail addresses, street addresses and telephone numbers
- To attest or re-attest to information provided during the credentialing or recredentialing process because a practitioner’s attestation cannot be dated any more than 365 days from the date the practitioner’s credentialing or recredentialing application is reviewed by the Chief Medical Officer or designee and/or Credentialing Committee

As part of the credentialing and recredentialing processes, each practitioner has the right to:
• Review information collected during the process (except references and National Practitioner Data Bank (NPDB) reports), upon request
• Be informed of the status of their credentialing or recredentialing application, upon request
• Be notified of information that is significantly different than reported by the practitioner, and be given the opportunity to correct erroneous information in writing
• Be notified about the approval of the credentialing application via letter within 30 days of the decision.

J. Alteration of Practitioners’ Credentialed Status

Cardinal Innovations maintains standards for practitioner participation that will ensure competent, effective and quality care. Cardinal Innovations has the right to sanction, suspend, and/or terminate a practitioner for activity, actions, and/or non-actions that are contrary to Cardinal Innovations’ standards of practice or the law.

1. The following conditions can effect a practitioner’s credentialing status:
   • The practitioner fails to maintain compliance with the credentialing and recredentialing criteria
   • The practitioner decides not to execute a Procurement Contract
   • The practitioner’s general area of practice or specialty, in the opinion of the Credentialing Committee, involves experimental or unproved modalities of treatment or therapy not widely accepted in the local medical community
   • The practitioner has breached a material term of his/her Procurement Contract, including failing to comply with any medical management or quality improvement requirements
   • The practitioner engages in any type of inappropriate relationship with a member, to include those of a sexual or amorous nature, or any violation of other clinician/member boundaries

2. Disciplinary actions which can be taken by Cardinal Innovations include, but are not limited to:
   • Sanctions, including any one or more of the following actions:
     o Letter of Censure
o Reduction or restriction of practice privileges
o Probation for specified time period

• Time limited suspension or a termination of credentials may occur for any of the following reasons:
  o Breach of Contract
  o Refusal to comply with sanction or suspension conditions
  o Failure to be re-credentialed in accordance with any governing rule or provision
  o Loss of licensure

If disciplinary action is taken, Cardinal Innovations will provide written notice of the action along with notice of any applicable due process rights available to the practitioner.

K. **Actions Against Practitioner Credentialing Reported to External Bodies**

All disciplinary actions based on professional competency, conduct which would adversely affect clinical privileges for a period longer than 30 days or which would require voluntary surrender or restriction of clinical privileges in order to avoid investigation, are required to be reported to the appropriate entity (i.e., state Medical Board, National Practitioner Data Bank, Federation of State Medical Boards, etc.).

L. **Applying for Additional Services and Sites**

In order for a contracted provider to be considered for additional sites and/or services, the provider must be in good standing, which includes, but is not limited to, having a signed contract, and being in compliance with all statutes, rules, regulations and contractual requirements. An application for additional services from any provider with a history of a suspension of referrals, major contract violations, concerns regarding the quality of services rendered, and/or a state-level violation will be reviewed on a case-by-case basis.

If the provider falls under any of the adverse criteria listed above, the provider should contact its assigned Network Relations staff to request that a decision be rendered prior to the submission of the additional site/service application.

An application for additional services may only be submitted in order to provide member service(s) located within the Cardinal Innovations Service Area unless a Cardinal Innovations member resides in another county and meets the medical necessity requirements for the specific service(s) requested.

Cardinal Innovations will not approve an application for additional services unless it has established there is sufficient need for the service(s) for which the request is made. Publication of the Service Needs List does not constitute an offer to contract with new entities, or to add sites or services to the contracts of providers that already are contracted with Cardinal Innovations. Rather, Cardinal Innovations operates a closed Provider Network and, therefore, reserves the right to extend applications for enrollment and/or approve applications for additional sites or services based on factors that, in Cardinal Innovations’ sole discretion, warrant the addition of such providers, sites and/or services. Furthermore, in some instances, Cardinal Innovations may, in its sole discretion, determine that it is preferable first to look to its existing network providers to render services identified on the Service Needs List before opening up its network to non-contracted entities for the rendering of those services.
For any site which is covered by the Home and Community Based Services (HCBS) rule, irrespective of which process is used to request the addition of such site, you must provide proof that the site is fully integrated before it can be approved for addition to your contract.

When an Application to Add a New Site or Service is Received, Cardinal Innovations will

- Determine if there is an established need for the services
- Review the performance record of the provider for quality citations, actions that resulted in suspension of referrals, Division of Health Services Regulation findings and Provider Performance Profile scores, as well as demonstrations of quality and use of best practices

To Request Permission to Add a New Site or Service, Contracted providers shall

- For all enhanced and residential services, and for any other service that is not on Cardinal Innovations’ published Service Needs List, submit to your assigned Network Relations staff a completed Provider Data Inquiry form to request permission to add the desired service and/or site. If this request is approved, or if the service involved is on the Service Needs List, the provider will proceed with the below referenced steps. This process is required for any change in location of service delivery.
- Complete Cardinal Innovations’ Routine Additional Service Application form or a Routine Additional Site Application form with all required elements and supporting documentation, which must include the following:
  - Identification of the specific service to be rendered and the locations where it will be rendered, as appropriate
  - Identification of the specific site to be added along with the services that will be rendered from it, as appropriate
- Submit the required materials to your assigned Network Specialist along with all documentation required in support of the Application as identified by the Network Relations staff
- Submit the Application with all required elements and supporting documentation within 60 days of the date the application was sent to you

If your application is not received within this time frame, you may be required to re-initiate the request process.

For a link to more information regarding this process, please see https://www.cardinalinnovations.org/Providers/Provider-Network?tab=1

Cardinal Innovations’ responsibility to providers is to:

- Direct providers interested in additional services/sites to the appropriate forms and/or processes
- Review and render a decision on the completed request/application within 45 days of its submission, unless additional time is needed to make an informed decision

M. Provider Monitoring and/or Site Reviews

Contracted providers within the Provider Network receive a monitoring review at least every two years. All monitoring reviews are scored utilizing the NC DHHS standardized monitoring tools, which are made available to providers on the Cardinal Innovations and the NC DHHS website. All reviews include an exit conference with the Network provider to
discuss the outcome of the review. The reviewer(s) will explain findings and review scores to include strengths and needs noted. Any follow-up to be completed by the provider or Cardinal Innovations will be identified during the exit conference.

Copies of monitoring review results are sent via email to the provider following the review. Documentation will outline areas reviewed, scores achieved and required follow-up.

Providers are given the opportunity to provide feedback regarding the monitoring review process during the exit conference.

The provider may present any additional information that could not be located during the review process before or during the exit conference. If applicable, scores will be altered at that time. However, after the review is concluded, any additional information that is located by the provider should be included in the plan of correction, and will not be used to change any established scores.

If a health and safety site visit is required for the new site or service, local Quality Management personnel will schedule a site visit. Any site requested to be added to the contract for the new service will be reviewed on all applicable criteria. During the site visit, Cardinal Innovations will evaluate the applicant’s readiness to provide services according to the requirements outlined in state regulations, the service definition, Best Practice guidelines and the provider’s Procurement Contract.

More information about the NC DHHS’s Monitoring Review Tool can be obtained at:

https://www.ncdhhs.gov/providers/provider-info/mental-health/provider-monitoring

N. Cardinal Innovations Network Development Plan

Cardinal Innovations annually completes a Network Development Plan that identifies a strategy for addressing service needs, utilization concerns and other factors that relate to the strength and quality of the provider network. Cardinal Innovations gathers the data for its Network Development Plan from all relevant state-approved sources.

Cardinal Innovations’ Capacity and Accessibility Studies can be accessed via the provider website or through the following link:


https://www.ncdhhs.gov/providers/provider-info/mental-health/provider-monitoring
Section IV:  
BENEFIT PACKAGE

A. Cardinal Innovations Benefit Plans

Depending upon an individual’s healthcare needs, income and other relevant factors, an individual may qualify for one or more of Cardinal Innovations’ benefit plans, which include:

- The NC MH/DD/SAS Health Plan (the 1915(b) Medicaid waiver)
- The NC Innovations Waiver (the 1915(c) Medicaid waiver)
- The state-funded benefit plan
- Federally funded block grant programs managed and operated by Cardinal Innovations

Cardinal Innovations’ Medicaid-funded benefit plans cover certain mental health, intellectual/developmental disability and substance use/addiction services for adults and children whose Medicaid originates from one of the counties covered by Cardinal Innovations. Individuals must live in North Carolina, provide proof of residency and have or have applied for a social security number to be eligible to receive Medicaid-funded services. Additionally, an individual must be a U.S. citizen or provide proof of eligible immigration status in order to receive Medicaid benefits.

Cardinal Innovations’ state-funded benefit plans support mental health, intellectual/developmental disability and substance use/addiction services for eligible individuals who reside in one of Cardinal Innovations’ counties, meet certain income requirements, and who satisfy the criteria for at least one benefit plan (formerly known as Target Population) as defined by the state of North Carolina. In addition, an individual who receives services under one of the state-funded benefit plans must meet the eligibility criteria of the service definition or the benefit plan, whichever is stricter.

Finally, individuals who reside in one of Cardinal Innovations’ counties but are not eligible for either Medicaid or state-funded benefit plans operated by Cardinal Innovations, may be eligible for federally funded block grant benefits through Cardinal Innovations. Cardinal Innovations manages several block grant programs aimed at serving specific mental health and substance use disorder populations. Providers who believe an individual may only be eligible to receive federally funded block grant benefits should contact Access for screening, triage and referral to an authorized provider.

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

B. Eligibility for Cardinal Innovations’ Medicaid Benefit Plans

1. The NC MH/DD/SAS Health Plan – the 1915(b) Medicaid waiver

The NC MH/DD/SAS Health Plan is a pre-paid inpatient health plan funded by Medicaid. The health plan is a 1915(b)
Medicaid waiver for Medicaid enrollees who need services for mental health, substance use disorder and/or intellectual/developmental disabilities. All Medicaid members enrolled in specified eligibility groups (such as Aged, Blind and Disabled, etc.) will automatically be enrolled into the NC MH/DD/SAS Health Plan for their mental health, intellectual/developmental disability and substance use disorder service needs. The services that are available include the current NC Medicaid Benefit Plan service array for Behavioral Health and Developmental Disabilities Services.

1915 (b)(3) services are additional supports for members who have Medicaid. They are available in addition to the services provided through the Medicaid state plan. Cardinal Innovations is able to offer these additional services as a component of the 1915 (b) waiver.

Cardinal Innovations also is able to create Medicaid In Lieu Of services. These services are in addition to the state Medicaid Plan services. They are offered as cost-effective alternatives to the services in the Medicaid State Plan. Cardinal Innovations does not enroll individuals directly into Medicaid. The Department of Social Services in the individual’s county of residence is responsible for making Medicaid enrollment determinations. Individuals who meet all of the criteria below are eligible to participate in the NC MH/DD/SAS Health Plan.

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
11. Member in Community Alternatives Programs and NC Innovations
12. Medicaid recipients living in ICF-IID Facilities or
13. Children beginning the first day of the month following their third birthday (except Innovations)

b. The individual’s Medicaid County of Residence is one of the following

1. Alamance
2. Cabarrus
3. Caswell
4. Chatham
5. Davidson
6. Davie
7. Forsyth
8. Franklin
9. Granville
10. Halifax
11. Mecklenburg
12. Orange
13. Person
14. Rockingham
15. Rowan
16. Stanly
17. Stokes
18. Union
19. Vance
20. Warren

For the most current listing of the counties comprising Cardinal Innovations’ service area, please consult the Cardinal Innovations website at [www.CardinalInnovations.org](http://www.CardinalInnovations.org)

Enrollment in Cardinal Innovations’ NC MH/DD/SAS Health Plan for individuals meeting the criteria listed above is mandatory and automatic once the individual is enrolled in Medicaid. Children are eligible beginning the first day of the month following their third birthday for 1915(b) services.

The following resource links are provided for further guidance:
[https://www.cardinalinnovations.org/consumer-families/consumer-affairs/about](https://www.cardinalinnovations.org/consumer-families/consumer-affairs/about)
[http://www.ncdhhs.gov/dma/services/piedmont.htm](http://www.ncdhhs.gov/dma/services/piedmont.htm).

2. **The NC Innovations Waiver – the 1915(c) Medicaid waiver:**

The North Carolina Innovations Waiver is a Medicaid Home and Community-Based Waiver. The NC Innovations Waiver funds services and supports for individuals with intellectual/developmental disabilities who are at-risk for institutional care.

The North Carolina Innovations Waiver offers community-based services and supports to promote choice and community membership. This waiver encourages members and their families to play an active role in developing community-based, person-centered plans and to make informed decisions about their health care.

Providers of Innovations services must comply with the federal HCBS Final Rule that applies to services provided in certain home and community based settings (HCBS). As an initial measure of compliance, providers of the covered services must complete electronic Provider Self-Assessments which are designed to measure whether the provider’s service meets the fully integrated status required by the HCBS rule. The HCBS Final Rule applies to Residential Supports, Day Supports and Supported Employment under the NC Innovations Waiver and to Adult Day Health under the Community Alternative Program for Disabled Adults. Additionally, the HCBS Final Rule applies to (b)(3) Supported Employment. For more information, please go to the state’s HCBS site at: [https://www.ncdhhs.gov/about/department-initiatives/home-and-community-based-services-final-rule](https://www.ncdhhs.gov/about/department-initiatives/home-and-community-based-services-final-rule)

Enrollment in the NC Innovations Waiver is limited. An individual with an intellectual/developmental disability/or a related condition that results in three or more functional skill deficits may be eligible to participate in the NC Innovations Waiver if all of the following criteria are met.

a. The individual is eligible for Medicaid coverage, based on assets and income of the applicant whether he/she is a child or an adult.

b. The individual meets the requirements for ICF-IID level of care.

c. The individual's Medicaid originates from one of the counties within the Cardinal Innovations region.
d. The individual lives in an ICF-IID institutional facility or is at high risk for placement in an ICF-IID institutional facility. High risk for ICF-IID institutional placement is defined as a reasonable indication that an individual may need such services in the near future (one month or less) but for the availability of Home and Community Based Services.
e. The individual's health, safety and well-being can be maintained in the community with waiver support.
f. The individual requires active treatment.
g. The individual, his/her family or guardian desire participation in the NC Innovations waiver program rather than institutional services.
h. The individual will use one waiver service per month for eligibility to be maintained.
i. Effective April 1, 2010, NC Innovations members who are new beneficiaries to the waiver must live in private homes or in facilities with six or fewer beds. For additional information, please see DMA Clinical Coverage Policy, 8P, amended November 1, 2016 at the following link: https://files.nc.gov/ncdma/documents/files/8P.pdf
j. Funding, commonly referred to as a “waiver slot,” is available for the individual.

The NC Innovations Waiver allows members to decide whether to self-direct services or to receive services through the more traditional provider agency model. Under the Provider Directed track, services are delivered in a conventional manner with members and family members selecting the providers they believe can best meet their needs. The self-direction option provides members and their families the opportunity to direct some or all of their services. It includes two models.

- Employer of Record: The member/legally responsible person becomes the employer. With the help of the Community Navigator the member learns to hire, set pay rates, schedule work, train and evaluate their staff. A Financial Supports agency manage the payroll functions.
- Agency with Choice: This option allows the member or legally responsible person to take part in some or all of the activities required to be an employer, yet the responsibility for employment and oversight of the services still lies with the provider agency.

The following resource link is provided for further guidance regarding the self-directed options of the Innovations waiver: https://www.cardinalinnovations.org/Resources/Resource-Library (and search Handbooks).

3. For more information about NC Innovations services, view Behavioral Health Clinical Coverage Policy 8-P: https://medicaid.ncdhhs.gov/providers/clinical-coverage-policies/behavioral-health-clinical-coverage-policies
Disenrollment from Cardinal Innovations’ Medicaid Benefit Plans:

When a member changes their county of residence for purposes of Medicaid eligibility to a county other than one of the counties within Cardinal Innovations’ service area, the member will be disenrolled from Cardinal Innovations’ Medicaid Benefit Plans. Disenrollment is not immediate; Cardinal Innovations will continue to be responsible for management of the member’s behavioral healthcare until the change to the member’s Medicaid enrollment is processed in the Eligibility Information System.

A member may be automatically disenrolled from the NC MH/DD/SAS Health Plan if:

1. The member is deceased
2. The member is confined to a correctional facility for more than 30 days
3. The member 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

C. Eligibility for State-Funded Services

Individuals who live in one of the counties within Cardinal Innovations’ service area who are not enrolled in Medicaid may be eligible to participate in Cardinal Innovations’ state-funded health plan. Eligibility for this benefit package is based on the individual’s income (including both first and third party ability to pay, and level of need); the individual’s physical location; and based on the relevant benefit plan to which the individual is assigned. Cardinal Innovations utilizes the state’s sliding fee schedule to determine the individual’s ability to pay for state-funded benefits. Individuals with third-party insurance that covers 100% of the cost of behavioral health benefits received by the individual, or whose income is sufficient to require payment for 100% of the cost of services out-of-pocket (including third-party liability), are not eligible for Cardinal Innovations’ state-funded benefits. Unlike Medicaid, state-funded benefits are not an entitlement, but are dependent upon available resources.

D. Eligibility for Federally Funded Block Grant Services

Cardinal Innovations manages various federally funded block grant resources, including the Substance Abuse Prevention and Treatment Block Grant (SAPTBG) and the Community Mental Health Services Block Grant (CMHBG). These federally funded block grant programs authorize priority treatment and supportive services that are not traditionally covered by Medicare, Medicaid or private insurance.

The SAPTBG subsidizes prevention activities as well as services for members who are at-risk or in need of treatment for substance use disorders. Specifically, SAPTBG funds are used to cover

- Pregnant women and women with dependent children
- Intravenous drug users
- Tuberculosis services
- Early intervention services for HIV/AIDS
- Primary preventive services

The CMHBG, on the other hand, is aimed at serving specific populations and specific service areas, offering federal assistance to support adults who have serious mental...
illness and children with serious emotional disturbances in rural and other targeted areas.

Individuals residing in the Cardinal Innovations’ catchment area who are not eligible for Medicaid or state-funded health benefits may be eligible to receive federally funded services if they satisfy one or more of the criteria listed above. This includes individuals who are unable to provide proof of residency. Furthermore, individuals are not required by law to verify immigration status or provide evidence of legal presence in order to receive these federally funded services. Providers who are contracted to provide federally funded block grant services must not require members to provide a social security number or other proof of United States citizenship to receive federally funded services. As with state-funded benefits, federally funded block grant services are not an entitlement and are dependent upon available resources.

E. **Eligibility and Enrollment Requirements**

Members who have their services paid for in whole or in part by Cardinal Innovations must be enrolled in the Cardinal Innovations system. If you have any questions about a member’s eligibility, please call the Access Center 1.800.939.5911. Individuals who are at 100% ability to pay according to Cardinal Innovations’ sliding fee schedule, or who have insurance coverage that pays 100% of their services, are not eligible to participate in Cardinal Innovations’ Medicaid and state-funded benefit plans and will not be enrolled into the Cardinal Innovations system.

Members with a Medicaid card for an eligible category of Medicaid, from any of the Cardinal Innovations counties are fully enrolled in the Cardinal Innovations system and are eligible to receive basic or enhanced services as authorized by Cardinal Innovations.

Members who are not Medicaid eligible but are eligible to participate in Cardinal Innovations’ state-funded or federally funded block grant programs are required to provide income verification, which will be used to determine the individual’s cost for services. When providing outpatient services, providers are required to use Cardinal Innovations’ sliding fee schedule to calculate the individual’s fee. This schedule is based on Federal Poverty Guidelines, member’s family income, and the number of dependents.

Sliding Fee and Income Verification Schedules can be found at: https://www.cardinalinnovations.org/Resources/Resource-Library.

Medicaid regulations prohibit the use of Medicaid funds to pay for services other than General Hospital Care delivered to inmates of public correctional institutions.

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. You should consult your contract to determine which funding source(s) for which you are contracted. If you have questions, please contact your assigned Network Specialist.

F. **Enrollment of Members**

It is important for all providers to ensure member enrollment data is up-to-date based on the most current Cardinal Innovations Enrollment Procedures and training. These
documents can be found under the member Enrollment section of the Cardinal Innovations website, or by accessing the following link https://www.cardinalinnovations.org/Resources/Resource-Library and selecting Handbooks. If enrollment data is not complete prior to service provision, authorizations and claims may be affected, resulting in denial of authorizations requested and/or claims submitted for reimbursement. (See Section X Finance for additional information.)

1. Service Categories

   a. Basic Services

   The Basic Benefit Package includes those services that are made available to individuals with Medicaid and, to the extent resources are available, to individuals enrolled in Cardinal Innovations’ state-funded and federally funded block grant programs. These services are intended to provide brief interventions for individuals. The Basic Benefit package is accessed through a simple referral from Cardinal Innovations to an enrolled Cardinal Innovations provider or by directly contacting a provider enrolled in the Cardinal Innovations Network. There are no prior authorization requirements for certain amounts of these services. Adult and Child Medicaid members referred for Basic Benefit Services can access up to 24 unmanaged visits from the Basic Benefit package. State-funded members referred for Basic Benefit Services can access up to eight unmanaged visits for Adults and 12 unmanaged visits for Children from the Basic Benefit package. Unmanaged visits start new for all of Cardinal Innovations counties on July 1 of every year. However, additional visits beyond the unmanaged limits will require prior authorization from Cardinal Innovations.

   Unmanaged visits may not be used for a member who is receiving Enhanced Services that include therapy as a component, such as Psychiatric Residential Treatment Facility (PRTF), Residential III, Day Treatment, Intensive In-Home Services (IIHS), Multi-systemic Therapy (MST), Community Support Team (CST) and Substance Abuse Intensive Out-Patient (SAIOP). If there is a need for outpatient therapy beyond what is provided in the Enhanced Service, the individual’s plan must provide justification for these services and an authorization is required.

   Once an authorization has been requested and approved, the service will become a managed service. A provider must bill against that authorization until the end date. During the period authorized, the provider is limited to the number of visits on the authorization. The service will be considered a managed service even if there are unmanaged sessions available. Therefore, it is recommended that providers only request authorization of a service when unmanaged sessions have been used.

   The Basic Benefit Package also includes those services that will be made available to individuals with Medicaid and, to the extent resources are available, to state-funded and
federally funded program members meeting Benefit Plan criteria. A member requiring this level of benefit is in need of more than the 24 unmanaged visits for adult and child Medicaid members, or the eight unmanaged visits for state-funded adults and 12 unmanaged visits for state-funded children under the Basic Benefit in order to maintain or improve his/her level of functioning. An authorization for the services available in this level will need to be requested through Cardinal Innovations Clinical Operations Department. Authorization is based on the member’s need and medical necessity criteria for the service requested.

b. Enhanced Services

The Enhanced Benefit package includes those services that will be made available to individuals with Medicaid and, to the extent resources are available, to state-funded and federally funded program members 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, which are more appropriate for individuals seeking to recover from more severe forms of mental illness, substance use disorder and intellectual/developmental disabilities, and who have 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 and more intensive and may be delivered for a longer period of time. A member may receive more than one enhanced service to the extent that the additional services 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 members’ services are highly coordinated, reflect best practices, and are connected to the person-centered plan authorized by Cardinal Innovations. Enhanced services require prior authorization from Cardinal Innovations. Cardinal Innovations is not obligated to pay for enhanced services provided if prior authorization was not obtained.

2. Benefit Plans

Benefit Plan designation is for state-funded and federally funded block grant program services. It does not apply to members who are only receiving Medicaid services. The provider – through review of screening, triage and referral information – must determine the specific Benefit Plan for the member according to the criteria established by the Division of MH/DD/SA. Each Benefit Plan is based on diagnostic and other indicators of the member’s level of need. Although the publicly funded MH/DD/SAS system may not serve all individuals, it is deemed public safety net for many individuals, and
its resources will be focused on those most in need.

To find the most current version of the Benefit Plan Criteria, you may access that information on the homepage for the NC Division of Mental Health/Developmental Disabilities/Substance Abuse Services, or by the following link:
https://www.ncdhhs.gov/providers/provider-info/health-care/nctracks

G. Special Needs Populations designated in the NC MH/DD/SAS Health Plan

Special Needs Populations are population cohorts 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 NC MH/DD/SAS Health Plan is to first identify these individuals and intervene in order to ensure that they receive both appropriate assessment and medically necessary services. Care Coordination is a managed care tool that is designed to proactively intervene and ensure optimal care for Special Needs Populations.

The Care Coordination function is provided through the Care Coordination Units in each of the Community Operations Centers. Cardinal Innovations Care Coordinators carry out this function in order to provide necessary support for members meeting the criteria defined below. The goal is to ensure that members are referred to and appropriately engaged with providers that can meet their needs, both in terms of mental health, intellectual/developmental disability and substance use disorder services, as well as medical care.

H. Service Array

For a listing of services, refer to the most current version of the service arrays by benefit level and disability. For services covered under the NC MH/DD/SAS Health Plan, more information can be found in the Division of Health Benefits (DHB) Clinical Coverage Policies for behavioral health, located at https://medicaid.ncdhhs.gov/providers/clinical-coverage-policies/behavioral-health-clinical-coverage-policies.

I. Hospital Admissions

DHB is responsible for payment of inpatient hospital services provided to members who are admitted prior to the effective date of their enrollment in the Medicaid waiver operated by Cardinal Innovations 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 Cardinal Innovations, Cardinal Innovations will provide authorization for all covered services, including inpatient and related inpatient services, according to Medical Necessity requirements.

J. Medicaid Transportation Services

Transportation services are among the greatest needs identified to assist members in accessing care. It is Cardinal Innovations’ goal to assist members in accessing generic public transportation. Providers are requested to assist in meeting this need whenever possible.

The Department of Social Services in each county has access to Medicaid approved transportation. Transportation is for medical appointments or getting prescriptions at the drug store. Riders have to request three to
five business 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.

For information on available transportation in your county please contact the local DSS office. DSS contact information can be found at: http://www.ncdhhs.gov/dss/local

There are no special publically funded medical transportation services in the evening and on weekends.
Section V: MEMBER RIGHTS AND EMPOWERMENT

Individuals who get Medicaid from any of the counties in the Cardinal Innovations Healthcare region are members of the NC MH/DD/SAS Health Plan. As members of the NC MH/DD/SAS Health Plan, they have the following rights and responsibilities for their care:

A. Member Rights

Every member has the right to:

• Receive information about Cardinal Innovations Healthcare, its services, its providers and practitioners, and have member rights and responsibilities presented in a manner you can understand
• Be treated with respect and with consideration for your dignity and privacy
• Receive information on available treatment options and alternatives in a manner you can understand
• Receive information about changes in benefits, services or providers; Cardinal Innovations will notify members in writing of any significant changes to programs or services
• Receive information in culturally and linguistically appropriate formats
• Make suggestions about Cardinal Innovations’ member rights and responsibilities policy
• Make suggestions to us about member rights and responsibilities and services by calling the 24-hour, toll-free Crisis and Referral Line at 1.800.939.5911 (for deaf or hard of hearing, dial 711 for NC Relay) and requesting to speak to a Member Engagement Specialist. You also may call our toll-free Anonymous Concern Line at 1.888.213.9687. If you would prefer to email your suggestions, they can be sent to the Member Engagement department at memberquestions@cardinalinnovations.org or to our Quality Management Department at QMEmail@cardinalinnovations.org. If you prefer to contact someone other than Cardinal Innovations, you may contact the NC Department of Health and Human Services (NC DHHS) Customer Service Center at 1.800.662.7030.
• Participate with providers and practitioners in making decisions about your health care, including the right to refuse treatment
• Prepare Advance Directives. These are instructions for your care if, in the future, you are unable to make decisions about your care
• An open discussion with service providers or practitioners on appropriate or medically necessary treatment options for your conditions, regardless of cost or benefit coverage. You may need to decide among relevant treatment options, risks, benefits and consequences, including your right to refuse treatment and to express your preferences about future treatment decisions regardless of benefit coverage limitations
• Voice complaints about us or the care we provide. You may voice your concerns or file a grievance by calling 1.888.213.9687 (at this number, you may leave a message to have someone return your call or you
may leave an anonymous message, if you prefer)
• Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation
• A second opinion from a qualified mental health professional within the Cardinal Innovations network, or one that is out of network at no cost to the member
• Request and file an appeal for changes in your Medicaid behavioral healthcare services
• If your service has been denied, reduced, suspended or terminated, you (or your provider with your permission) can request Reconsideration within 60 days of such notice. This is the first step in the Appeal Process. For more information call your assigned Care Coordinator or contact the Appeals Coordinator at 704.939.7700
• A state-level Fair Hearing
• Request and receive a copy of your medical records and to request that the medical records be amended or corrected. If a doctor or therapist determines that this would be detrimental to your physical or mental wellbeing, you can request that the information be sent to a physician or professional of your choice
• Disagree with what is written in your medical records. If you disagree, you have the right to write a statement to be placed in your file. However, the original notes will also stay in the record until the time for retention ends according to the MH/DD/SAS retention schedule (11 years for adults; 12 years after a minor reaches the age of 18; 15 years for DUI records)
• Take part in creating a written, person-centered treatment plan that builds on your needs, strengths and preferences. A treatment plan must be put into action within 30 days after services start

• Participate in the creation of an Individual Support Plan (ISP) to request services specific to people with IDD
• Help create and update your treatment plan or ISP and consent to treatment goals in that plan
• Freedom of speech and freedom of religious expression
• Equal employment and educational opportunities
• Treatment in the most natural, age-appropriate and least restrictive environment possible
• Ask questions when you do not understand your care or what you are expected to do
• If you live in an Adult Care Home, you have the right to report any suspected violation of your rights to the appropriate regulatory authority, which is North Carolina Division of Health Service Regulation. https://www2.ncdhhs.gov/dhsr/ciu. You may contact them by phone at 1.800.624.3004 or 919.855.4500.

Rights of Minors

Under NC state law, minors have the right to treatment for the following conditions without the consent of a parent or guardian:

• Sexually Transmitted Infections
• Pregnancy
• Use of controlled substances or alcohol
• Emotional disturbances

Your Responsibilities

In addition to your rights as a member of the NC MH/DD/SAS Health Plan, you can reach the best outcomes for yourself by taking on the following responsibilities:

• Supplying information (to the extent possible) that Cardinal Innovations and
our providers need to provide care for you
• Following the plans and instructions for care that you have agreed to with your providers
• Understanding your health problems and taking part, to the degree possible, in creating treatment goals; telling the doctor or nurse about any changes in your health and asking questions when you do not understand your care or what you are expected to do
• Inviting people who will be helpful and supportive to you to be included in creating your treatment plan
• Respecting the rights and property of other members and of provider staff
• Respecting other members' needs for privacy
• Working on the goals of your person-centered plan
• Keeping all the scheduled appointments that you can
• Canceling an appointment at least 24 hours in advance, if you cannot keep it
• Paying for services, if included in your established agreement
• Informing staff of any medical condition that is contagious
• Taking medications as they are prescribed for you
• Telling your doctor if you are having unpleasant side effects from your medications, or if your medications are not helping you feel better
• Telling your provider if you do not agree with their suggestions
• Telling your provider when or if you want to end treatment
• Carrying your Medicaid or other insurance card with you at all times
• Cooperating with those trying to care for you

• Being considerate of other members and family members
• Seeking additional support services in your community
• Reading, or having read to you, written notices from Cardinal Innovations about changes in benefits, services or providers
• Requesting a discharge plan when you leave a provider; being sure you understand it and being committed to following it
• Contacting our toll-free Anonymous Concern Line at 1.888.213.9687 if you feel that your rights have been violated. You may also email our Quality Management Department at QMEmail@cardinalinnovations.org or our Member Engagement Department at memberquestions@cardinalinnovations.org. If you prefer to contact someone other than Cardinal Innovations, you may contact the NC DHHS Customer Service Center at 1.800.662.7030.

B. **Civil Rights**

Members are entitled to all Civil Rights including:

• To register and vote
• To own, buy and/or sell property
• To sign contracts
• To sue others who have wronged them
• To marry or get a divorce
• To procreate and raise children

Individuals determined to be incompetent and who 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 member rights is a crucial component of the service
delivery system. All members are assured the rights provided by law, and it is expected that providers will respect these rights at all times. It is further expected that providers will give members continual education regarding their rights, as well as support them in exercising their rights to the fullest extent possible.

North Carolina General Statutes (GS 122C 51-67) and the North Carolina Administrative Code (ASPM 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. Providers also are expected to maintain an ongoing knowledge of changes to the governing statutes and regulations, and immediately will alter their operations to comply with any such changes.

Each network provider that is contracted with Cardinal Innovations as an Agency type entity is expected to maintain a Client Rights Committee consistent with regulations outlined in North Carolina General Statutes and Administrative Code. Providers are required to submit the minutes of their Client Rights Committee meetings to Cardinal Innovations on a quarterly basis. Providers should remove any information that is not related to Cardinal Innovations members.

Cardinal Innovations maintains a Client Rights Committee that is responsible for the monitoring and oversight of Provider Client Rights Committee functions. This Committee is a subcommittee under Cardinal Innovations’ Continuous Quality Improvement Committee. For more information, you may contact a Member Engagement Specialist at 704.939.7700.

Additional information for providers working with Cardinal Innovations members can be found in Section I of this Manual. Client Rights regulations are set out in N.C.G.S. §122C-51-67; APSM 95-2; AAPSM 30-1; NCASC §§ 27G.0504; 27G.0103; and NC Council Communication Bulletin #30.

C. **Informed Consent**

An individual 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 individual also has the right to give or withhold consent for treatment unless:

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

D. **Advocacy for Members**

Cardinal Innovations 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.
Furthermore, Cardinal Innovations will not:

1. Restrict a provider from advocating for medical care or treatment options
2. Restrict a provider from providing information the member needs to decide among all relevant treatment options, including the risks, benefits, and consequences of treatment or non-treatment options
3. Restrict a provider from providing information to the member concerning their right to participate in decisions regarding their health care, including the right to refuse treatment, and to express preferences about future treatment decisions
4. Take punitive action against a provider that supports a member’s appeal of a Medicaid action as identified in 42 CFR 438.410.

A provider may file an appeal on behalf of a member with the member’s written consent in accordance with 42 CFR 438.402.

E. Psychiatric Advance Directives (PAD)

In 1997, North Carolina developed a way for individuals who receive mental health services to plan ahead for treatment they might want to receive in the event of a crisis that rendered the individual unable to communicate for themselves, or to 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 individuals to write down treatment preferences or instructions in case they experience 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 can be used.

A PAD document can include an individual’s wishes about medications; electroconvulsive therapy (ECT); 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 individual is hospitalized. The individual also could include an advance instruction to contact a particular doctor or other clinician and follow his/her instructions. Such instructions could be used to support the member at critical moments when the member is unable to communicate due to confusion or other emergency issues.

Providers that assist members with completing PADs should plan on holding several meetings to thoroughly discuss crisis symptoms, medications, facility preferences, emergency contacts, and preferences for staff interactions, visitation permissions, and other instructions.

Members also can choose someone they trust (like a family member) to make treatment decisions for them in the event they cannot make the decisions themselves by designating a Health Care Power of Attorney.

The Psychiatric Advanced Directive and Health Care Power of Attorney legal forms were designed by Duke University. They can be obtained by calling Cardinal Innovations’ and asking for assistance from the Member Engagement Department at 704-939-7700.
F. **Crisis Plan**

- Your treatment team will help you write your crisis plan. You also can have your crisis plan recorded into a computer database so that anyone treating you can follow your instructions.
- Writing a crisis plan will:
  - Protect your right to make medical decisions and choices about your health care
  - Help family members make decisions if you cannot make your own decisions
  - Help you remember allergies to medications or foods
  - Communicate your wishes to your doctor or practitioner
  - Stay in recovery longer and decrease the chance of another crisis
  - Increase your self-esteem in dealing with stress
  - Arrange for someone to be with you if you are fearful
  - Identify who can pay your rent and bills, or take care of your pets if you are hospitalized

G. **Living Will**

A Living Will tells others that you want to die a natural death if you are incurably sick and cannot receive nutrition or breathe on your own. This document must be notarized.

All three of these documents must be written and signed by you while you are able to understand your condition and treatment choices, and are able to make your wishes known. Two qualified people must witness all three types of advance directives. The Health Care Power of Attorney and the Living Will must be notarized.

H. **Confidentiality**

The Network Provider shall ensure that all individuals providing services under the provider’s authority will maintain the confidentiality of any and all member information received in the course of providing services. Further, the provider shall ensure that all individuals providing services under such circumstances 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 the member’s 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 to or treating an individual), and 42 CFR, Subchapter A, Part 2 (which addresses confidentiality of records of substance use disorder patients).

Information can be used without consent to help in treatment, for health care operations, for emergency care, and given 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 member has not objected to that disclosure.

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

Since there is no guarantee of adequate firewalls for **electronic mail**, Cardinal Innovations staff and contractors cannot
exchange e-mails with members concerning their personal or health matters. Private, member-related information should be communicated by paper mail, face-to-face, by telephone or over a secure electronic connection, such as Provider Direct.

Confidentiality Rules (ASPM 45-1) were adopted in accordance with General Statute 150B-14C. Confidentiality and privacy practices are also based on the federal Health Information Portability and Accountability Act (HIPAA) regulations.

I. Second Opinion

A Medicaid member has the right to a second opinion if the member does not agree with the diagnosis, treatment or the medication prescribed. The Cardinal Innovations Clinical Operations Department can arrange for the second opinion to be obtained. Members are informed of the right to a second opinion in the Cardinal Innovations Member & Family Handbook, which is available to them when they enroll with Cardinal Innovations. The role of the Network Provider is to be aware of this right of all Medicaid members, and to refer the member to the Clinical Operations Department at Cardinal Innovations if a second opinion is requested.

J. Decisions to Deny, Reduce, Suspend, or Terminate a Medicaid Service

It is important that providers understand the following rights so they may discuss the member’s case with them, if asked. If a member wishes to appeal, that appeal can be filed by the Enrollee, legally responsible person, a provider, or other designated personal representative acting on behalf of the Enrollee with the Enrollee’s signed consent. If the treating physician/practitioner/provider would like to discuss the case with the Cardinal Innovations’ UM Care Manager or the physician/psychologist, the provider may call 704-939-7700 to be connected with the Utilization Management Department.

Cardinal Innovations will make every effort to provide information on adverse decisions and the appeals process to members in a culturally and linguistically appropriate manner. Interpreter services are available 24 hours a day through the Access line at 1-800-539-5911.

There are times when a member’s request for services may be denied, and there are times when a current service authorization may be changed (i.e., reduced, suspended or terminated) by Cardinal Innovations Utilization Management. All such adverse decisions are made by a psychiatrist or doctoral level psychologist after careful review of all information submitted.

**NOTE:** Cardinal Innovations is prohibited from implementing UM procedures which provide incentives for the individual or entity conducting utilization reviews to deny (reduce, suspend or terminate), limit or discontinue medically necessary services to any member. UM decision-making is based only on appropriateness of care and service, and the existence of coverage. Cardinal Innovations does not reward providers or other individuals for issuing denials of coverage or services. There are no financial incentives for UM decision-makers that would encourage decisions resulting in under-utilization.

- **Denial:** A denial could occur if the criteria are not met to support a new authorization request for a service. A denial could be for the whole request or part of the request (e.g., the amount,
frequency, or duration requested). If a service is denied, once the current authorization runs out, the individual is not entitled to receive the services in dispute during the appeal period.

- **Reduction, Suspension, or Termination:** Services a member is currently receiving may be reduced, suspended or terminated based on different factors including, but not limited to, the following clinical guidelines or not continuing to meet medical necessity for the frequency, amount, or duration of a service. Members/guardians will receive a letter by certified mail at least 10 days before the change occurs explaining how to request a Reconsideration Review. If the member/guardian requests a Reconsideration Review by the deadline stated in the letter, the services may be able to continue through the appeal process or to the end of the original authorization, whichever comes first. The Notice of Decision letter sent to the member/guardian will explain how this “Continuation of Benefits” may be able to occur.

**K. Reconsideration Reviews (Appeals)**

Under the NC MH/DD/SAS Health Plan (1915(b) waiver) and the NC Innovations Waiver (1915(c) waiver), a member who does not agree with Cardinal Innovations’ decision to deny, reduce, suspend, or terminate Medicaid services, is entitled to a Reconsideration Review through the Cardinal Innovations Reconsideration Review process.

To request a Reconsideration Review, the member/guardian must complete and return the Reconsideration request form by fax, mail or by bringing the form to Cardinal Innovations in person. A member may request a Reconsideration Review orally, but will still need to submit the proper request form unless there is a health and safety concern and the reconsideration is requested to be expedited. The member/guardian has 60 days after the date of notice on the action to request a Reconsideration Review. During a Reconsideration Review, the member/guardian and/or anyone they choose may represent them. The member/guardian 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. Any member may call 704-939-7700 to ask to speak with an Appeals Specialist if they need assistance in the appeals process or with completing the appeals forms.

- **Exception:** A member may be able to have his or her services continue during the appeal process. This process is called Continuation of Benefits, and it does not apply if Cardinal Innovations’ decision is a denial of an initial request. In order to continue with existing services during the appeal process, the member/guardian must request a Reconsideration Review within 10 days of the date of the notification letter and indicate that he or she wants his/her services to continue. The services may then be able to continue until the end of the original authorization period or the appeals process, as long as the member remains Medicaid eligible. The Notice of Decision letter sent to the member/guardian will explain how this Continuation of Benefits 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 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 and rules and regulations.

If the final resolution of the appeal is not decided in the member/guardian’s favor (that is, Cardinal Innovations’ decision was upheld), Cardinal Innovations may recover the cost of the services furnished to the member/guardian under Continuation of Benefits while the appeal is pending. This is not applicable if Cardinal Innovations issued a denial or if the member received services pursuant to a valid authorization.

A Cardinal Innovations Reconsideration Review is an impartial review of Cardinal Innovations’ 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 member’s condition or disorder and was not previously involved in Cardinal Innovations’ initial decision. If a decision to deny, reduce, suspend, or terminate services is made, Cardinal Innovations will provide written notice and an explanation of the appeal process. In the event any of the processes explained in the notice differ from those in this manual, the member should follow the steps in the notice. For a standard Reconsideration Review a decision will be made as expeditiously as the member’s health condition requires or within 30 days of Cardinal Innovations receiving the request. This deadline may be extended up to an additional 14 days if the member requests the extension or Cardinal Innovations can show there is a need for additional information, and that this extension is in the member’s best interest. A member may file a grievance if they disagree with the extension.

a. Steps to file a Reconsideration Review Request

To request a Cardinal Innovations Reconsideration Review, the member/guardian or the Provider (if making the request on the member/guardian’s behalf or supporting the member/guardian’s request with written consent) must complete and return the Cardinal Innovations Reconsideration Review Request Form by one of the following methods:

- Submission of a written request by fax to 704.939.7507
- Oral request to file, which request must be followed by a written, signed appeal
- Mailing or hand-delivering a written request to: Cardinal Innovations Medicaid Appeals Coordinator, NASCAR Plaza, 550 South Caldwell St., Suite 1500, Charlotte, NC 28202
- E-mailing the request to appeals@cardinalinnovations.org

b. Expedited Reconsideration Review Process

An Expedited Reconsideration Review may be requested by the member/guardian or the provider (if making the request on the member/guardian’s behalf or supporting the member/guardian’s request), if it is indicated that taking the time for a
standard review could seriously jeopardize the member’s life; health; or ability to attain, maintain, or regain maximum function. If an expedited request is received, it is reviewed to determine if there is sufficient evidence to support the need for this type of review. If so, a clinical Reconsideration Review will be completed within 72 hours and the member will be notified of the decision. This deadline may be extended up to an additional 14 days if the member requests the extension or Cardinal Innovations can show there is a need for additional information and this extension is in the member’s best interest. A member may file a grievance if they disagree with the extension. If there is not sufficient evidence to require an expedited review, the member/guardian will be notified of the reason and the process will follow the normal reconsideration timelines.

Documentation reviewed during the initial decision and/or the reconsiderations can be requested to be mailed by contacting the appeals department at 704.939.7700.

State Fair Hearing Process

If the Reconsideration Reviewer does not fully overturn Cardinal Innovations’ decision, the member may file a request for a state fair hearing as the next step of the appeal. Member/guardian must file their appeal with the North Carolina Office of Administrative Hearings, Department of Health and Human Services and Cardinal Innovations within 120 days from the date of the Reconsideration Review decision to the addresses listed on the form.

a. Mediation

Once the appeal form is received by the Office of Administrative Hearings, a mediator will contact the member/guardian to offer an opportunity to mediate the disputed issues in an effort to informally resolve the pending Appeal. Mediation is where a neutral third-party will try to help the member and Cardinal Innovations reach a resolution. A mediator cannot force the member and Cardinal Innovations to come to an agreement. Mediation will generally be completed within 25 days of the request. If the issues are resolved at mediation, the case will be dismissed. If the member/guardian does not accept the offer of mediation or the case is unable to be resolved at mediation, the case will proceed to a hearing and will be heard by an Administrative Law Judge with the Office of Administrative Hearings.

b. Hearings

This state-level hearing is conducted by an Administrative Law Judge (ALJ) at the Office of Administrative Hearings (OAH). The member/guardian may represent their self in this process; they may ask a relative, friend or spokesperson to speak for them; or they may hire an attorney to represent them during the appeal process. Typically, the ALJ will hold an informal “status conference” to learn background information about the case, and then give Cardinal Innovations and the member one more opportunity to try to resolve things. If they are not able to, the ALJ will schedule a hearing.
The hearings are typically held telephonically, although the member can request that a hearing be held in person. They can last anywhere from one-half of a day to two to three days, and include both sides making arguments, having witnesses testify, and presenting documents. After both sides have an opportunity to present evidence, the ALJ will make a decision, typically within 20 days of the date of the hearing.

If the appeal involves a reduction, termination or suspension of services, the member elected a Continuation of Benefits during the appeal, and the final resolution of the Appeal is not decided in the member/guardian’s favor, Cardinal Innovations may recover the cost of the services furnished to the member/guardian while the appeal was pending. This is not applicable if Cardinal Innovations issued a denial or if the member received services pursuant to a valid authorization.

**Requesting UM Criteria for Service Authorization**

The medical policies and criteria for Medicaid services authorized by Cardinal Innovations can be found on the state’s website or by clicking on this link: https://medicaid.ncdhhs.gov/providers/

To receive written copies of these documents by mail can be made by calling 1-800-939-5911.

**L. Non-Medicaid Service Appeal Process**

If Cardinal Innovations denies, reduces, suspends or terminates a non-Medicaid service, the member/guardian affected will be notified in writing. If a member/guardian disagrees with Cardinal Innovations’ decision they may submit a Local Appeal Request within 15 business days from the decision date. In addition, the written Local Appeal request may be submitted by email, in person, or by fax. Cardinal Innovations will notify the member of the results of the appeal within seven business days of receiving the request. For more information, please click on: https://www.cardinalinnovations.org/Contact/Report-concerns

**M. Grievances**

Providers must have a grievance processes to address any concerns of the member and the member’s family related to services provided. Providers must keep documentation on all grievances received – including dates the grievances were received, points of grievances and resolution information. Any unresolved concerns or grievances should be immediately referred to Cardinal Innovations. Information concerning providers’ grievance processes must be given to all members and their family members upon admission and upon request. Providers must advise members and families that they may contact Cardinal Innovations directly about any concerns or grievances. The provider also may file a grievance with Cardinal Innovations on behalf of a member.

Grievances may be filed with Cardinal Innovations either orally or in writing by a member or individuals including providers on behalf of members. Complainants can file a grievance without identifying themselves or request that their identity remain confidential. Cardinal Innovations maintains a toll-free Concern Line on which callers may leave a voicemail regarding their concerns at 800-357-9084. Cardinal Innovations’ Member Engagement Department will assist anyone who requests help in submitting a grievance.
All grievances submitted to Cardinal Innovations will be assigned to appropriate staff for resolution. Cardinal Innovations’ Quality Management Department exercises oversight for the review and resolution of member grievances. The Quality Management Department’s oversight is carefully monitored by the NC Department of Health and Human Services. Any grievance where a member’s health or safety is at risk will be sent to Cardinal Innovations’ Quality Management Department for immediate intervention. If the complainant left his/her contact information, they will receive an acknowledgment letter from Cardinal Innovations within five business days.

The Cardinal Innovations staff member assigned to the grievance will gather any additional information pertinent to the grievance. Most grievances are resolved within 30 calendars days of when Cardinal Innovations received the grievance. Cardinal Innovations may extend the timeframe by up to 14 calendar days if the member requests the extension, or Cardinal Innovations documents (to the satisfaction of DHHS upon its request) that there is a need for additional information and that the delay is in the member’s interest. If Cardinal Innovations extends the timeframe without the request of the member, staff will:

- Make reasonable efforts to give the member prompt oral notice of the delay
- Give the member written notice of the reason for the decision to extend the timeframe within two calendar days
- Inform the member of the right to file a grievance if he/she disagrees with that decision
- Resolve the grievance as expeditiously as the member’s health condition requires and no later than the date the extension expires.

Upon resolution the Cardinal Innovations staff member responsible for the grievance will send the member and all other affected parties a letter notifying them of the resolution.

A copy of the Formal Level of Review Form will accompany the resolution letter. If the complaint is not satisfied with the resolution of the grievance they can request a Formal Level of Review. The complainant can submit the Formal Level of Review Form or request a Formal Level of Review orally within 15 business days following the date indicated on the Grievance Resolution Letter. If the complainant needs assistance filing a Formal Level of Review, they can contact Cardinal Innovations’ Community Operations Department. The Formal Level of Review will be forwarded to the appropriate Department Director or appropriate executive for review. The Department Director or other executive will respond to the complainant within 30 business days following receipt of the request for the Formal Level of Review. For additional assistance, members may contact the N.C. Bar Association’s Referral Service at 800.662.7660, or the Bar Association’s Pro Bono Project at 800.662.7407.

Cardinal Innovations also may directly receive member grievances about a provider’s services or staff. Based on the nature of those grievances, Cardinal Innovations may choose to investigate them to determine their validity or ask the provider to complete an internal review and respond with findings. Investigations may be announced or unannounced. Providers must fully cooperate with all investigative requests; refusal to comply with any grievance follow-up or
investment is a breach of the provider’s Procurement Contract.

The responsibility to investigate these matters is vested with Cardinal Innovations, and Cardinal Innovations takes seriously all such issues with the goal of fully resolving the issues. Cardinal Innovations maintains a database in which all grievances and resolutions are recorded. Cardinal Innovations also maintains documentation on all follow-up and findings of any grievance investigation and provides written summaries of the results to Providers. If problems are identified during the investigation, the Provider may be required to complete a plan of correction.

N. Client Rights Committee

The Client Rights Committee (CRC) has a responsibility to oversee Cardinal Innovations’ compliance with federal and state rules regarding member rights, confidentiality and grievances. The Cardinal Innovations’ CRC is made up of members and family members and expert advisors who meet quarterly.

- The CRC reviews and monitors trends in the use of restrictive interventions, abuse, neglect and exploitation, deaths and medications errors
- The CRC also makes reports to Cardinal Innovations and DMA/DMH
- The CRC reviews grievances regarding services as an advisor to the Continuous Quality Improvement Committee at the Corporate office
- Members or family members of members that wish to apply to serve on the CRC may call Community Operations at 704-939-7700

For additional information, you may go to https://www.cardinalinnovations.org/About/Committees-councils/Client-Rights-Committee

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

O. Consumer and Family Advisory Committee (CFAC)

The Consumer and Family Advisory Committee (CFAC) membership consists of members and family members of members who receive Mental Health, Intellectual/Developmental Disability and Substance Use/Addiction services. CFAC is a self-governing committee that serves as an advisor to Cardinal Innovations’ Community Offices, Cardinal Innovations’ administration and its Board of Directors.

The purpose of CFAC is to ensure that members are involved in oversight, planning and operational committees at Cardinal Innovations. This is accomplished through CFAC representation on the following operational committees within Cardinal Innovations:

- Network Council
- Global Continuous Quality Improvement Committee
- Clinical Advisory Committee

Cardinal Innovations has enjoyed a strong and mutually supportive relationship with CFAC. This ongoing interaction has resulted in important involvement from members and family members across Cardinal Innovations organization.
Any member, family member or provider can bring issues of concern to the CFAC’s attention by emailing CFAC@cardinalinnovations.org, or calling 704.939.7700.

CFAC members serve for a maximum of three consecutive three-year terms with a one-year rotation off of CFAC before potential reconsideration of membership. If providers know of individuals that would like to serve on this committee, please advise them to call Member Engagement or email at memberquestions@cardinalinnovations.org. For more information about CFACs, go to https://www.cardinalinnovations.org/consumer-families/rights-responsibilities/cfac
The NC MH/DD/SAS Health Plan and the NC Innovations Waiver are important building blocks in the foundation of a system that strives to effectively and efficiently address the needs of individuals with mental health, intellectual/developmental disabilities and substance use/addiction disorders. Cardinal Innovations maintains a Clinical Design Plan, which outlines our approach to developing and maintaining high quality and highly accessible services for our members. The Clinical Design Plan emphasizes the following goals:

1. To implement the NC MH/DD/SAS Health Plan and the NC Innovations Waiver consistent with our contractual responsibilities and enhance these Plans by maximizing the effect of additional state and local funding resources.

2. To ensure our clinical system is consistent with our clinical governing principles of quality and accountability; clinical innovation; cultural and linguistic competence; recovery and community integration; person-centeredness and quality of life; and, safety and wellbeing.

3. To utilize high quality managed care tools to consistently reinforce best practice care for our members. These tools include having a Clinical Advisory Committee comprised of internal and external experts; multidisciplinary cross-functional teams; a 24/7 access call center; highly monitored contracting and credentialing processes; strategic network development based upon assessed gaps and needs; utilization management focused on high need member monitoring, data analytics and best practice promotion; tailored interventions for special population management; expert medical oversight; forward-facing and person-centered care coordination; internal and external quality and performance monitoring; and community stakeholder engagement.

4. To emphasize a clinical model based on core best practices of measurement based care, coordination of care, and use of clinical practice guidelines. These practices are aimed at improving member outcomes, symptoms and skills; improvement in quality of life; reduction in the need for highly restrictive levels of care; and a reduction in the total cost of care for our members, even though additional resources may be required within Cardinal Innovations’ clinical system.

5. To ensure our youth and adult members with MH/SU disorders have access to a network of high quality services which provide members with best practice assessments, psychotherapy, medication management, enhanced/wrap services, residential services and crisis services.

6. To provide our youth and adult members with IDD services that are consistent with the Home
and Community Based standards by giving those members access to high quality assessments, NC Innovations Waiver services, and other Medicaid and state-funded services.

For additional information concerning the Clinical Design plan, please go to the Resource Library on the website and search for Clinical Design Plan. The plan can be accessed on the Cardinal Innovations website through the following link: https://www.cardinalinnovations.org/Cardinal.Innovations/media/Documents/Resource%20Library/Guidelines/Clinical-Design-Plan_1.pdf

Clinical Practice Guidelines are adopted as recommended by the Cardinal Innovations Clinical Advisory Committee (CAC), which is comprised of clinically licensed practitioners from our provider network and internal Cardinal Innovations staff. Clinical Practice Guidelines are systematically developed tools, usually evidence based, that help guide decisions about appropriate health care. Cardinal Innovations maintains Clinical Practice Guidelines for mental health conditions, mental health conditions specific to children and adolescents, substance use disorders, and intellectual/developmental disabilities. These guidelines are reviewed by the CAC regularly to ensure they reflect the most current research and practice standards. The adopted guidelines are intended to inform community standards of practice.

Providers are expected to be familiar with the guidelines and to use them to inform their behavioral healthcare activities. Adopted clinical guidelines are available online at: https://www.cardinalinnovations.org/Providers/Clinical-Practice-Guidelines?sort=0

Screening Tools

Cardinal Innovations Healthcare has identified screening instruments that can assist in identifying early onset of substance use disorder and mental health conditions. These screening tools were identified to better support members and identify needs in a comprehensive manner.

It is recommended that mental health providers complete a substance use screening as part of their assessment process and that substance use disorder providers use one or more of the mental health screenings as part of their assessments.

The tools have been reviewed by the Clinical Advisory Committee and recommended for use by Cardinal Innovations.

These can be found on the website at: https://www.cardinalinnovations.org/Providers/Communication-bulletins/Screening-Instruments.
Section VII:
ACCESS, ENROLLMENT AND AUTHORIZATION OF SERVICES

NOTE: The general processes listed below apply to the NC MH/DD/SAS Health Plan [1915(b)], NC Innovations Waiver [1915(c)], (b)(3), In Lieu Of and Alternative Service Definitions.

For more specific information on service and eligibility criteria, please refer to the service descriptions available on the Cardinal Innovations website at https://www.cardinalinnovations.org/Members/How-Coverage-Works

A. Access Department Description

Access to care is a critical function of Cardinal Innovations. Cardinal Innovations is responsible for timely response to the needs of members and for the quick linkage of members to qualified Network Providers. To ensure the simplicity of the system requested by our members and stakeholders, Cardinal Innovations maintains a toll-free number for members. Calls are routed to the Cardinal Innovations Access Call Center. They are answered 24 hours per day, 7 days per week, 365 days per year for telephonic assessments and crisis intervention for people seeking assistance with mental health, intellectual/developmental disability and substance use disorder needs. The Access Call Center also provides our communities with information and referral for MH, IDD and SUD services within our catchment area. This area includes the following counties: Alamance, Cabarrus, Caswell, Chatham, Davie, Davidson, Forsyth, Franklin, Granville, Halifax, Mecklenburg, Orange, Person, Rockingham, Rowan, Stanly, Stokes, Union, Vance and Warren.

Cardinal Innovations’ Access Department can be reached toll-free at 1.800.939.5911.

If for any reason, a caller cannot get through using this number, the caller may dial the main number at the Cardinal Innovations Headquarters (704.939. 7700), and ask to be transferred to the Access Call Center.

The Access Department is staffed by:
• Director
• Access Managers
• Access Supervisors
• Access Coordinators
• Access Clinicians

1. Access Coordinators
Access Coordinators are Bachelor’s level or non-licensed Qualified Professionals. Access Coordinators answer telephone calls coming in to the Access Call Center; they collect demographic information, verify insurance eligibility and complete a brief intake screening to determine the appropriate type and level of services needed. If the caller presents with a referral request (routine, urgent or emergent need), the Coordinator can connect the call to an Access Clinician. The Access Coordinator may also provide information about community resources.
as well as make direct appropriate referrals for service members, veterans, and their family members.

2. **Access Clinicians**
   Access Clinicians are Masters-level, licensed professionals who work in the same capacity as the Access Coordinators. However, additional responsibilities include appointment referrals as well as care coordination referrals, emergency services, and crisis intervention calls. Access Clinicians will continue to follow-up with any emergency contact until they determine that the member has been able to receive the most appropriate care to meet the member’s clinical needs. Access Clinicians are available to take over calls from Coordinators with members who are in distress.

**B. Access Call Center Process**

Cardinal Innovations’ Responsibilities to Providers are to:

1. Answer calls placed to the Access Line within 30 seconds. During times of heavy call volume, excess calls may be routed to internal overflow staff.
2. Have Access Staff screen the urgency of the call and, if appropriate, refer to an Access Clinician who will collect important demographic information such as name, address, and telephone number to identify the member (person requesting services or information); and his/her current location, in case the call becomes emergent.
3. Provide interpreter services to callers, as necessary.
4. Based on the member’s response to the greeting and prompting questions from the Access Staff, those staff will address the following issues:
   - Provide Information about community (non-treatment) resources
   - Enroll an individual
   - Address eligibility questions
   - Provide referral for Routine Assessment
   - Manage and provide referrals for Urgent Calls
   - Manage and provide referrals for Emergent Calls
   - Identify grievances and route the caller to the grievance line
   - Assist providers
   - Transfer calls to appropriate departments for specialized questions
   - Provide general information about Mental Health, Substance Use Disorders, and Developmental Disabilities

Your responsibility as a Cardinal Innovations Contracted Provider is to:

Be as clear as possible in requesting information or services to enable our Access Center to help you in the most efficient and effective way possible.

C. **Access to Services**

1. **Routine Service**

This process pertains to referrals for Routine Services. The Access Standard for Routine Services is to arrange for services within 14 calendar days of contact at the Access Line. The geographic access standard for services is 30 miles or 30 minutes driving time in urban areas, and 45 miles or 45 minutes driving time in rural areas. It is the responsibility of all Access Call Center staff to ensure that Routine Referrals are handled in the appropriate way.
Routine Referral Process:

a. The Access Call Center staff will collect demographic information on the caller and the member and search for the member in the CI System.

b. If the member is not located in the eligibility file, the Access Call Center staff will advise the member of this, and proceed with collection of enrollment data on the most current Cardinal Innovations Enrollment Form.

c. The Access Call Center staff will evaluate the member’s clinical need as follows:
   - Complete the state-mandated Screening, Triage and Referral (STR) tool and document the information obtained following the current CI System;
   - Retrieve and review the member’s historical information, if available; and
   - Use the information provided to determine the type of clinical services indicated.

d. The Access Call Center staff will offer the member a choice of at least three providers (when available) and document in the CI System the providers offered and the provider selected.
   Choice is provided by considering providers in the following areas:
   - Availability of service
   - Proximity to member
   - The member’s desired attribute in provider or provider specialty

e. The Access Call Center staff will call the chosen provider for immediate scheduling with the member on the line or utilize electronic provider web-based calendars to schedule appointments. If an appointment is not available within availability guidelines, the member may choose another provider.
   - The Access Call Center staff will give the provider a brief overview of the member’s need for service and indicate the service to be provided.
   - The Access Call Center staff will either remain on the line with the provider and member to obtain the date of the initial appointment, or request that the provider call back to provide this information. This process is to ensure appointments are being set within the state-required time frame for the determined level of care, and that the information is documented in the computer system.
   - In the event that the member chooses to contact the selected agency on his/her own, Access Call Center staff will indicate this in their documentation. The appointment date will be obtained by review of claims information.
   - Access Call Center staff will give the provider the STR number so the Provider can access the screening information in Provider Direct.
   - This process cannot be followed for SUD referrals due to restrictions in release of SUD information covered under 42 CFR Part 2 confidentiality regulations. In cases where referrals are made for SUD services, the member or caller will be given the contact information for the appropriate service providers.
Note: Cardinal Innovations Network Providers are held to the following standard regarding Appointment Wait Time for Routine Referrals: Scheduled – one hour; Walk-in – within two hours.

2. Urgent Service:

There are several steps that Cardinal Innovations’ Access Call Center staff will take to ensure appropriate care for members with Urgent care needs. The following describes how referrals for Urgent services are handled within Cardinal Innovations’ Access Unit.

The Access Standard for Urgent Care requires services to be rendered within 48 hours of contacting the Access Line. The geographic access standard for services is 30 miles or 30 minutes driving time in urban areas, and 45 miles or 45 minutes driving time in rural areas. If an Access Coordinator receives an urgent call from a member seeking access to care, the Access Coordinator will warm-transfer the member to an Access Clinician for further screening, assessment and referral.

To ensure individuals are seen within 48 hours, attempts will be made to schedule the individual same day or next day from the date of screening.

Urgent Referral Process

a. A member’s clinical need may be considered Urgent under the following circumstances (including, but not limited to):
   - A member reporting a potential substance-related problem
   - A member being discharged from a jail
   - The member seems at risk for continued deterioration in functioning if not seen within 48 hours
b. The Access Staff will collect the enrollment data and proceed with a state screening form to identify treatment needs.
c. After completing the screening, the Access staff will offer the member a choice of three providers (when available) and document in the CI System the providers offered and the provider selected.
d. The Access Staff will use electronic scheduling or call the chosen provider to schedule an appointment, which must be available within 48 hours. If this does not occur, an explanation will be documented.
e. If there are no scheduled appointments available within the mandated timeframe, the member will be referred to walk-in services to an Advanced Access Provider.
f. The Access Clinician will remind the member that the Cardinal Innovations Access Call Center is available 24 hours a day, and will instruct the member to re-contact the Access Call Center by telephone at any time should the situation escalate and require immediate attention.
g. Cardinal Innovations’ Access Staff will continue to follow-up with any Urgent contact until they determine that the member has been able to receive the most appropriate care to meet the member’s clinical needs or the member has refused all services.

NOTE:

- Cardinal Innovations Network Providers are held to the following standard regarding Appointment
Wait Time for Urgent Cases:
Scheduled Appointment— one hour;
Walk-in – within two hours.

- Urgent callers (not Medicaid/IPRS) are typically referred to walk-in centers, cross-referencing known insurances that providers accept, if known. These callers are also encouraged to follow up with either the provider or their insurance companies to verify coverage for those services.

- If a member requires emergent care, the member will be referred to a provider regardless of funding status (Medicaid, Medicare, private insurance, etc.).

3. Emergent Service:

There are several steps required to ensure that referrals for emergency care are handled and documented in an appropriate manner. The following describes how referrals for Emergency services are handled within Cardinal Innovations’ Access Unit.

The access standard for Emergence services requires services to be rendered within two (2.0) hours, or immediately, for life-threatening emergencies. The geographic access standard for services is 30 miles or 30 minutes driving time.

NOTE: In potentially life-threatening situations, the safety and well-being of the member has priority over administrative requirements. Eligibility verification will be deferred until the caller receives appropriate care.

Emergent Referral Process:

a. Any calls that are deemed to be Emergent, if answered by an Access Coordinator, are immediately transferred to an Access Clinician via a warm transfer.

b. An Emergent situation is indicated if the member demonstrates one or more of the following (including, but not limited to):

- Real and present or potential danger to self or others as indicated by behavior, plan or ideation
- Labile or unstable and demonstrates significant impairment in judgment, impulse control, and/or functioning due to psychotic symptoms, chemical intoxication, or both
- Immediate and severe medical complications concurrent with or as a consequence of psychiatric or substance abuse illness and its treatment
- Caller indicates (either by request or through assessed need) a need to be seen immediately
- The Access Clinician will determine through clinical screening whether the member represents an immediate danger to self or others. If the member is an imminent danger to self or others, the Access Clinician will implement crisis intervention procedures as an attempt to stabilize the member.
- The Access Clinician will attempt to determine any available supports for the caller and when possible speak to them directly for assistance.
If the member is able to be stabilized:

The Access Clinician will initiate a call to the Mobile Crisis Management Agency to follow up with the member.

If the member is unable to be stabilized:

a. The Access Clinician will, with assistance from other staff when needed, contact the appropriate emergency agency (e.g., law enforcement/Crisis Intervention (CIT) Responder, emergency medical services, etc.) to respond and attempt to keep the caller on the phone until they arrive. The other Access staff member assisting the Access Clinician will collect the remaining enrollment data from the crisis worker when it becomes available.

b. Cardinal Innovations’ Access Clinicians will continue to follow-up with any emergency contact until they determine that the member has been able to receive the most appropriate care to meet the member’s clinical needs.

NOTE:

- Access staff will inform the caller about the availability and type of nearest emergency services. This information also is available in the member handbook, which is available on the Cardinal Innovations website. This member handbook contains information on the ways in which members can access emergency services. In addition, it is the responsibility of Access Call Center staff to inform members of the availability and type of the nearest emergency services as they are assisting the member in an emergency.

- Cardinal Innovations Network Providers are held to the following standard regarding Appointment Walk-In Time for Emergencies: provider will see all emergencies within two hours, or immediately if the situation is life threatening.

D. Process for Acute Service Authorization Requests

1. Telephonic Process

Both Access and UM Clinicians can conduct telephonic reviews that require pre-service authorization of the following services due to the acute nature of the need:

- State hospital authorization requests
- All other services requiring prior authorization

Once Cardinal Innovations UM Clinicians review and approve Treatment Authorization Requests (TARs) in the CI system, a UM Note is entered in the Provider Notes section of the TAR. If a provider has a question regarding a pre-service authorization request, they are to reach out to the dedicated Provider Line at 855.270.3327, option 2, during normal business hours. If the call is after hours, it will be answered by the Access Call Center staff. Either the Provider Line or Access staff will confirm eligibility and enrollment of the member. If the member is not enrolled, the Access Staff will assist the provider in enrolling the member (see Eligibility and Enrollment above). If during normal business hours, the Provider Line will link to the Service Center to aid with the enrollment process. If there is a question about the member’s eligibility – even if eligibility is not confirmed at the
time of the call – the pre-service authorization review will be conducted by the UM Clinician and a decision made, with a disclaimer given that eligibility must be confirmed in order for payment to occur.

2. **Non-Telephonic Process**

UM Clinicians will conduct reviews of acute service authorizations that are submitted through Provider Direct.

3. **Authorization Review**

   a. If the member’s situation meets Cardinal Innovations’ established clinical criteria for the requested service, the UM Clinician will authorize the service based on the Authorization Guidelines. In addition, the UM Clinician will advise the caller of the authorization, and generate an authorization number, by completing a TAR.

   b. If the member’s condition does not appear to meet the criteria for the requested service, the UM Clinician will explore treatment alternatives with the provider and member.

      • If agreement is reached regarding treatment at a different level of care or with a different service, the UM Clinician will document the treatment plan agreed upon and complete the authorization/notification procedures for that level of care or service.

      • If the provider continues to request authorization for services which do not appear to meet Cardinal Innovations’ applicable clinical criteria and guidelines, the UM Clinician will advise the provider that a review will be necessary with a Cardinal Innovations physician and/or psychologist, and that arrangements will be made by the UM Clinician.

      • All determinations and related actions will be recorded in the Cardinal Innovations CI System.

      • Any denial of service will follow the Medicaid Appeals process for Medicaid services and/or the local Cardinal Innovations Non-Medicaid Appeal Process for non-Medicaid services.

4. **Discharge**

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 systems; 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.

Care Coordinators assist with the discharge planning for members in acute levels of care. Among other functions, Care Coordinators:

• Identify members who have multiple admissions to acute care facilities and make recommendations, when appropriate, that enhanced services start prior to member discharge.
- Make follow-up appointments with appropriate community providers within 48 hours of discharge, when available

5. **Follow up after Discharge:**

Cardinal Innovations recognizes the importance of follow-up care after a member is discharged from an acute level of care. Every effort is made to ensure the member is engaged in treatment. All discharge appointments are checked by the Follow-Up Specialist or by an assigned Care Coordinator by contacting the Provider to verify that the appointment was kept. This appointment, along with the next appointment date, is monitored in the CI system.

*If an appointment is not kept, the Follow-Up Specialist:*

a. Documents the reason (e.g., no show, member canceled, provider canceled, etc.) and whether the appointment was rescheduled
b. Attempts to contact the member to discuss barriers and schedule another appointment
c. May make a discharge engagement referral requesting face-to-face contact for the purpose of engaging the member in services if all prior attempts to do so were unsuccessful.

E. **Enrollment**

Please refer to the most current version of Cardinal Innovations’ Enrollment training material on the Provider Direct website. The enrollment process is different for members who receive only Medicaid-funded services than for those who receive state-funded or federally-funded block grant services.

The following describes the general process for enrollment of a new member. At a minimum, all parties must ensure all information is accurate and complete when enrolling a member into the Cardinal Innovations system.

1. **Process for Enrollment:**

   a. An individual who resides within Cardinal Innovations’ service area calls the Call Center Number (1.800.939.5911) for a referral to services.
   b. The Access staff member determines if a request for service is routine, urgent or emergent (see Access to Services above).
   c. The Access staff member determines whether the individual who resides within Cardinal Innovations’ catchment area is enrolled via current CI System member search. If the individual is not already enrolled, the Access staff member will discuss eligibility and, if eligible, complete the initial enrollment data in the CI System.
   d. The individual then will be referred for an assessment and the enrollment data is forwarded to the receiving provider via secure web portal (Provider Direct).
   e. The provider conducts an assessment and completes the Additional Enrollment Data on the enrollment form. The provider collects documentation of Medicaid process for enrollment or information on ability to pay.
   f. The provider submits the completed enrollment to Cardinal Innovations via Provider Direct.
g. Enrollment is reviewed for completeness and accuracy by the Eligibility and Enrollment Specialist and entered into the CI System.

Providers who have the ability to electronically submit confidential documents securely to Cardinal Innovations must use the following process to enroll individuals:

2. Process for handling enrollment electronically

   a. Walk-Ins at a provider site.
      • The provider assesses for life-threatening situation.
         o If life-threatening situation is present, the provider proceeds with emergency response as clinically indicated.
         o If not life-threatening, the provider determines whether the individual is enrolled with Cardinal Innovations by
            ▪ Checking the enrollment status in Provider Direct or
            ▪ Calling the Access Center and inquiring about the individual’s enrollment status.
      • If the individual is enrolled and has been previously seen by the provider, the provider will conduct an assessment and request services per Cardinal Innovations Utilization Management Procedures. The provider should also ensure the accuracy of the member’s information and complete a Clinical Update if needed.
      • If the individual is not enrolled, the provider will collect enrollment information on the most current Cardinal Innovations Enrollment Form and send it electronically through Provider Direct.

   b. Member Call-Ins to a provider site.
      • The provider will schedule an appointment to conduct an assessment. Enrollment information will be collected on the most current Cardinal Innovations Enrollment Form and transmitted to Cardinal Innovations through Provider Direct.
      • Cardinal Innovations Enrollment and Eligibility Specialist will check the enrollment data for completeness and accuracy and will verify insurance eligibility.

F. Initial Assessment

Providers should complete an initial assessment addressing the elements required in the current Service Records Manual (APSM 45-2).

Provider should use standardized screening tools and the clinical practice guidelines that have been adopted as part of their assessment processes whenever possible. The assessment should screen for co-occurring conditions in addition to the presenting need. These guidelines are consistent with clinical best practices based on member diagnosis(es), and can help guide the most appropriate treatment services, treatment recommendations, and clinical practices. The Utilization Management Department can review provider compliance to the clinical
practice guidelines. These guidelines can be found in the Resource Library by searching Practice guidelines.

**Treatment Authorization Request:**

A Treatment Authorization Request (TAR) is an electronic form that captures demographic and clinical information.

1. **Acute Service Requests:** Cardinal Innovations has formulated a Treatment Authorization Request form (TAR) that captures demographic and clinical information. When the TAR is completed thoroughly, the Care Management staff will be able to use this form to make the clinical determination required for the member’s needs. If the form is not completed fully, including all clinical information required, a delay in the approval of a service request or a denial of the TAR may occur. Cardinal Innovations will respond to all initial acute service TARs within 72 hours. Acute Service re-authorization/concurrent reviews will be conducted within 24 hours of receipt. Providers will be monitored for TAR completeness and will be identified for additional training as indicated by the quality of the TAR submissions.

   • **Extension of Review Timelines:** Extensions of review timelines may be made to extend the timeline for review to 28 days in situations where additional clinical information or clarification is necessary to make a decision on the requests. In these cases formal notification of the extension will be provided to the individual, guardian, and/or legally responsible person, in addition to the submitting provider. Extensions may also be requested by the provider or the member through notification to the Utilization Management team and providing documentation supporting how this is in the best interest of the enrollee.

2. **Non-Acute Service Requests:** Again, when the TAR is completed thoroughly, the Utilization Management staff will be able to use this form to make the clinical determination required for the member’s needs. If the form is not completed fully, including all clinical information required, a delay in the approval of a service request or a denial of the TAR may occur. Cardinal Innovations will respond to all TARs within 14 calendar days, but may extend the timeframe by up to an additional 14 calendar days if additional information is needed. The Utilization Management staff will attempt to obtain the information through contact with the provider but, in some cases, this can take several days to complete. Providers will be monitored for TAR completeness and will be identified for additional training as indicated by the quality of the TAR submissions.

Training material is available by logging into Provider Direct and selecting the Training Menu option at [http://providerdirect.cardinalinnovations.org](http://providerdirect.cardinalinnovations.org). A provider can request technical assistance on TAR submissions, in general, by contacting the Cardinal Innovations Utilization Management Unit at 704.939.7700. Acute Service Providers may request specific technical assistance on TAR submission by contacting the Acute Service Provider Referral Line at 1.855.270.3327. In some cases, Utilization Management may identify a technical issue requiring providers to contact the IT Department for additional assistance.
G. **Initial Authorization**

**NOTE:** Cardinal Innovations 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 service and the existence of coverage. Cardinal Innovations does not reward practitioners or other individuals for issuing denials of coverage or services. There are no financial incentives for Utilization Management decision-makers that would encourage decisions that result in under-utilization.

The following information identifies the steps required in processing prior-authorization of services. Prior-authorization of services is the responsibility of Cardinal Innovations’ Utilization Management Department. However, submitting the request for prior Authorization is the responsibility of the provider.

To learn more about the state Medicaid Plan Service Definitions and Criteria, please consult the following 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)

**1. Process for Prior Authorization of Services**

Prior-authorization is required for all Cardinal Innovations covered services, with the following exceptions:

a. Initial 24 outpatient services (assessment, individual, family and group therapy) for Medicaid-eligible members
b. Initial eight outpatient services (assessment, individual, family and group therapy) for non-Medicaid eligible adults
c. Initial 12 outpatient services (assessment, individual, family and group therapy) for non-Medicaid eligible children
d. Psychological evaluations – six unmanaged units for psychological testing and eight unmanaged units for neuropsychological testing
e. Psychiatric Services – medication services and evaluations by physicians
f. Emergency/crisis services for behavioral healthcare
g. Codes specifically agreed upon by Cardinal Innovations and the provider to be listed as No Authorization Required under a contract (please see your contract for applicability)

The Cardinal Innovations Utilization Management Unit within the Clinical Operations Department is only able to make decisions (approval, denial or extensions when appropriate) when a complete request for authorization is received. For a request to be considered complete, it must contain the following elements:

- Recipient/member name
- Medicaid ID
- Date of birth
- Social Security Number
- Provider contact information and signatures
- Date of request
- Service(s) requested
- Service Order as applicable
• Completed check boxes (Signature Page/Service Order Yes or No check boxes related to medical necessity, direct contact with the individual, and review of the individual’s Clinical Assessment)
• Individualized Service Plan/Person Centered Plan (ISP/PCP), when required

If all of these elements are not included in the request, Cardinal Innovations will mark the request as unable to process, and a new request with the required elements will have to be submitted.

Some of these elements will be contained in the corresponding Treatment Authorization Request (TAR). Submission of a TAR constitutes a request for service authorization and starts the timeline for review. Submission of an Individualized Service Plan (ISP) or Person-Centered Plan (PCP), without more, does not constitute a request for the authorization of a service, as it does not meet the criteria identified above. In particular, neither the ISP nor PCP identifies the service provider and requested services dates (this information is submitted via the TAR). Indeed, Cardinal Innovations discourages the listing of specific provider names on ISPs/PCPs in the event a transfer to another provider is needed. Instead, this information would be identified on the TAR.

If a TAR is received containing a request for a service or frequency that is different from the PCP, Cardinal Innovations will mark the TAR as unable to process.

If a TAR that requires a corresponding PCP/ISP is received without the required Plan, the TAR will be marked as unable to process, requiring submission of a new TAR with the required PCP/ISP.

2. Initial Authorization of Basic Services:

a. Prior-authorization for all Basic services may be requested once unmanaged units are utilized. A request can be submitted through submission of the TAR form. (An expedited prior-authorization can be requested by telephone for any service, if immediate access is clinically indicated.) Please refer to the most current version of Cardinal Innovations’ TAR and TAR Instructions, available in the Provider Direct Portal, by selecting the Training Materials tab through the following link: www.cardinalinnovations.org
b. Telephonic pre-authorization (see Section VII.D above for details).

3. Initial Authorization of Enhanced Services:

Enhanced level services will be authorized through the review of the TAR and approved Person-Centered Plan as submitted by the Clinical Home Provider. Services will be identified through the person-centered planning process in a coordinated effort between the Clinical Home Provider, the member, the member’s family and providers.

a. Authorization of Enhanced Services:
   • Enhanced level services needing authorization should be submitted through the Provider Direct system and the electronic Treatment Authorization Request (TAR) form. An Initial or Individualized Service Plan (ISP) or Person-Centered Plan (PCP) must be uploaded through
Provider Direct at the same time as the submission of the TAR. Please note that all NC Innovations Waiver services should be requested by the Care Coordinator via the ISP and corresponding TAR because NC Innovations Waiver services qualify as Enhanced services. Therefore, the Care Coordinator is responsible for submitting service requests and all changes for those requests.

- The Clinical Home Provider completes the ISP/PCP with input from the member, the member’s family and other providers. The services should be listed with any noted limitations, and the provider for each service should be listed on the TAR.
- The PCP and TAR should be submitted to Utilization Management for review.
- All UM actions will be documented in the CI System.
- If the ISP/PCP and TAR are missing information, contain incorrect information or the information lacks all required elements, the TAR may be marked as unable to process, returned and delayed for receipt of the additional, corrected information; or it may be clinically denied. If a TAR is denied, UM staff will document the reason for denying the service in the TAR.
- Depending on the status of the request, the provider should return the information needed within the time specified by UM Staff, or submit a new TAR with all required information. All versions of the request will be maintained in the CI System.
- An Initial Authorization Letter is automatically generated by the CI System, and can be obtained through Provider Direct. The letter will indicate the time period for which the service is authorized and when a re-authorization, if needed, will be due.

b. Reauthorization of Enhanced Services:
- The next review date is indicated by the end date on the authorization letter. It is the provider or facility’s responsibility to conduct a clinical review and submit a request for further service authorization to Cardinal Innovations’ UM Unit prior to the expiration of the current authorization.
- The request for additional services must be made no earlier than 30 days and no later than 15 days before the current service authorization expires. In acute situations, it is recommended that, when possible, the clinical review should be conducted at least 24 hours prior to the expiration of the current authorization.
- If the Clinical Home submits the request the day the authorization expires, UM still has up to 14 days to review the request and possibly return for additional information. This will delay the provider’s ability to submit claims. When medical necessity is met for reauthorization, the date authorized will be the start date requested on the TAR or submission date if the start date is earlier. UM is not allowed to authorize services prior to the
submission date. UM Care Managers refer to the Authorization Guidelines to determine when reviews should be conducted for each level of care.

- Based on a review of the information provided, the UM Care Manager will make a decision to authorize or deny the request.
- If the request is denied, the member and provider will be notified and appeal rights will be provided.

- All determinations and related actions will be recorded in the Cardinal Innovations CI System.

4. Additional Authorization of Basic Services:

When unmanaged visits for basic services have been exhausted, a Treatment Authorization Request should be submitted via Provider Direct for review of whether the member meets the continuation of services criteria.

a. The request for additional services must be made no earlier than 30 days and no later than 15 days before the current service authorization expires. In acute situations, it is recommended that, when possible, the clinical review should be conducted at least 24 hours prior to the expiration of the current authorization.

b. If the Clinical Home submits the request the day the authorization expires, UM still has up to 14 days to review the request and possibly return for additional information, potentially delaying a provider’s ability to submit claims. When medical necessity is met for reauthorization, the date authorized will be the start date requested on the TAR or submission date if the start date is earlier. UM is not allowed to authorize services prior to the submission date. UM Care Managers refer to the Authorization Guidelines to determine when reviews should be conducted for each level of care.

- Based on a review of the information provided, the UM Care Manager will make a decision to authorize or deny the request.
- If the request is denied, the member and provider will be notified and information will be provided on appeal rights.

- All determinations and related actions will be recorded in the Cardinal Innovations CI System.

5. 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. It is the clinical home’s responsibility to take the lead in the discharge planning process and include all relevant parties such as the member, family, Care Coordinator, other providers and stakeholders.

Discharge planning includes the following:

- Development of measurable and realistic criteria as defined in the PCP/ISP
- Readiness for discharge
- Step-down plans, including consideration of both paid and natural supports
- Anticipated discharge date
• The member’s understanding and input in the discharge plan

The discharge planning process includes use of the member’s strengths and support systems; 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.

6. Utilization Management’s Role in Discharge Planning:

Utilization Management monitors discharge planning and provides feedback and recommendations when appropriate. Utilization Management monitors discharge planning during initial, reauthorization and discharge requests. Any request may be returned if discharge plans are unclear. In addition, Utilization Management will:

• Identify members who remain hospitalized, or at any other level of care, who do not meet criteria for that level of care and help develop a plan to get the right service at the right level
• Monitor members to assure that they receive clinically indicated services
• Include a follow up appointment within five working days whenever a member is discharged from detoxification, inpatient psychiatric or partial hospitalization care as part of the discharge plan. Cardinal Innovations will work with the discharging facility to ensure that an appointment is made and monitor whether the member kept the appointment.
• Coordinate with the member’s Clinical Home to ensure there are appropriate services in place following discharge. If the member does not have a Clinical Home, and the member meets Special Needs Population criteria, the UM Care Manager will refer to the Care Coordination Department for follow-up by a Care Coordinator.

7. Discharge Treatment Authorization Request:

Discharge TARs are expected with any level of care. The Discharge TAR has less information required to help expedite providers’ submission of discharge information. Residential levels of care for MH/SA and IDD have specific timelines for discharge. As to all other services, discharge information should include the following:

• Progress at the time of discharge
• Date, time and agency(ies) to which member was referred
• All applicable plan updates and signatures verifying the discharge plan
• Providers should contact Utilization Management with any questions
Section VIII: 
STATE AND MEDICAID SERVICE DEFINITIONS AND CRITERIA

A. State Service Definitions and Criteria

1. State Service Definitions

All state-funded services are based upon a finding of medical necessity, which is determined by generally accepted North Carolina community practice standards, which must be verified by Cardinal Innovations as the LME/MCO. There must be a current diagnosis reflecting the need for treatment; and the services provided must be medically necessary to meet specific preventive, diagnostic, therapeutic and rehabilitative needs for the individual. The meaning of these terms along with all other relevant and essential information and criteria for state-funded MH/DD/SUD services can be found in the corresponding service definitions at: [https://www.ncdhhs.gov/divisions/mhddsas/servicedefinitions](https://www.ncdhhs.gov/divisions/mhddsas/servicedefinitions)

2. Alternative Services

LME-MCOs may develop and reimburse state-funded services that are substantial changes to existing services or completely new services. These Alternative Services are cost-effective options to state-funded services. Alternative Services may be LME/MCO-specific. Definitions can be accessed on the Cardinal Innovations website in the Resource Library at:

B. Medicaid-Funded Service Definitions and Criteria

1. NC MH/DD/SAS Health Plan – 1915(b) Waiver

The NC MH/DD/SAS Health Plan services follow the NC State Medicaid Plan Service Array for Behavioral Healthcare. Please follow the link below for the most current version of the service definitions and admission, continuation and discharge criteria.

- Clinical Coverage Policies: [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)

2. NC Innovations Waiver – 1915(c) Waiver

The NC Innovations Waiver is a 1915(c) Home and Community-Based Waiver. An individual must be a participant of the NC Innovations Waiver in order to receive these services. For further information, please refer to the resources below:

- Clinical Coverage Policy: [https://files.nc.gov/ncdma/documents/files/8-P_2.pdf](https://files.nc.gov/ncdma/documents/files/8-P_2.pdf)
- DHB website: [https://medicaid.ncdhhs.gov/nc-innovations-waiver](https://medicaid.ncdhhs.gov/nc-innovations-waiver)
3. **(b)(3) Services**

The (b)(3) services are Medicaid services that are funded through a separate capitation payment. Definitions can be accessed on the Cardinal Innovations website in the Resource Library at:

https://www.cardinalinnovations.org/Members/How-Coverage-Works/Medicaid-funded-coverage?tab=2

4. **In Lieu Of Services**

LME-MCOs may develop and reimburse Medicaid-billable services in addition to those covered under the Medicaid State Plan. A Medicaid In Lieu Of Service is a substantial change to an existing service in the Medicaid State Plan or a completely new service. In Lieu Of Services are cost-effective options to Medicaid State Plan services. These services may be LME/MCO-specific. Definitions can be accessed on the Cardinal Innovations website in the Resource Library at:

https://www.cardinalinnovations.org/Members/How-Coverage-Works/Medicaid-funded-coverage?tab=3

See Section VII for instructions on Access, Enrollment and Authorization of Services.
Section IX: RESOURCES FOR PROVIDERS

Contracted providers must keep abreast of rule changes at the state level, attend workshops and trainings to maintain clinical skills and/or licensure, be knowledgeable on evidence-based and emerging practices, and be current on coding and reimbursement. Cardinal Innovations will provide a number of resources to assist providers in meeting these requirements. We will communicate information regarding workshops through various media outlets and will offer trainings or technical assistance as needed.

The Network Management Department will coordinate the trainings offered by internal departments and post it on www.cardinalinnovations.org. The following links navigate to trainings and resources.

The following resources are provided as assistance and linkage and are not designed to be a comprehensive list for providers.

Additionally you may wish to reference our Provider Orientation Companion link

A. **Training and Technical Assistance**
   
   [http://www.cardinalinnovations.org](http://www.cardinalinnovations.org)

   Provider Direct training is online and available to all provider staff who have a Provider Direct login. Provider staff members who wish to be system administrators must take a special system administrator training, and will receive the training link for that training via email when the System Administrator Designee form is received. All other Provider Direct users should use the training menu option to view training videos.

   You can access the Provider Direct System Administrator Designee Form by going to the Resource Library on Cardinal Innovations’ website and search Forms.

B. **Advocacy**

   National Alliance on Mental Illness (NAMI):
   [https://www.nami.org](https://www.nami.org)

   North Carolina Assistive Technology Program:
   [https://www.ncdhhs.gov/divisions/vocational-rehabilitation-services/north-carolina-assistive-technology-program](https://www.ncdhhs.gov/divisions/vocational-rehabilitation-services/north-carolina-assistive-technology-program)

   Benchmarks:
   [http://www.benchmarksnc.org](http://www.benchmarksnc.org)

   Customer Service and Consumer Empowerment:

   North Carolina Provider Council:
   [http://ncproviderscouncil.org/](http://ncproviderscouncil.org/)

C. **Associations**

   American Academy of Child and Adolescent Psychiatry:
   [www.aacap.org](http://www.aacap.org)

   American Academy of Psychoanalysis and Dynamic Psychiatry:
   [www.aapsa.org](http://www.aapsa.org)
American Association for Geriatric Psychiatry: www.aagponline.org

American Association of Marriage and Family Therapy: www.aamft.org

ACPE The Standard for Spiritual Care & Education: www.acpe.edu

American Psychiatric Association: www.psychiatry.org

American Psychological Association: www.apa.org

Association for Psychological Science (APS): www.psychologicalscience.org

American Society of Addiction Medicine: www.asam.org

Autism Society of America: www.autism-society.org

National Disability Rights Network: www.ndrn.org/

National Association of Psychiatric Health Systems: www.nabh.org/

National Association of Social Workers: www.socialworkers.org

National Association of State Mental Health Program Directors (NASMHPD): www.nasmhpdp.org

Mental Health America: www.mhanational.org

The North Carolina Association for Behavioral Analysis (NCAABA): http://www.nc-aba.com

North Carolina Council of Community Programs: www.nc-council.org

North Carolina Board of Licensed Professional Counselors: http://www.ncblpc.org

North Carolina Substance Abuse Professional Practice Board: http://www.ncsappb.org

Psychiatric Rehabilitation Association and Foundation: www.psychrehabassociation.org

D. Behavioral Healthcare Resources

American Society of Addiction Medicine (ASAM): https://www.asam.org/resources/the-asam-criteria

Behavioral Healthcare Institute: www.bhifl.com/

Centers for Disease Control and Prevention: www.cdc.gov

Council on Accreditation (COA): http://coanet.org/home/

Council for Affordable Quality Healthcare (CAQH): www.caqh.org

Commission on Accreditation of Rehabilitation Facilities (CARF): www.carf.org
Manisses Communication Group, Inc.:  
https://www.bloomberg.com/research/stocks/private/snapshot.asp?privcapId=22218969

National Committee for Quality Assurance (NCQA):  
www.ncqa.org

National Institute of Health:  
www.nih.gov

National Institute of Mental Health:  
www.nimh.nih.gov

National Latino Behavioral Health Association:  
www.nlbha.org

North Carolina Foundation for Alcohol and Drug Studies  
www.ncfads.org

Research and Training Center for Children’s Mental Health:  
http://rtckids.fmhi.usf.edu/default.cfm

The Council of Quality and Leadership (CQL):  
https://c-q-l.org

The Joint Commission (TJC):  
https://www.qualitycheck.org

Disability Rights North Carolina:  
http://www.disabilityrightscn.org/self-advocacy-resources-0

Federation of Families for Children’s Mental Health:  
www.ffcmh.org

National Consumer Supporter Technical Assistance Center:  
http://www.samhsa.gov/programs-campaigns

National Empowerment Center:  
www.power2u.org

National Mental Health Consumers’ Self-Help Clearinghouse:  
http://www.mhselfhelp.org

**F. Cultural Competence**

Cardinal Innovations Cultural Competence Page:  
Go to the Resource Library at www.cardinalinnovations.org and search Culture Competence under Providers

Annie E. Casey Foundation:  
www.aecf.org

Association of Gay and Lesbian Psychiatrists:  
www.aglp.org

Association for Lesbian, Gay, Bisexual & Transgender Issues in Counseling:  
www.algbtic.org

Diversity Inc.:  
http://www.diversityinc.com

**E. Member and Family Resources**

Association for Person in Supported Employment (APSE):  
www.apse.org

Children and Adults with Attention-Deficit/Hyperactivity Disorder (CHADD):  
www.chadd.org
Georgetown University—National Center for Cultural Competence:
http://nccc.georgetown.edu

International Multicultural Institute:
http://www.imciglobal.org

Indian Country (The nation’s leading American Indian news source):
https://newsmaven.io/indiancountrytoday/

Medline Plus has health information in over 40 different languages:
www.medlineplus.gov

National Asian American Pacific Islander Mental Health Association:
www.naapimha.org

National Congress of American Indians:
www.ncai.org

National Latino Behavioral Health Association:
www.nlbha.org

National NAMI (with resources also available in Spanish):
www.nami.org

National Network to Eliminate Disparities in Behavioral Health:
http://nned.net

National Organization of People of Color Against Suicide:
http://nopcas.org

National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care: A Blueprint for Advancing and Sustaining CLAS Policy and Practice
https://www.thinkculturalhealth.hhs.gov/assets/pdfs/EnhancedCLASStandardsBlueprint.pdf

Native Web (resources for indigenous cultures around the world):
www.nativeweb.org

Pan American Health Organization:
www.paho.org

The Association of Black Psychologists:
www.abpsi.org

The Office of Ethnic Minority Affairs of the American Psychological Association:
http://www.apa.org/pi/oema

Treatment Improvement Protocol Improving Cultural Competence:
Go to the Resource Library at www.cardinalinnovations.org and search Culture Competence

Unidos US:
https://www.unidosus.org

U.S. Department of Health & Human Services Office of Minority Health:
https://minorityhealth.hhs.gov

World Health Organization—this website can be accessed in Arabic, Chinese, English, French, Russian and Spanish:
www.who.int/en

G. Developmental Disabilities

The Arc of NC:
http://www.arcnc.org

Autism Speaks:
www.autismspeaks.org
Autism Research Institute: www.autism.org

Centers for Medicare and Medicaid: www.cms.gov

Council for Exceptional Children (CEC): www.cec.sped.org

Exceptional Children’s Assistance Center: www.ecac-parentcenter.org

Family Support Network of North Carolina: www.fsnnc.org

NC Child: The Voice for North Carolina’s Children: http://www.ncchild.org

Piedmont Parent: http://www.piedmontparent.com/PP/Health-Development/Mental-Health

The Arc: www.thearc.org

The Autism Society of NC: www.autismsociety-nc.org

The Beach Center/Family Training: www.beachcenter.org

National Inclusion Project: www.inclusionproject.org

H. Federal Government

US Department of Health and Human Services – Substance Abuse and Mental Health Services Administration: www.samhsa.gov

Centers for Medicare and Medicaid: https://www.cms.gov/

Medicare.gov: www.medicare.gov

National Council on Disability: www.ncd.gov

National Institute on Alcohol Abuse and Alcoholism: http://www.niaaa.nih.gov

National Institute on Drug Abuse: www.drugabuse.gov

United States Department of Housing and Urban Development: www.hud.gov

U.S. Department of Health & Human Services Office of Minority Health: https://minorityhealth.hhs.gov


I. Grants and Request for Proposals (RFPs)


Grants—Online Announcements and Applications: https://www.grants.gov

US Department of Health and Human Services – Substance Abuse and Mental Health Services Administration: www.samhsa.gov
North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (Review tools, citations and guidelines for Substance Abuse Prevention and Treatment Block Grant (SAPTBG), the Community Mental Health Services Block Grant (CMHSBG), the Social Services Block Grant (SSBG), the System of Care (SOC) Expansion Grant and State Funds:  
https://www.ncdhhs.gov/divisions/mhddsas/LME-MCO/audit

North Carolina Prevention Training and Technical Assistance Center (for Prevention Block Grants):  
http://ncpreventiontta.org

U.S. Government Publishing Office  
45 CFR Part 96, Subpart L, the Substance Abuse Prevention and Treatment Block Grant (SAPTBG) 42 USC Part B, Subpart I, Block Grants for Community Mental Health Services (CMHBG):  
https://www.gpo.gov

J. North Carolina State Links

North Carolina Coalition to End Homelessness:  
www.ncceh.org

North Carolina Department of Health and Human Services:  
https://www.ncdhhs.gov

North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (Records Management and Documentation Manual (RM&DM)):  

North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (NC Treatment Outcomes and Program Performance System (NC-TOPPS)):  

North Carolina Division of Social Services:  
https://www.ncdhhs.gov/divisions/dss

North Carolina General Assembly (NC General Statutes):  
http://www.ncga.state.nc.us/gascripts/statutes/Statutes.asp

North Carolina Office of Administrative Hearings (NCAC Rules):  
http://reports.oah.state.nc.us/ncac.asp

North Carolina Housing Coalition:  
www.nchousing.org

North Carolina Housing Finance Agency:  
www.nchfa.com

NC Tracks System:  
www.nctracks.nc.gov/content/public/providers.html

K. Other State Links

New York State Office of Mental Health:  
www.omh.ny.gov

South Carolina Department of Mental Health:  
www.scdmh.org
Tennessee Department of Mental Health and Substance Abuse Services:
www.tn.gov/behavioral-health

Virginia Department of Behavioral Health and Developmental Services:
wwwdbhds.virginia.gov

I. Anonymous Reporting of Fraud, Waste, or Abuse

Cardinal Innovations Healthcare:
1.800.357.9084 or
https://www.cardinalinnovations.org/Contact/Report-fraud-abuse
Section X:  
GETTING PAID - FINANCE REQUIREMENTS

A. Enrollment and Eligibility Process

1. Eligibility Determination

Members who have their services paid for in whole or in part by Cardinal Innovations must be enrolled in the Cardinal Innovations system. If you have any questions about a member’s eligibility, please call the Access Call Center at 800.939.5911. Individuals who have 100% ability to pay according to Cardinal Innovations’ sliding fee schedule or who have insurance coverage that pays 100% of their services must not be enrolled in the Cardinal Innovations system. However, the person may still receive and pay for services from a provider independent of Cardinal Innovations’ involvement. State funds are limited and are not an entitlement.

It is the responsibility of each provider to make a complete and thorough investigation of a member’s ability to pay prior to enrolling the individual in the Cardinal Innovations system. This requires that the provider determine:

- If the member has Medicaid or whether the member may be eligible for Medicaid
- If the member has Medicare or any other third-party insurance coverage
- If there is any other payer involved – worker’s compensation, EAP program, court ordered services paid for by the court, etc.

- If the member meets Cardinal Innovations criteria for use of local or state funds to pay for services:
  - Medicaid eligible members receiving non-Medicaid funded services
  - Non-Medicaid eligible members
- If the member already has been enrolled in the Cardinal Innovations system

If the member has Medicaid and already has been enrolled in the Cardinal Innovations system, they are financially eligible for Medicaid reimbursable services from Cardinal Innovations. If they are not yet enrolled, the provider must provide the information necessary to enroll the member. Member enrollment can be performed electronically through the Provider Direct System or by contacting the Access Center at 1.800.939.5911. Assistance can be found on the Provider Direct website using the current version of Cardinal Innovations’ enrollment documentation. Providers should assist members who may be eligible for Medicaid to apply through their County Department of Social Services.

Member Confidentiality

Members who request enrollment in the Cardinal Innovations system should be asked to sign a Privacy Notice 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 Cardinal Innovations Enrollment Procedures and training. These documents can be found in the NC MH/DD/SAS Health Plan Operations Manual at https://www.ncdhhs.gov/divisions/mhddsas

Training documentation can be accessed by logging into Provider Direct and clicking on the Training Materials link.

If enrollment data are not complete prior to service provision, authorizations and claims will be affected, including authorization and claims denials. Members’ Medicaid information must be provided to the Access Center 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 Cardinal Innovations is to be a secondary payer.

3. **Effective Date of Enrollment**

Enrollment into the Cardinal Innovations 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 Cardinal Innovations system and to complete the enrollment process prior to providing services. Crisis services provided in emergency situations are the exception to this rule. In these cases, the provider must enroll the member within seven days of the first date of service and indicate the date of enrollment as the date that the emergency services were provided. Services billed with service dates prior to an enrollment date will be denied.

4. **Member ID**

The Member ID Number identifies the specific member receiving the service and is assigned by the Cardinal Innovations information system. The member must be enrolled in the Cardinal Innovations system in order for the provider to obtain a Member ID number and for a claim to be accepted. All claims submitted with incorrect Member ID numbers, or for members whose enrollments are no longer active, will be denied.

B. **Authorizations Required for Payment**

1. **System Edits**

The Cardinal Innovations system is specifically designed to identify authorization data prior to approving claims. The system contains edits that are verified, so providers must be very attentive to authorized units to ensure maximum reimbursement.

2. **Authorization Number and Effective Dates**

Each authorization has a unique number, a start date and an end date. Only claims with dates of service within these specific time frames will be approved. Dates and/or units outside these parameters will be denied.
3. **Service Categories or Specific Services**

Each authorization indicates specific categories of services or in some cases very specific services that have been authorized. Each service is validated against the authorization to ensure that the service matches the authorization. Services outside of these parameters will be denied.

4. **Units of Service**

Each authorization indicates the maximum number of authorized service units. As each claim is processed, the system validates units claimed against the units of service authorized. The system will deny any claims that exceed the limits. Providers must establish internal procedures to monitor units of service against authorizations to avoid claim denials due to exceeding units of service.

5. **Exceptions to Authorization Rule**

Certain services are approved without an authorization. These services are limited in scope and are limited in total number to a member, not to a provider. Once the annual limit has been reached for a member, then all services without an authorization, regardless of the provider of the service, will be denied. Providers must be constantly aware of this issue in order to avoid denied claims.

C. **Payment of Claims and Claims Inquiries**

Providers must submit claims through Provider Direct or an 837 file, unless their contract specifically states an alternative method. Providers are encouraged to produce routine billings on a weekly or bi-monthly schedule.

1. **Timeframes for Submission of Claims**

Non-hospital providers must submit electronic claims within 90 calendar days of the date of service to ensure payment, unless otherwise specified in the provider’s contract. Hospital claims and claims involving coordination of benefits (COB) must be received within 180 days of the date of service. Claims submitted outside of the allowable billing days will be denied.

2. **Payment for Clean Claims**

a. Claims are paid by electronic funds. The Electronic Funds Transfer (EFT) information may be accessed from the Cardinal Innovations website by going to the Resource Library and searching Forms.

b. Payments are processed based on the check write schedule which is available in the Resource Library.

c. Claims must be submitted by 5 p.m. on the cutoff date in order to receive payment for approved claims the following week.

3. **Claims Denial Information:**

Refer to the Frequently Asked Question (FAQ) document for a compilation of the most common questions and answers for denied claims. The FAQ document can be accessed from the Resource Library.

4. **Provider Direct Claims Submission**

Providers are contractually required to submit billing electronically. Provider Direct is a web-based system available to Cardinal Innovations providers upon completion of a Trading Partner Agreement (TPA). Billing through the Provider Direct System is Direct Data...
Entry (DDE) where an electronic CMS1500 or UB04 form is accessed, and billing information is entered and submitted to Cardinal Innovations for reimbursement. The Provider Direct Manual (a user manual for Provider Direct claim submissions) gives very specific instructions on information needed to complete a claim form. (The Provider Direct Manual is available after logging into the website.)

5. 837 Claims Submission

Detailed instructions are provided in the 837I and 837P Companion Guides, the user manuals for electronic 837 submissions. Information can be accessed in the Resource Library. The Companion Guides give specific instructions regarding information required to submit claims electronically to Cardinal Innovations. The entire testing and approval process is outlined in this document. The HIPAA-compliant American National Standards Institute (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-compliant transactions. Cardinal Innovations will accept only HIPAA-compliant transactions, as required by law. Cardinal Innovations provides the following HIPAA-compliant transaction files back to Providers: 999 (an acknowledgment receipt), 824 (a line by line acceptance/rejection response) and 835 (an electronic version of the remittance advice).

Other general guidelines to consider include the following:

a. Formats

NC Innovations Services, Outpatient Therapy, Residential and other daily and periodic services must be submitted using the ANSI 837P (Professional) format or the electronic CMS 1500 form if billed through the Provider Direct System. Inpatient, Therapeutic Leave, Residential Services (Medicaid funded), Outpatient Revenue Codes and ICF Services must be submitted using the ANSI 837I (Institutional) format or the electronic UB04 form if billed through the Provider Direct System.

b. Multiple Occurrences of Same Service in a Day

When a specific service is rendered multiple times in a single day at the same location, the services must be billed using multiple bundled units rather than as separate line items. Doing so will prevent a duplicate billing denial.

c. Authorization:

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.
National Provider Identifier (NPI)

Providers are required to obtain an NPI number to submit billing. The NPI number and taxonomy code are required for claims to be accepted and processed. Failure to comply with these guidelines will result in denied billing.

Verification and Notification

Cardinal Innovations provides the following responses to ensure that electronic 837 billing is accepted into the Cardinal Innovations system for processing and payment:

- 999 X12 File—this file acknowledges receipt of the 837 billing file
- 824 X12 File—this file provides feedback regarding whether line items in the 837 file have been accepted or rejected; if the line item has been rejected, a detailed explanation will be provided

These files are available in the File Transfers>View File Repository from MCO option of the Provider Direct system. It is the provider’s responsibility to review these responses to verify billing has been accepted into the Cardinal Innovations system for processing so reimbursement is not interrupted due to file formatting issues.

Providers are able to perform claim inquiries within Provider Direct. The Provider Direct Manual can be accessed via the Training link located in Provider Direct: https://providerdirect.cardinalinnovations.org

Inquiries regarding the status of claims should be directed to the Service Center Claims Specialist Staff.

Detailed claim form instructions can be found at the following websites:

- UB04: http://www.nubc.org
- CMS1500: http://www.nucc.org

6. Process for Submission of Replacement and Voided Claims:

Professional Claims – Claims that were originally submitted within 90 days from original date of service will receive an additional 90 days to submit a replacement claim (180 days total if proper replacement guidelines are followed).

7. Instructions for Professional claims submitted through Provider Direct

Replacement claims

- In Box 22 on the CMS1500, enter 10 and the original claim number as the reference number found on the Remittance Advice (RA) where the claim was paid

Void claims

- In Box 22 on the CMS1500, enter 12 and the original claim number as the reference number found on the Remittance Advice (RA) where the claim was paid

8. Instructions for Professional claims submitted via an 837 transaction set

Replacement claims

- In Loop 2300 – Claim segment/fifth element (CLM05-03), 7 (code for
replacement) should be submitted along with a REF segment with F8 as reference code identifier and the original claim number found on the RA where the claim was paid. Here is an example:

CLM*01319300001*500***11::7*Y*A *Y*Y***02******N~REF*F8*111111~

- In Loop 2300 – Claim segment/fifth element (CLM05-03), 8 (code for reversal) should be submitted along with a REF segment with F8 as reference code identifier and the original claim number found on the RA where the claim was paid. Here is an example:

CLM*01319300001*500***11::8*Y*A *Y*Y***02******N~REF*F8*111111~

Once a replacement claim has been received the original claim will deny and the replacement claim will be processed according to the billing guidelines. Voided claims will be reverted from our system and the original claim payment will be recouped.

Institutional Claims – Claims that were originally submitted within 180 days from the original date of service will receive an additional 180 days to submit a replacement claim (360 days total if proper replacement claim guidelines are followed).

9. **Instructions for Institutional claims submitted through Provider Direct**

**Replacement claims**

- In Box 4 on the UB04, use 7 as the fourth digit, which indicates replacement of prior claim. You will reference the original claim number in Box 64A (Document Control Number).

**Void claims**

- In Box 4 on the UB04, use 8 as the fourth digit, which will indicate reversal of prior claim. You will reference the original claim number in Box 64A (Document Control Number).

10. **Instructions for Institutional claims submitted via an 837 transaction set**

**Replacement claims**

- In Loop 2300 – Claim segment/5th element (CLM05-03), 7 (code for replacement) should be submitted along with a REF segment with F8 as reference code identifier and the original claim number found on the RA where the claim was paid. Here is an example:

CLM*01319300001*500***11::7*Y*A *Y*Y***02******N~REF*F8*111111~

**Void claims**

- In Loop 2300 – Claim segment/fifth element (CLM05-03), 8 (code for reversal) should be submitted along with a REF segment with F8 as reference code identifier and the original claim number found on the RA where the claim was paid. Here is an example:

CLM*01319300001*500***11::8*Y*A *Y*Y***02******N~REF*F8*111111~

Once a replacement claim has been received the original claim will deny and the replacement claim will be processed according to the billing guidelines. Voided claims will be reverted from Cardinal Innovations’ system and the original claim payment will be recouped.
D. **Service Codes and Rates - Contract Provisions**

**Publishing of Rates:**

Provider contracts include a listing of eligible services. All providers are reimbursed at the Cardinal Innovations published rates unless otherwise communicated to providers. Providers must use only the service codes in their contract or claims will be denied as non-contracted services. Providers can submit claims for more than the published rates, but only the published or contracted rate will be paid. If a provider submits a rate less than the published rate, the lower rate will be paid. It is the provider’s responsibility to monitor the publishing of rates and to make necessary changes to their billing systems.

Cardinal Innovations also publishes a Sliding Fee Schedule that providers must use to determine a member’s ability to pay for services and Medicaid members’ ability to pay for non-Medicaid billable services.

Information on rates and the Sliding Fee Schedule can be found in the Resource Library on Cardinal Innovations’ website.

E. **Standard Codes for Claims Submission**

Providers should bill CPT/HCPCS/Revenue codes applicable to their contract with Cardinal Innovations. The following codes can be found on the Cardinal Innovations website in the Resource Library.

1. **Diagnosis Codes**

   Providers must use diagnosis codes from the ICD-10 Code Manual.

2. **Place of Service Codes**

   https://www.cardinalinnovations.org/Resources/Resource-

F. **Definition of Clean Claims**

A clean claim is defined as a claim that can process without manual intervention, has all of the required data elements, is submitted in the correct format and meets the terms of the contract between Cardinal Innovations and the provider.

G. **Coordination of Benefits**

Cardinal Innovations is the payer of last resort. Providers are required to collect all third-party funds prior to submitting claims to Cardinal Innovations for reimbursement. Providers are required to reduce the billed amount by the first-party liability amount. 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 that can be billed to pay for the services provided to the member, including workers’ 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.

Cardinal Innovations will conduct coordination of benefits audits to ensure that the coordination of benefits has been properly assigned. Providers are subject to audit, at a minimum, on an annual basis. Audit samples for each quarter are generated randomly from paid claims from the previous six months. Audits are conducted via a desk review and providers are given a 21 to 28 calendar day notice to submit supporting documentation for the audit. Documentation should be submitted securely through...
Provider Direct. Claims that are billed incorrectly to Cardinal Innovations that resulted in overpayment will require a payback from the provider. In addition, self-audits may be required when a trend of out-of-compliance billing practices is identified. Provider organizations are strongly encouraged to designate a main contact person and a backup that are familiar with coordination of benefits for the audit. These persons should also participate in trainings and technical assistance related to the coordination of benefits audits. Training can be accessed through the Cardinal Learning Center.

1. **Eligibility Determination Process by Provider**

Providers should conduct a comprehensive eligibility determination process whenever a client 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 the member. It is the provider’s responsibility to monitor this information and to adjust billing accordingly. First- or third-party insurances should be added to the member’s record by completing the Add Third Party Insurance option on the Client Homepage in Provider Direct, or by completing a Client Update in Provider Direct.

2. **Obligation to Collect**

Providers must make good faith efforts to collect all first- and third-party funds prior to billing Cardinal Innovations. First-party charges must be shown on the claim whether they were collected or not. The Cardinal Innovations System validates third-party payers and can deny or adjust the claim.

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. Providers must bill any third-party insurance coverage, including workers’ compensation, Medicare, EAP programs, etc. Providers must wait a reasonable amount of time in order to obtain a response from the insurance company. However, it is important that providers not exceed the 90 day rule before submitting claims. If an insurance company pays after a claim has been submitted to Cardinal Innovations, the provider must notify Cardinal Innovations and reimburse Cardinal Innovations.

4. **State Funded Services**

State funding is a “payer of last resort.” Provider shall coordinate benefits so that costs for services otherwise payable by non-Medicaid funds are avoided or recovered from a liable first- or third-party payer. This means that all third-party insurance carriers, including Medicare, and private health insurance carriers, must process the claim before state funding is used to process the claim. Additionally, providers must report any such payments from third parties on claims filed with Cardinal Innovations for payment.

Claims are paid using the lessor of logic, which means if the service is covered by state funding, Medicare or another health
For example: If a member has Medicare or a commercial third-party insurance and receives a State-funded outpatient service, the provider must first coordinate benefits with the third-party insurer and deduct any payments from the insurer. If there is a remaining balance for patient liability, the provider must apply the sliding fee scale to determine the patient’s first-party liability and subtract this amount. Any remaining amount after first- and third-party liability has been deducted can be submitted to Cardinal Innovations for payment.

H. **Sliding Fee Schedule for State-Funded and Federally Funded Block Grant Benefit Plans**

1. **Eligibility for Benefit Determination**

All members enrolled or participating in state-funded or federally funded benefit plans must be evaluated at the time of enrollment on their ability to pay. It is the responsibility of the provider to update this determination at least quarterly to ensure compliance with the Sliding Fee Schedule.

2. **Process to Evaluate the Sliding Fee**

Each member enrolled in the Cardinal Innovations’ state-funded or federally funded block grant plans must complete the financial eligibility process to establish any third-party coverage and to establish the individual’s ability to pay for services. The combination of a member’s adjusted gross monthly income and the number of dependents determines the payment amount based on the Sliding Fee Schedule established by Cardinal Innovations.

Medicaid members are not subject to Sliding Fee Schedules for services paid for by Medicaid.

If an individual’s income exceeds the maximum allowed for eligibility for State-funded or federally funded block grant benefit plans, the individual is responsible for 100% of the cost of services being provided. In this case, the member should not be enrolled in the Cardinal Innovations system and claims should not be submitted to Cardinal Innovations for reimbursement.

3. **Process to Modify**

If there are known changes to the member’s income or family status, the provider should update its 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. All first-party and third-party liability must be reported on all claims.
submitted for reimbursement. This compliance issue may be audited.

I. Response to Claims

1. Remittance Advice

The Remittance Advice is Cardinal Innovations’ method of communicating back to the provider community exactly how each and every claim has been adjudicated. Cardinal Innovations provides the Remittance Advice in the form of Adobe Acrobat (*.pdf) files. The Remittance Advice can be accessed via the Provider’s File Repository from Cardinal Innovations in an outbound folder in Provider Direct by selecting the File Transfers Menu option.

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 reports 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 process allows providers the ability to manage and monitor their accounts receivables.

3. Management of Accounts Receivable – Provider Responsibility:

Providers are responsible for the management of their member accounts receivable. Cardinal Innovations produces Remittance Advices based on the current check write schedule. Cardinal Innovations produces a weekly claims status report, which is an Excel document of cumulative processed claims for the current fiscal year. Providers may select, sort and manage their billings, payments and denials. This file can be accessed through the providers’ File Repository from Cardinal Innovations in Provider Direct.

J. Fee-For-Service Equivalency (FFSE)

1. Contract Agreement

All provider contracts define the payment terms. On an exception basis, some agencies may have grant-funded or Fee-For-Service Equivalency (FFSE) contracts. These contracts allow providers to be paid a pre-established amount of funding with the expectation of a determined amount of services being provided. Only state and local funds can be paid using this methodology.

2. Review of FFSE Process

Providers must submit claims to Cardinal Innovations in the same manner as fee-for-service claims. Providers receive a weekly Claims Status Report showing all adjudicated claims which can be accessed via the provider’s outbound folder in Provider Direct. The FFSE claims will show as being fully adjudicated, but with a zero dollar amount paid. Payments will be made on a monthly basis as determined in the contract.

3. Reconciliation:

It is important that providers post the zero paid claims against their accounts receivable system. Even though these FFSE claims are zero dollars, they are considered paid in full and will be counted against their FFSE contract obligations.
K. Claims Investigations – Abuse and Fraud

1. Trends of Abuse and Potential Fraud

One of the primary responsibilities of Cardinal Innovations is to monitor the Provider Network for fraud and abuse. Cardinal Innovations is responsible for investigating any and every allegation of potential fraud and/or abuse to ensure compliance with all federal and state laws and, in particular, the Medicare/Medicaid fraud and abuse laws. Specifically, Cardinal Innovations must validate the presence of material information to support billing of services consistent with Medicaid and state regulations. Cardinal Innovations systematically monitors paid claims data to look for trends or patterns of abuse.

Reports of potential fraud and/or abuse related to claims submitted to Cardinal Innovations Healthcare should be reported to Cardinal Innovations’ toll free, anonymous reporting hotline at 1.800.357.9084 or via email at fraud-abuse@cardinalinnovations.org.

2. Fraud and Abuse Investigation Process

The Cardinal Innovations Special Investigations Unit (SIU) is responsible for the prevention, detection and investigation of fraudulent claims and other program waste and abuse by members and service providers. The Finance Department is primarily responsible for collecting any paybacks that result from an SIU investigation.

Investigations into allegations of provider fraud, waste and/or abuse may include an announced or unannounced on-site provider visit, desk review, interviews, or other appropriate investigative methods.

Investigation findings form the basis for a determination as to whether the alleged fraud, waste and/or abuse requires referral to appropriate authorities at DHB or law enforcement officials. If Cardinal Innovations determines that the allegation rises to the level of a credible allegation of fraud, a referral to DHB will be made within five (5) business days of the determination.

3. Role of Finance Department

The Finance Department will assist the QM Department with the review of financial reports, financial statements and accounting procedures.

4. Voluntary Repayment of Claims

It is the provider’s responsibility to notify Cardinal Innovations in writing of any claims billed in error that require repayment. Providers are required to complete a Claims Adjustment Request Form in the Resource Library on the Cardinal Innovations website. Cardinal Innovations will make adjustments to the claims in the Cardinal Innovations system which will appear on the next Remittance Advice.

5. Reporting to State and Federal Authorities

Cardinal Innovations is obligated to report each case of a credible allegation of fraud involving a Provider to the Division of Medical Assistance.

L. Repayment Process/Paybacks

If Cardinal Innovations, through any manner, determines that a provider has been paid for a service or a portion of a service that Cardinal Innovations determines—in its sole
discretion—should not have been paid, based on but not limited to, audits, fraud, abuse, waste, acts or omissions, clinical models, medical necessity, policies/procedures or waivers, Cardinal Innovations shall notify the provider of the service or portion of service that should not have been paid. The notification shall identify the reason for the payback and the amount improperly paid by Cardinal Innovations. The notification will also include the provider’s ability to request reconsideration of the payback decision. See Section XII for additional information concerning Reconsideration.

The provider shall contact the Finance Department at financegroupmailbox@cardinalinnovations.org within 10 business days from the date the provider receives the payback notification to establish a mutually agreed upon payback payment agreement. The payback payment agreement will specify, if applicable, the time period within which the payback must be paid and the method of payment. If the provider fails to contact the Finance Department within this 10 day period, or fails to file an appeal with OAH within 60 days of notification of the payback amount, Cardinal Innovations shall withhold payment to the provider from current pending and/or future submitted claims. If no current pending and/or future claims exist for the provider, Cardinal Innovations shall automatically invoice the provider for the full payback payment amount. If the provider fails to submit payment within 30 calendar days of the invoice date, Cardinal Innovations reserves the right to take any and all action to collect the outstanding balance from the provider.

Payment methods may include, but are not limited to, one or a combination of the following: provider’s check, recoupment of current claims and/or recoupment of future claims, until the payback payment amount is in paid-in-full.

If the provider fails to comply with the mutually agreed upon payback payment agreement, all current pending and/or future submitted provider claims shall be withheld for payment by Cardinal Innovations and be applied to the payback payment amount until the payback payment amount is paid in full. Notwithstanding this recovery method, Cardinal Innovations reserves the right to, at any time, invoice the provider for any or the entire unpaid payback payment amount if the provider fails to comply with the payback payment agreement. If the payback payment amount exceeds outstanding provider claims, Cardinal Innovations may invoice the provider for the remaining payback payment amount owed to Cardinal Innovations. The provider shall have 30 calendar days from the invoice date to pay the remaining payback payment amount. If the provider fails to repay funds within 30 calendar days, Cardinal Innovations reserves the right to take any and all action to collect the outstanding balance from the provider.

If advance payments have been made for services not provided as of the notification date of termination, Cardinal Innovations will invoice the provider for the amount due to be repaid to Cardinal Innovations. The provider shall submit payment within 30 calendar days of the invoice date. If the provider fails to submit payment within 30 calendar days of the invoice date, Cardinal Innovations reserves the right to take any and all action to collect the outstanding balance from the provider.
M. Termination Audits

Upon the notification date of termination of a provider’s contract, Cardinal Innovations reserves the right, at its sole discretion, to withhold any future payments to the provider until Cardinal Innovations completes a contract termination audit to ensure that all contractual and other fiscal requirements have been fulfilled. The provider shall return all original client records to Cardinal Innovations in accordance with Article II, Paragraph 15 of the General Conditions governing agency providers, and Article IX, Paragraphs d and e of the General Conditions governing LIP providers. Cardinal Innovations’ termination audit may include a review of, but not be limited to, billing records, fiscal records, and any other documentation Cardinal Innovations deems necessary—in its sole discretion—to complete the termination audit. Cardinal Innovations shall complete its contract termination audit, if it elects to conduct a termination audit in its sole discretion, within 60 days of receipt of all necessary contractor records. If Cardinal Innovations has elected, at its sole discretion, to not withhold future payments to the provider upon the notification date of termination, Cardinal Innovations still reserves the right to make adjustments for amounts due to Cardinal Innovations from the provider through recoupment, payback or any other method.

If advance payments have been made for services not provided as of the notification date of termination, Cardinal Innovations will invoice the provider or the amount due to be repaid to Cardinal Innovations. The provider shall submit payment within 30 calendar days of the invoice date. If the provider fails to submit payment within 30 calendar days of the invoice date, Cardinal Innovations has the right to take any and all action to collect the outstanding balance from the provider.

All continuing obligations of the provider shall remain in effect after termination including, but not limited to, those set forth in the Contract and in the Cardinal Innovations Healthcare Provider Manual, Innovations and NC MH/DD/SAS Plan Manuals.

N. Review and Determination Process

Effective June 1, 2014.

This process does not supersede a Network Provider’s responsibility to follow all existing guidelines surrounding claims or authorization processes as referenced in the Provider Manual, Communication Bulletins and the provider’s contract. The Provider Guidelines, Provider Manual and Communication Bulletins are available on the Cardinal Innovations’ website at www.cardinalinnovations.org/providers under Provider Resources. A Network Provider’s assigned Cardinal Innovations’ Network Specialist is also available for information or technical assistance. If you do not know who your Network Specialist is, you may find it in the Resource Library on our website here, or call the Provider Line toll-free at 855-270-3327 to receive the Specialist’s name and contact information.

1. Authorization Issues – within 60 days from the date of service

Cardinal Innovations authorizes services prior to the date they are rendered. Claims will deny when there is a missing authorization; thus, reimbursement may be delayed. If there is a unique reason that prevented timely filing of a Treatment Authorization Request (TAR), the Network Provider will contact
Cardinal Innovations’ Utilization Management Manager or Access Clinician Supervisor. It is a provider’s responsibility to submit timely authorization requests via a TAR in Provider Direct. For information about timelines for authorization requests, access the Authorization Guidelines on Cardinal Innovations’ website at: https://www.cardinalinnovations.org/Resources/Resource-Library?

It is also a provider’s responsibility to comply with service specific prior approval requirements as defined in the Division of Medical Assistance’s Clinical Coverage Policies and Cardinal Innovations Authorization Guidelines.

A Utilization Management Manager or Access Clinician Supervisor will reevaluate the authorization issue and make a decision based on the information presented. To request this reevaluation, the Network Provider will contact Cardinal Innovations within 60 days from the date of service via one of the following:

For MH/SUD population:

MHSA UM Manager
Cardinal Innovations UM Care Manager
550 South Caldwell Street, Suite 1500
Charlotte, NC 28202
Main: 704.939.7700
Fax: 704.743.2130
UtilizationM@cardinalinnovations.org

For IDD population:

ID/DD Manager
Cardinal Innovations DD Care Manager
550 South Caldwell Street, Suite 1500
Charlotte, NC 28202
Main: 704.939.7700
Fax: 704.743.2120
ID-UM@cardinalinnovations.org

For Acute Services population:

Access Clinician Supervisor
Cardinal Innovations Acute Service Care Manager
550 South Caldwell Street
Suite 1500
Charlotte, NC 28202
Main: 704.939.7700
Fax: 704.743.2120
AccessManagement@cardinalinnovations.org

Eligibility status may change from month to month if financial and household circumstances change. For this reason, the North Carolina Basic Medicaid Billing Guide requires providers to verify the Medicaid member’s eligibility each time a service is rendered. There are various methods outlined under the Certification Methods subsection in the NC Basic Medicaid Billing Guide.

When a member’s Medicaid eligibility is approved after a service has been rendered, the provider will contact the Cardinal Innovations’ UM Manager or Access Clinician Supervisor and provide a thorough explanation of the circumstances leading to provision of services without prior authorization. The UM Manager or Access Clinician Supervisor will provide instructions regarding the submission of a TAR.

2. Claim Denial

When a provider incurs billing or claim issues/denials, they can contact the Claims Department at claims@cardinalinnovations.org or 855.270.3327, Option 3 for assistance.
If the provider is not satisfied with the resolution communicated by Cardinal Innovations Customer Service, they may ask to speak with a Claims Supervisor.

3. Review and Determination Request

The Review and Determination form and process are located on the Cardinal Innovations’ website in the Resource Library by searching Forms. Supporting documentation (if applicable) and detailed explanations will assist with the re-evaluation.

In any event, the provider must first exhaust resolution options on current claims and authorization guidelines/processes before proceeding to the Review and Determination Process. Claims denied for reason code 1018-Claim received after billing period are not appealable.
Section XI:
QUALITY MANAGEMENT AND COMPLIANCE

A. Introduction

Cardinal Innovations is committed to working in collaboration with the Provider Network to achieve the highest standards of quality in service delivery.

B. Quality Improvement

Cardinal Innovations maintains a strong commitment to continual improvement of its services and those services provided directly to members. A focus on quality requires an understanding of basic principles, which include:

- Involvement of the members in all areas and levels of the service system in regards to analysis, planning, implementing changes, and assessing quality and outcomes
- Viewing the system as a collection of interdependent processes, we can understand how problems occur and how the resolution of such problems can strengthen the system as a whole
- Encouraging participation and teamwork of every member of the system to assure quality and empower them to solve problems and recommend improvements
- Making decisions based on reliable information by collecting and analyzing accurate, timely and objective data; and encouraging different members of the system to work together to improve quality by sharing information freely and coordinating their activities

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 Cardinal Innovations extends to members of its Provider Network. All such network providers are required to be in compliance with all Quality Assurance and Improvement standards outlined in North Carolina Administrative Code as well as the governing Cardinal Innovations Procurement Contract. These items include:

- Establishment of a formal Quality Committee to evaluate services, plan for improvements and assess progress made toward goals
- Assessment of need and the determination of areas for improvement based on accurate, timely and 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 Cardinal Innovations’ Quality Management Department

C. Performance Measurement

1. Data collection and verification—Cardinal Innovations is required to measure outlined performance indicators in the following domains: Access, Availability, Quality of Care, Quality of Services, Appropriateness of Services, System Performance, and Satisfaction, in order to assure compliance with DMH and DMA contract requirements.
2. Performance improvement – Cardinal Innovations will complete Quality Improvement Activities (QIAs) as indicated in DMH and DMA contracts and NCQA Standards. These QIAs may require provider participation.


D. Performance Monitoring

An important part of Cardinal Innovations’ role as a LME/MCO is to monitor the performance of providers in its network. Cardinal Innovations maintains a system to assist in monitoring the health and safety of members, rights protections and quality of care.

All providers in the network receive a monitoring review at least every two years. All monitoring reviews are scored utilizing the DHHS standardized monitoring tools, which are made available to providers on the DHHS website. Find copies of DHHS Monitoring tools at https://www.ncdhhs.gov/providers/provider-info/mental-health/provider-monitoring

These tools also identify items that will be requested or reviewed during the review and on-site visit conducted by Cardinal Innovations. All reviews include an exit conference with the provider to discuss the outcome of the review. The reviewer(s) will explain findings and review scores, to include strengths and needs noted. Any follow-up to be completed by the provider or Cardinal Innovations will be reviewed during the exit conference.

Copies of monitoring review results are sent to the provider following the review. Documentation outlines the areas reviewed, scores achieved and required follow-up. The Quality Management Department periodically seeks feedback from providers regarding the monitoring review process.

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

1. Provider Monitoring Reviews

The Cardinal Innovations Quality Management Department conducts monitoring reviews for new providers after the provider serves Cardinal Innovations members for at least 90 days. During this review, a full monitoring review is conducted, and any areas cited as non-compliant will be reviewed. If the review findings identify any non-compliant issues, a Plan of Correction will be required. A payback may also be required.

2. Monitoring of Incidents

An incident is an event at a facility or in a service that is likely to lead to adverse effects upon a member. Incidents are classified into several categories according to the severity of the incident. Providers are required to develop and maintain a system to collect documentation on any incident that occurs in relation to a member, including 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 to Cardinal Innovations.

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, including:

- A review of all incidents on an ongoing basis to monitor for trends and patterns
- Strategies aimed at the reduction/elimination of negative trends/patterns
- Documentation of the improvement efforts, as well as an evaluation of ongoing progress
- Following mandatory reporting requirements
- As to providers located within North Carolina, compliance with entering Level II and III incidents into the State’s Incident Response Improvement System (IRIS). Out-of-state providers must adhere to this requirement as indicated by their individual state rules and regulations

There are specific State laws governing reports of abuse, neglect or exploitation of members. It is important that the provider’s procedures include all of these requirements. If a report alleges the involvement of a provider’s staff in an incident of abuse, neglect or exploitation, the provider must ensure that members are protected from involvement with that staff person until the allegation is determined to be unsubstantiated. The provider must take action to correct the situation if the report of abuse, neglect or exploitation is substantiated. With all allegations of abuse, neglect, or exploitation of a member, the provider must submit an IRIS report. If the alleged/suspected abuse, neglect, or exploitation of a member is made against a staff of the provider agency, the provider agency must also completed the Health Care Personnel Registry (HCPR) tab within the IRIS report. The provider may return to the IRIS report at a later date to complete the HCPR form with results of their internal investigation.

3. **Cardinal Innovations Incident Review Process**

Under the North Carolina Administrative Code, Cardinal Innovations is required to monitor certain types of incidents that occur within the Provider Network, as well as providers in Cardinal Innovations’ catchment areas. Regulations regarding the classification of incidents (Levels I, II or III), as well as requirements related to the submission of incident reports to home and host LME/MCOs and state agencies can be found in the North Carolina Administrative Code. Cardinal Innovations is also required to monitor the state IRIS system. For more information regarding these classifications, also please see the following websites: https://iris.dhhs.state.nc.us http://www.ncoah.com

Cardinal Innovations’ Quality Management Department shall review all incidents when received for completeness, appropriateness of interventions, and achievement of short- and long-term follow up both for the individual member, as well as the
provider’s service system. This may require the provider to submit additional documentation such as internal investigation reports, medical records, case notes, assessments, ASAM, level of care determination and other service documentation to Cardinal Innovations’ Quality Management Department for review. In the event a provider does not respond to these requests a plan of correction may be implemented. If questions or concerns are noted when reviewing the incident report, the Quality Management Department will work with the provider to resolve these. If concerns are raised related to the member’s care or services or the provider’s response to an incident, QM may elect to conduct an on-site review of the provider. If possible, the review will be coordinated with the provider and, if deficiencies are found, QM will work with the provider on the implementation of a plan of correction.

4. **Quality of Care Monitoring**

The Cardinal Innovations Quality Management Department is charged with conducting monitoring reviews to assess compliance, which includes reviews of medical records, administrative files, the physical environment, clinical quality reviews, focused reviews, post-payment reviews and cultural competency reviews as indicated by DHHS review tool or Cardinal Innovations’ monitoring initiatives. QM performs compliance safety reviews of facilities; monitors providers; and reviews critical incidents, death reports and restrictive interventions to assure the protection of rights and the health and safety of members.

QM reviews reported incidents and determines whether any follow up is needed. QM may conduct investigations of incidents reported directly by providers on incident reports, as well as reports provided by members, families and the community. Cardinal Innovations may be required to submit quarterly reports to the state on reported incidents and the organization’s monitoring activities.

Cardinal Innovations may also require providers’ participation in selected improvement initiatives or activities.

5. **Grievances**

Cardinal Innovations’ management of grievances is carefully monitored by DHHS, and Cardinal Innovations maintains a database in which all grievances and resolutions are recorded. Cardinal Innovations may receive grievances from providers, stakeholders, members, families, legal guardians or anonymous sources regarding Cardinal Innovations’ Provider Network, and/or a specific provider’s services or staff. Based on the nature of the grievance, Cardinal Innovations 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. It is important to understand that this is a serious responsibility. Cardinal Innovations must take all grievances very seriously until resolution. Upon request, Cardinal Innovations’ Community Operations Department will assist anyone who requests help with submitting a grievance.
If problems are identified, the provider involved may be required to complete a plan of correction.

6. **Member Satisfaction Surveys**

Cardinal Innovations values the satisfaction of members, family members and stakeholders with services provided in the Provider Network. Cardinal Innovations has methods by which member satisfaction is measured. This typically consists of conducting annual surveys of pertinent stakeholders to obtain the information. The goal of these initiatives is to gather feedback on how various Cardinal Innovations departments perform. This system has provided information that has been used to pinpoint the need for additional staff training or other performance improvement initiatives. Cardinal Innovations has expanded the use of these tools to monitor provider customer service.

**E. Compliance**

Cardinal Innovations expects all of its providers’ employees and contractors to practice honesty, directness and integrity in relationships with one another, business partners, the public, the business community, internal and external stakeholders, members, families, suppliers, elected officials and government authorities.

1. **Primary Areas Covered by Compliance**

   Compliance deals with the prohibition, recognition, reporting and investigation of suspected fraud, defalcation, misappropriation and other similar irregularities.

   The term fraud includes dishonest or fraudulent acts, embezzlement, forgery or alteration of negotiable instruments, such as:
   - Checks and draft negotiable instruments
   - Misappropriation of a provider agency’s, employee, customer, partner or supplier assets
   - Conversion to personal use of cash, securities, supplies or any other provider agency assets
   - Unauthorized handling or reporting of provider agency transactions
   - Falsification of a provider agency’s records, claims or financial statements for personal or other reasons

   The above list is not all-inclusive, but is intended to be representative of situations involving fraud. Fraud may be perpetrated not only by a provider agency’s employees, but also by agents and other outside parties. All such situations require specific action.

   Within any provider agency, management bears the primary responsibility for detecting potentially fraudulent activities.

2. **Compliance Plan:**

   Agency providers are required under federal law to develop a formal Corporate Compliance Plan that includes procedures designed to guard against fraud and abuse. The plan should include:
   - An internal audit process to verify that services billed were furnished by appropriately credentialed staff and appropriately documented
   - Revisions to ensure that staff performing services under the
Cardinal Innovations contract have not been excluded from participation in Federal Health Care Programs under either Section 1128 or 1128A of the Social Security Act.

- Requirement that the provider consult with the Health and Human Services Office of the Inspector General’s list of excluded individuals, the Medicare Exclusion Databases (MED) and the list of excluded parties now found at SAM.gov (see https://exclusions.oig.hhs.gov and http://sam.gov).

- Written policies, procedures and standards of conduct that articulate the provider’s commitment to comply with all applicable state and federal standards for the protection against fraud and abuse.

- Designation of a Compliance Officer and Compliance Committee.

- A training program for the Compliance Officer and provider employees.

- Systems for reporting suspected fraud and abuse by employees and members and protections for those reporting.

- Provisions for internal monitoring and auditing.

- Procedures for response to detected offenses and for the development of corrective action plans.

- Reporting to monitoring and law enforcement agencies, including Cardinal Innovations.

Note: All providers must monitor the potential for abuse and fraud, and take immediate action to address reports or suspicions. The first two bulleted items above are required of all Cardinal Innovations providers, regardless of the amount of funding received. This list may not be all inclusive, and provider agencies should consult all applicable rules, laws and regulations to determine what elements may need to be included in their compliance plans. Providers may report potential allegations of fraud or abuse via the toll free, anonymous number at 1.800.357.9084.

3. Monitoring and Auditing

Cardinal Innovations has taken reasonable steps to monitor and audit its own compliance, including the establishment of monitoring and auditing systems that are reasonably designed to detect conduct in violation by the organization’s employees.

Cardinal Innovations has established a reporting system to support efforts to identify non-compliance issues. Providers may access this reporting system’s toll free, anonymous number at 1.844.231.0963. Callers can make reports anonymously, or may provide their names. Reports may also be made by calling 704.939.7700 and asking for the Compliance Officer.

It is a violation of Cardinal Innovations policy to intimidate or impose any form of retribution on an employee, agent or provider that utilizes the organization’s reporting system in good faith to report suspected violations (except that appropriate action may be taken against such employee, agent or provider if such is implicated as one of the wrongdoers).

4. Investigation of Violations

When Cardinal Innovations receives information regarding an alleged compliance violation, an investigation will occur to evaluate such information as to
gravity and credibility. Cardinal Innovations also may disclose the results of investigations to regulatory and/or law enforcement agencies depending on the nature of the allegation.

F. General Medical Records
Requirements/Treatment Records Standards


G. Management Information Systems

Each provider must have internet capacity.


Most providers are required to participate in the Health Information Exchange and all providers are encouraged to do so, as sharing information to coordinate care is best practice. See the following link for the requirements mandated by the North Carolina General Statue, including a list of exempt provider types. See [https://hiea.nc.gov/about-us/what-does-law-mandate](https://hiea.nc.gov/about-us/what-does-law-mandate)

Providers are responsible for understanding the requirements as well as the benefits of the HIE. Resources for the NC HIE are available at [https://hiea.nc.gov/about-us/about-nc-hiea](https://hiea.nc.gov/about-us/about-nc-hiea).
Section XII: RECONSIDERATION REVIEW PROCESS FOR PROVIDERS

This section explains the process by which providers can request reconsideration of certain actions taken by Cardinal Innovations.

Reconsideration Process

A. Request for Reconsideration

1. When a provider receives notice of one of the actions outlined below, the provider has 10 business days to request reconsideration of the action. All requests for reconsideration must be in writing and must be directed to the Chair of the Reconsideration Committee at Cardinal Innovations Healthcare, NASCAR Plaza, 550 South Caldwell Street, Suite 1500, Charlotte, NC 28202. Unless directed otherwise, requests for reconsideration should be sent return-receipt requested. If delivered in person, a receipt will be issued to the provider by Cardinal Innovations. It is the provider’s responsibility to request a receipt if one is not offered.

2. The provider must provide any additional written documentation to be considered during the reconsideration process at the time the Request for Reconsideration is submitted.

3. To the extent that the provider requesting reconsideration does not explicitly challenge a particular issue or outcome, they waive their rights to challenge it further.

4. Reimbursement may continue during the reconsideration process, unless the provider is cited for gross negligence, the provider is suspected of committing fraud or abuse, or at the sole discretion of Cardinal Innovations. Continued reimbursement is likely to increase any payback amount due.

   a. Cardinal Innovations may require the provider to submit documentation of services provided in order to continue to receive reimbursement during the reconsideration process.

   b. Such required documentation must be in either original or certified copy form.

5. Reconsideration Request forms and additional information regarding the provider reconsideration process can be accessed from the Resource Library on the Cardinal Innovations website.

B. The Cardinal Innovations Reconsideration Process

1. The standard timeframe for the Reconsideration Committee to make a decision is 60 calendar days.

2. The Reconsideration Committee, at its discretion, may extend the time it has to make a decision by up to an additional 30 calendar days. If the Reconsideration Committee chooses to extend this
timeframe, the provider will be notified in writing. The provider may be allowed to submit additional information during this time, as directed by Cardinal Innovations.

3. Once the Reconsideration Committee makes its decision, the provider will be notified in writing. If the sanction under reconsideration is a payback, and the decision requiring the payback is upheld in reconsideration, the payback will be due and payable by the provider to Cardinal Innovations within 60 days upon receipt by the provider of the letter communicating that decision, unless a payment plan is expressly requested as directed in the Reconsideration Decision Letter.

C. A Provider May Request Reconsideration for All of the Following Circumstances

1. A provider may request reconsideration of the following decisions:
   a. A finding that the provider is out of compliance with Medicaid or Cardinal Innovations documentation requirements or other service requirements established in the applicable Clinical Coverage Policy or the provider’s Procurement Contract
   b. Imposition of a payback for out of compliance area(s)
   c. Imposition of a plan of correction
   d. Imposition of a referral freeze
   e. Unilateral decision to remove a site or service from the Procurement Contract
   f. Decision to terminate the provider’s Procurement Contract
   g. Decision to suspend payments

2. With the exception of paybacks, Cardinal Innovations’ decisions are not pended while the reconsideration process takes place.
A. **Cardinal Innovations Website**

The Cardinal Innovations website can be accessed at [www.cardinalinnovations.org](http://www.cardinalinnovations.org). This website provides information and resources for members and their families, providers, government officials and other stakeholders. Providers may utilize the website to access important practice documentation, and policies and resources. They also may refer members to the website for information specific to their individual needs.

The website also features a search function that allows members and family members to search for a provider by selection criteria that includes county, disability and service, and languages spoken.

B. **Official Communication Bulletins**

All Official Communication Bulletins are posted on Cardinal Innovations’ provider webpages at [https://www.cardinalinnovations.org/Providers/Communication-bulletins](https://www.cardinalinnovations.org/Providers/Communication-bulletins). You will also see announcements on this webpage.

Communication Bulletins from specific departments or areas are designated as shown below:

1. **Access (AC)**
   
   FY-(fiscal year)-AC-(# of Bulletin)-(Title of Bulletin)
   
   Example: FY-1819-AC-01-Title

2. **Area Administration (AA)**
   
   FY-(fiscal year)-AA-(# of Bulletin)-(Title of Bulletin)
   
   Example: FY-1819-AA-01-Title

3. **Service Center (SC)**
   
   FY-(fiscal year)-SC-(# of Bulletin)-(Title of Bulletin)
   
   Example: FY-1819-SC-01-Title

4. **Care Coordination (CC)**
   
   FY-(fiscal year)-CC-(# of Bulletin)-(Title of Bulletin)
   
   Example: FY-1819-CC-01-Title

5. **Finance (FN)**
   
   FY-(fiscal year)-FN-(# of Bulletin)-(Title of Bulletin)
   
   Example: FY-1819-FN-01-Title

6. **Information Technology (IT)**
   
   FY-(fiscal year)-IT-(# of Bulletin)-(Title of Bulletin)
   
   Example: FY-1819-IT-01-Title

7. **Medicaid Program (MP)**
   
   FY-(fiscal year)-MP-(# of Bulletin)-(Title of Bulletin)
   
   Example: FY 1819-MP-01-Title

8. **Medical Department (MD)**
   
   FY-(fiscal year)-MD-(# of Bulletin)-(Title of Bulletin)
   
   Example: FY 1819-MD-01-Title
9. **Network Management (NM)**

   FY-(fiscal year)-NM-(# of Bulletin)-(Title of Bulletin)
   Example: FY-1819-NM-01-Title

10. **Quality Management (QM)**

    FY-(fiscal year)-QM-(# of Bulletin)-(Title of Bulletin)
    Example: FY-1819-QM-01-Title

11. **Utilization Management (UM)**

    FY-(fiscal year)-UM-(# of Bulletin)-(Title of Bulletin)
    Example: FY-1819-UM-01-Title

The Communications and Marketing Department publishes and disseminates an electronic newsletter, InfoSource, which contains relevant provider, member and stakeholder information and communications. Individuals may subscribe to this newsletter by clicking the subscription link at the bottom of the newsletter or contacting corporatecommunications@cardinalinnovations.org.

The Communications and Marketing Department periodically disseminates electronic mail communications to providers on behalf of other departments within Cardinal Innovations. In most instances, these communications contain time-sensitive information and should be carefully reviewed as soon as they are received. Thus, it is imperative that you maintain current and accurate contact information on file with Cardinal Innovations.

The Communications and Marketing Department also sends enrollment-related materials pertaining to services, member rights, and privacy and confidentiality practices to Cardinal Innovations members on an annual basis. Copies of these documents are available on the Cardinal Innovations website as well.
**Section XIV:**
**GLOSSARY OF TERMS**

**Ability-to-Pay Determination:** The amount a member is obligated to pay for state-funded services. The ability to pay is calculated based on the member’s income and number of dependents. The Federal Government Poverty Guidelines are used to determine the member’s payment amount. See [http://www.cms.gov](http://www.cms.gov) or [http://aspe.hhs.gov/poverty/index.cfm](http://aspe.hhs.gov/poverty/index.cfm).

**Abuse:** Practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes beneficiary practices that result in unnecessary cost to the Medicaid program (Guidelines for Addressing Fraud and Abuse in Medicaid Managed Care, October 2000).

**Access Center:** Access management is a critical function of Cardinal Innovations. Cardinal Innovations is responsible for timely response to the needs of members and for quick linkages to qualified network providers. To ensure Cardinal Innovations is able to meet these obligations, Cardinal Innovations maintains a toll-free call system to receive all inquiries. This includes information, access to care, emergency, and network provider assistance. The toll-free call system relies on information systems management software to assist in tracking and responding to calls.

**Action:** In the context of a sanction imposed by Cardinal Innovations, this term identifies the sanctions for which a provider can seek a Reconsideration Review: imposition of a payback for areas of non-compliance; imposition of a Plan of Correction; imposition of a Referral Freeze; a termination; a finding that the provider is out of compliance with Medicaid or Cardinal Innovations documentation requirements; a decision to suspend payment(s); and/or a decision to remove sites and/or services from a provider’s contract.

**Adverse Benefit Determination:** Pursuant to 42 CFR § 438.400, as the denial or limited authorization of a requested service, including the type or level of service; the reduction, suspension, or termination of a previously authorized service; the denial, in whole or in part, of payment for a service; the failure to provide services in a timely manner, as defined by the state; the failure of PIHP to act within the timeframes provided in 42 C.F.R. 438.408(b); the denial of a request to dispute a financial liability. An adverse benefit determination means the denial of a Medicaid enrollee’s (member’s) request to obtain services outside the network:

a. From any other provider in terms of training, experience, and specialization) not available in the Network

b. From a provider not part of the network that is the main source of a service to the recipient—provided that the provider is given the same opportunity to become a participating provider as other similar providers. If the provider does not choose to join the Network or does not meet the qualifications, the enrollee is given a choice of participating providers and is transitioned to a participating provider within 60 days.
c. Because the only plan or provider available does not provide the service because of moral or religious objections.
d. Because the enrollee’s provider determines that the recipient needs related services that would subject the recipient to unnecessary risk if received separately and not all related services are available within the network.

**Adjudicate:** A determination to pay or reject a claim.

**Administrative Review:** A review of documentation to determine whether Cardinal Innovations procedures were followed, and if any additional information provided warrants a change in a previous determination.

**Advanced Directive:** A communication given by a competent adult that gives directions or appoints another individual to make decisions concerning a person’s care, custody or medical treatment in the event that the person is unable to participate in treatment decisions.

**Agency:** An Area Facility as defined by NCGS 122C-3 subsection 14A. An agency may deliver a number of services, and submits/bills claims under a tax ID number.

**Alternative Services:** Cost-effective options to state-funded services that are substantial changes to existing services or completely new services. These services may be LME/MCO-specific.

**American National Standards Institute (ANSI):** The national coordinating institution for voluntary standards, conformity assessment and related activities in the United States, through which organizations may cooperate in establishing, improving and recognizing standards based on the consensus of the relevant parties.

**Appeal:** A request for review of an adverse benefit determination, as adverse benefit determination is defined in this glossary. The first step in an Appeal is a Reconsideration Review. If the member is dissatisfied by the results of the Reconsideration Review, the member may further appeal and request a State Fair Hearing.

**Appellant:** An individual filing an appeal.

**Assessment:** A procedure for determining the nature and extent of need for which the individual is seeking services as well as the specific service(s) or level of service that is appropriate for the individual.

**Authorized Service:** Medically necessary service that has been pre-approved by Cardinal Innovations.

**Basic Benefit Package:** The Basic Benefit Package includes those services that are made available to individuals with Medicaid and, to the extent resources are available, to individuals enrolled in Cardinal Innovations’ state-funded and federally-funded block grant programs. These services are intended to provide brief interventions for individuals with acute needs.

**Benchmark:** A standard by which something can be measured, judged or compared.

**Beneficiary (or Recipient):** A member who is receiving services.

**Best Practices:** Recommended practices – including evidenced-based practices – that consist of clinical and administrative practices that have been proved to consistently produce specific, intended results.

**Business Associate:** A person or organization that performs a function or activity involving Protected Health Information on behalf of a covered entity but is not part of the covered entity’s work force. A business associate can also
be a covered entity in its own right. See the HIPAA definition as it appears in 45 CFR 160.103.

**CALOCUS:** The Child and Adolescent Level of Care Utilization System (CALOCUS) is a standardized assessment tool for measuring the level of care needs for children and adolescents.

**CAQH (Council for Affordable Quality Healthcare):** A nonprofit alliance of the nation’s leading health plans and networks working to simplify healthcare administration by, among other tasks, serving as a clearinghouse for applications submitted by licensed practitioners seeking credentials with Cardinal Innovations or other participating LME/MCOs. More information is available at: [www.caqh.org](http://www.caqh.org).

**Care Coordination:** Using trained healthcare professionals to identify people within special needs populations who are in need of additional support and providing service linkage and monitoring, and case management to ensure that those people are appropriately assessed and engaged in medically necessary services aimed at achieving positive treatment outcomes. Core components of Care Coordination include the use of person-centered planning with people for whom care is being coordinated, and the promotion of member self-management.

**Care Coordinator:** A trained healthcare professional who coordinates, manages and monitors care and transitions across the continuum of health care, in various settings, and in conjunction with individuals, providers and others in order to connect components of the healthcare team and improve outcomes for individuals.

**Care Management:** A multidisciplinary, disease-centered approach to managing care using outcome measures to identify best practices, all aimed at identifying the level of risk, stratifying services according to risk, and prioritizing recipients for services. The approach uses collaboration of services, systematic measurement and reporting and resource management.

**Catchment Area:** The geographic part of the state of North Carolina served by PIHP, as defined in N.C.G.S. § 122C-3(5). Cardinal Innovations’ catchment area is comprised of 20 designated counties in North Carolina.

**Centers for Medicare and Medicaid Services (CMS):** The federal agency within the U.S. Department of Health and Human Services which, among other functions, administers Medicare, and works in partnership with state governments to administer Medicaid and the state Children’s Health Insurance Program.

**Child:** An enrollee (member) who has not reached his/her 21st birthday unless otherwise defined by the user of this term.

**Claim:** A request for reimbursement under a benefit plan for services.

**Clean Claim:** As per 42 CFR 447.45(b), this is a claim that can be processed without obtaining additional information from the provider of the services or a third party. It does not include a claim under review for medical necessity or a claim from a provider that is under investigation by a governmental agency for fraud or abuse.

**Client:** As defined in the NC General Statutes 122C-3 (6).

**Clinical Prevention:** “Services [which] both prevent and detect illnesses and diseases...in their earlier, more treatable stages, significantly reducing the risk of illness, disability, early death, and medical care costs” (Healthy People 2020, 2017). According to the U.S. Preventive Services Task Force, clinical prevention services include screening, counseling services, and preventive medication (USPSTF, 2017).
**Closed Provider Network:** The group of providers that have contracted with PIHP to furnish covered mental health, intellectual or developmental disabilities, and substance use disorder services to enrollees, as set forth at N.C.G.S. § 108D-1(2).

**Care Coordination Department:** A department within Cardinal Innovations that is responsible for numerous services and activities such as Housing, IDD Assessments, IDD Care Coordination, Acute Transitional Care, Population Health Management, MH/SUD Care Coordination, Transitions to Community Living and System of Care.

**Comprehensive Community Clinic (CCC):** A Cardinal Innovations designation for contracted provider agency sites that provide a robust array of services, including basic assessments, therapy and medication management services to both children and adults for the treatment of both substance use and mental health conditions. These clinics are established by county and provide the full array of basic services in the county where the designation is granted. These clinics are considered the MH/SUD safety net in these counties. In addition to providing robust basic services, CCCs are expected to meet certain specific clinical standards that ensure access to essential services by Cardinal Innovations members. See full description set forth in Section III, Subsection C.1.b.

**Concurrent Review:** A review conducted by Cardinal Innovations during a course of treatment to determine whether services meet medical necessity and quality standards. The review also determines whether services should continue as prescribed or should be altered, changed or terminated.

**Contract Term:** The period of time during which the contract is in effect.

**Contractor:** An entity providing services to the LME/MCO described in either the Procurement Contract for Provision of Services to members with Disabilities or the Consultant Contract for the Provision of Services.

**Covered Services:** The services that the LME/MCO agrees to provide, arrange for, or otherwise bear responsibility for the provision of, to eligible members pursuant to the terms of the Contract.

**Credentialing:** As applied to network providers, the term credentialing refers to the pre-contract screening and decision process, including primary source verification (PSV), conducted by Cardinal Innovations to verify that the licensed independent practitioner, agency or hospital applicant is qualified to deliver services to enrollees and is eligible to participate and be enrolled and contracted in Cardinal Innovations’ closed provider network.

As applied to clinicians seeking to render services to members on behalf of a contracted network provider, the term credentialing refers to the review and verification process used to confirm the qualifications of licensed clinicians who are seeking to render services to Cardinal Innovations’ members. The process also includes primary source verifications as described above.

**Crisis Intervention:** Unscheduled assessment and treatment for the purpose of resolving an urgent/emergent situation requiring immediate attention.

**Crisis Plan:** A Crisis Plan is an individualized written plan developed in conjunction with the member and treatment team. The Plan contains information to assist in deescalating a crisis as well as clear directives to the individual crisis workers or others involved. Crisis plans are developed for members who are receiving an enhanced, (b)(3) or IDD service and/or are at-risk for inpatient treatment, incarceration or out-of-home placement.
Critical Access Behavioral Healthcare Agency (CABHA): This state-issued designation is being sunset and will no longer be operative in North Carolina.

Cultural Competency: The understanding of the social, linguistic, ethnic and behavioral characteristics of a community or population and the ability to translate systematically that knowledge into practice in the delivery of behavioral health services. Such understanding may be reflected in the ability to identify and value differences; acknowledge the interactive dynamics of cultural differences; continuously expand cultural knowledge and resources with regard to populations served; collaborate with the community regarding service provisions and delivery; and commit to cross-cultural training of staff and develop policies to provide relevant, effective programs for the diversity of people served.

Days: Except as otherwise noted, refers to calendar days. "Working days" or "business days" means days on which the LME/MCO is officially open to conduct its affairs.

Denial of Service: A determination made by the LME/MCO in response to a Network Providers request for approval to provide in-plan services of a specific duration and scope which the LME/MCO either denies the request entirely, or approves the request in an amount or frequency less than what was requested.

Developmental Disabilities (DD): North Carolina General Statute 122C-3(12a) currently defines a developmental disability as "a severe, chronic disability of a person which

- Is attributable to a mental or physical impairment or combination of mental and physical impairments;
- Is manifested before the person attains age 22, unless the disability is caused by traumatic head injury and is manifested after age 22;
- Is likely to continue indefinitely;
- Results in substantial functional limitations in three or more of the following areas of major life activity: self-care, receptive and expressive language, capacity for independent living, learning mobility, self-direction and economic self-sufficiency;
- Reflects the person’s need for a combination and sequence of special interdisciplinary, or generic care, treatment, or other services which are of a lifelong or extended duration and are individually planned and coordinated; or
- When applied to children from birth through four years of age, may be evidenced as a developmental delay."

Disenrollment: Action taken by DHB to remove an enrollee’s name from the monthly enrollment following DHB’s determination that the enrollee is no longer eligible for enrollment in PIHP.

Dispute Resolution Process: Cardinal Innovations’ process to address verbal concerns, grievances, and/or disputes by Providers in a consistent manner.

Early Periodic Screening Diagnosis and Treatment (EPSDT): The federal law which provides that Medicaid must provide all medically necessary health care services to Medicaid-eligible children. Even if the service is not covered under the NC Medicaid State Plan, it can be covered for recipients under 21 years of age if the service is listed in 1905(a) of the Social Security Act and if all EPSDT criteria are met.

Eligibility: The determination that an individual meets the requirements to receive services as defined by the payer.

Emergency Medical Condition: A medical condition manifesting itself by acute symptoms
of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in

- Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

**Emergency Services:** With respect to a member, covered inpatient and outpatient services that
- Are furnished by a Provider that is qualified to furnish such services, and
- Are needed to evaluate or stabilize an emergency medical condition as defined above.

**Emergent Need – Mental Health:** A life-threatening condition in which a person is suicidal, homicidal, actively psychotic, displaying disorganized thinking, reporting hallucinations and delusions that may result in self harm or harm to others, and/or displaying vegetative signs and is unable to care for self.

**Emergent Need – Substance Use:** A life threatening condition in which the person is – by virtue of their use of alcohol or other drugs – suicidal, homicidal, actively psychotic, displaying disorganized thinking, reporting hallucinations and delusions which may result in self-harm or harm to others, and/or is unable to adequately care for self without supervision due to the effects of chronic substance use or dependence.

**Encounter Data:** A record of a Covered Service rendered by a provider to an enrollee (member) who is enrolled in PIHP (Cardinal Innovations) during the date of service. It includes all services for which Cardinal Innovations incurred any financial responsibility; in addition, it may include claims for reimbursement that were denied by Cardinal Innovations.

**Enhanced Service Package:** The Enhanced Benefit package includes those services that will be made available to individuals with Medicaid and, in rare circumstances to the extent resources are available, to state-funded and federally funded program participants 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, which are more appropriate for individuals seeking to recover from more severe forms of mental illness, substance use and intellectual and developmental disabilities, and who have 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.

**Enrollee:** A Medicaid beneficiary whose Medicaid eligibility arises from residency in a county covered by the PIHP (Cardinal Innovations) or who is currently enrolled in Cardinal Innovations.

**Enrollment:** When referring to enrollees, this means an action taken by DMA to add a Medicaid beneficiary’s name to the monthly Enrollment Report following the receipt and approval by DMA of Medicaid Eligibility for a person living in the defined catchment area. When referring to providers, this means the process of submitting a credentialing application for consideration to become a provider in the PIHP Closed Network, unless the context is referring to the process of submitting an online enrollment application via NCTracks for consideration to become a Provider in the NC Medicaid or Health Choice programs.
**Enrollment Period:** The time span during which a recipient in enrolled with the LME/MCO as a Medicaid waiver eligible recipient.

**Facility:** Any premises (a) owned, leased, used or operated directly or indirectly by or for Cardinal Innovations; or (b) maintained by a sub-contractor to provide services on behalf of Cardinal Innovations.

**Fee-For-Service:** A method of making payment directly to health care providers enrolled in the state Medicaid Program for the provision of health care services to Medicaid beneficiaries based on the payment methods set forth in the state plan and the applicable policies and procedures of the DMA.

**Fidelity:** Adherence to the guidelines as specified in the evidenced-based best practice.

**Financial Audit:** Audit generally performed by a Certified Public Accountant in accordance with Generally Accepted Accounting Principles to obtain reasonable assurance about whether the general purpose financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. Audits also include assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall general purpose financial statement presentation.

**Fiscal Agent:** An agency that processes and audits provider claims for payment and performs certain other related functions as an agent of DMA and DMH/DD/SAS.

**Fiscal Review:** A review performed by Cardinal Innovations’ Service Center that includes a review of the provider’s evaluation of member’s income, member’s determined ability to pay, third party insurance verification, first and third party billing, receipts and denials.

**Fraud:** Intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself/herself or some other person. It includes any act that constitutes fraud under applicable federal or state law. See the Fraud, Waste, and Abuse Referral Guidelines for Use by Managed Care Plans, May 2012 at: [https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/ProviderCompliance](https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/ProviderCompliance)

**Good Standing:** With respect to providers, being current with all licensing and other documentation requirements; and, at the time the good standing determination is made, being free from all sanctions/penalties imposed by Cardinal Innovations, federal, state or local regulatory bodies, or any other governing entity having the authority to sanction or impose penalties.

**Grievance:** Pursuant to 42 C.F.R. 438.400, an expression of dissatisfaction by or on behalf of an enrollee (member) about any matter other than an “adverse benefit determination” as defined herein. The term is also used to refer to the overall system that includes grievances and appeals handled at PIHP (MCO) level and access to the State Fair Hearing process. Possible subjects for grievances include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a Provider or employee, or failure to respect the Enrollee’s rights regardless of whether remedial action is requested. Grievance includes a member’s right to dispute an extension of time proposed by PIHP (Cardinal Innovations) to make an authorization decision.

**Grievance and Appeal System:** The processes that the PIHP (Cardinal Innovations) implements to handle appeals of an adverse benefit
determination and handle grievances, as well as the processes to collect and track information about grievances and appeals.

**Grievance Procedure:** The written procedure pursuant to which members may express dissatisfaction with the provision of services by the LME/MCO and the methods for resolution of member’s grievance by the LME/MCO.

**Health Plan Employer Data and Information Set (HEDIS):** A collection of standardized performance measures designed to reliably compare the performance of managed health care plans.

**HIPAA:** The Health Insurance Portability and Accountability Act of 1996 (HIPAA) that required the adoption of federal privacy protections for individually identifiable health information. The U.S. Department of Health and Human Services issued rules governing the protection of individual health information, commonly known as the Privacy Rule. Additionally, the HIPAA Security Rule requires covered entities to adopt appropriate administrative, physical and technical safeguards to ensure the confidentiality and security of electronic protected health information.

**Hospital/Emergency Department Biller:** A hospital that elects to be listed in Cardinal Innovations’ CI System as a non-contracted hospital biller in order to have its claims for inpatient or emergency department services processed more easily. However, these providers will not be listed as choices for Cardinal Innovations’ members for inpatient care, nor will they have any status within the Provider Network.

Likewise, these providers may not use this process to bill for those services. This process is merely designed to facilitate reimbursement to a non-contracted hospital for providing inpatient and/or emergency services to Cardinal Innovations’ members. If a Cardinal Innovations member receives non-emergency services from a non-enrolled, non-contracted provider, Cardinal Innovations will not pay for those services.

**In Lieu of Services:** Medicaid-billable services that are substantial changes to existing services in the Medicaid State Plan or a completely new service. In Lieu Of Services are cost-effective options to Medicaid State Plan services. These services may be LME/MCO-specific.

**Incident:** An unusual occurrence as defined in APSM 30-1. Incidents are reported as Level I, II, or III as defined in APSM 30-1.

**Individual Budget Tool (IBT):** The IBT is used during the annual service planning process for enrollees (members) on the Innovations Waiver. The IBT is composed of four tables that specify the IBT amounts that a member assigned to a particular level is authorized to receive without additional authorization (in the form of a temporary increase or intensive review during the utilization review process).

**Innovations Waiver:** The 1915(c) Home and Community Based Services (HCBS) Waiver supports that supports members intellectual/developmental disabilities.

**Institution for Mental Diseases (IMD):** This is defined by 42 CFR Sec. 435.1010. An Intermediate Care Facility for Individuals with Intellectual Disability is an IMD.

**International Classification of Diseases (ICD):** A diagnostic tool for epidemiology, health management and clinical purposes.

**Intra-Departmental Monitoring Team (IMT):** A team led by DHB and consisting of qualified DHB
and DMH staff who provide monitoring of PIHP throughout the course of these contracts.

**Initial Authorization (also called Pre-Authorization or Prior Approval):** Approval of medically necessary services at a given level of care prior to services being rendered.

**Integrated Care:** “The systematic coordination of general [physical] and behavioral healthcare” (Substance Use Mental Health Services Administration [SAMHSA], n.d.). While behavioral health refers to substance use disorders and mental health, integration is also particularly important in the care of individuals with intellectual disabilities and developmental disabilities (IDD) (Kastner & Walsh, 2012). Levels of integration span from minimal coordination to full integration and entail adaptations to provider locality/proximity, clinical service delivery, client/patient experience, organizational culture, and business model (see SAMHSA’s Six Levels of Collaboration/Integration).

**Least Restrictive Environment:** The least intensive/restrictive setting of care.

**Licensed Independent Practitioner:** Practitioners who are eligible to bill under their own licenses – including:

- Medical Doctors (MD)
- Doctors of Osteopathy (DO)
- Licensed Psychologists (LP) [inclusive of Ph.D. and Psy.D.]
- Licensed Psychological Associates - Master's Level (LPA)
- Master's Level Social Workers (LCSW)
- Licensed Marriage and Family Therapists (LMFT)
- Licensed Professional Counselors (LPC)
- Licensed Addiction Specialists (LCAS)
- Certified Clinical Supervisors (CCS)
- Certified Substance Abuse Prevention Consultants (CSAPC)
- Board Certified Behavior Analysts (BCBA and BCBA-D)
- Advanced Practice Psychiatric Clinical Nurse Specialists (PMH CNS)
- Psychiatric Nurse Practitioners (PMHNP)
- Nurse Practitioners (NP)
- Licensed Physician Assistants (PA)
- Occupational Therapists (OT)
- Speech Language Pathologists (SLP)
- Licensed Dietitians/Nutritionists (LDN)
- Physical Therapists (PT)
- Recreational Therapists (RT)
- All provisionally/associate licensed Practitioners under the above disciplines

**LME:** A Local Management Entity (LME) is a local political subdivision of the state of North Carolina as established under NC General Statute 122C.

**LME/MCO Authorization:** Approval of medically necessary services for continued service delivery.

**LME/MCO Authorization Request Form:** The most currently approved Treatment Authorization Request (TAR) used by providers to request initial or continuing services.

**Local Appeal:** If the MCO denies, reduces, suspends or terminates a non-Medicaid service, the member/guardian may request a Local Appeal to review the decision. For specific details about this process, including relevant time frames for the process, please see Section V, Member Rights and Empowerment.

**LOCUS:** The Level of Care Utilization System (LOCUS) is a standardized assessment tool for measuring the level of care needs for adult mental health adult mental health members.

**Managed Care Organization (MCO):** The entities within North Carolina that are charged with administering limited allocations of public funds to provide behavioral health services for persons, located within the geographical areas in which they operate, who have behavioral health needs...
and/or developmental disabilities. This term is used interchangeably with such terms as Managed Care Entity and Prepaid Inpatient Health Plans.

Management Information System (MIS): An integrated group of procedures and computer processing operations developed to help control administrative costs, facilitate service delivery to members, and improve claims processes/information retrieval. An example of an MIS is the NC Tracks system which is used by the state of North Carolina.

Medicaid Identification (MID) Card: The Medical Assistance Eligibility Certification card issued monthly by DHB to Medicaid entitled individuals.

Medicaid for Infants and Children (MIC): A program for medical assistance for children under the age of 19 whose countable income falls under a specific percentage of the Federal Poverty Limit and who are not already eligible for Medicaid in another category.

Medicaid Management Information System (MMIS): The mechanized claims processing and information retrieval system used to track the claims for reimbursement by state Medicaid agencies and required by federal law.

Medicaid for Pregnant Women (MPW): A program for medical assistance for pregnant women whose income falls under a specified percentage of the Federal Poverty Limit and who are not already eligible in another category.

Medical Assistance (Medicaid) Program: DHB’s program to provide medical assistance to eligible citizens of the State of North Carolina, established pursuant to Chapter 58, Articles 67 and 68 of the North Carolina General Statutes and Title XIX of the Social Security Act, 42 U.S.C. 1396 et. seq.

Medical Record: A single complete record, maintained by the provider of services, which documents all of the treatment plans developed for any behavioral health, intellectual developmental disability and substance use/addiction services received by the member.

Medically Necessary Treatment, Services or Supplies: According to NCGS Section 58-3-200, covered services or supplies that are:

a. Provided for the diagnosis, treatment, cure or relief of a health condition, illness, injury, or disease; and, except as allowed under NCGS Section 58-3-255, not for experimental, investigational, or cosmetic purposes;
b. Necessary for and appropriate to the diagnosis, treatment, cure, or relief of a health condition, illness, injury, disease, or its symptoms;
c. Within generally accepted standards of medical care in the community; and
d. Not solely for the convenience of the insured, the insured’s family, or the provider.

Mediation: The process of bringing individuals or agencies in conflict together with a neutral third party who assists them in reaching a mutually agreeable solution.

Natural Resource Linking: Processes that maximizes the use of family and community support systems to optimize member functioning.

NC Department of Health and Human Services: The state agency charged with, in collaboration with partners, providing “essential services to improve the health, safety and well-being of all North Carolinians.”

NC Department of Health and Human Services, Division of Health Benefits (DHB): The division within the state’s Department of Health and Human Services, which manages the state’s Medicaid and NC Health Choice health care programs.
programs, pharmacy benefits, and behavioral health services. This division also oversees community alternatives programs for children and disabled adults, home health care, and helping people transition from nursing homes to live in their own communities. It works closely with the North Carolina Department of Justice to identify and prosecute fraud, waste and abuse of the Medicaid program. Also called NC Medicaid.

**NC Division of Mental Health Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS):** The division within the state’s Department of Health and Human Services charged with “providing quality support to achieve self-determination for individuals with intellectual and/or developmental disabilities and quality services to promote treatment and recovery for individuals with mental illness and substance use disorders.”

**NC Medicaid:** The division within the state’s Department of Health and Human Services which manages the state's Medicaid and NC Health Choice health care programs, pharmacy benefits, and behavioral health services. This division also oversees community alternatives programs for children and disabled adults, home health care, and helping people transition from nursing homes to live in their own communities. It works closely with the North Carolina Department of Justice to identify and prosecute fraud, waste and abuse of the Medicaid program. Also called the NC Department of Health and Human Services, Division of Health Benefits (DHB).

**NC MH/DD/SAS Health Plan:** A 1915(b) Medicaid Managed Care Waiver, which allows for a waiver of freedom of choice of Providers so that the LME/MCO can determine the size and scope of the Provider Network. It also allows for use of Medicaid funds for alternative services.

**NCQA:** The National Committee for Quality Assurance (NCQA) is an independent, 501(c)(3) non-profit organization whose mission is to improve health care quality through accreditation (a rigorous on-site review of key clinical and administrative processes); through the Health Plan Employer Data and Information Set (HEDIS®), a tool used to measure performance in key areas; and through a comprehensive member satisfaction survey.

**NC tracks:** The multi-payer Medicaid Management Information System for the NC Department of Health and Human Services (NC DHHS).

**Network Council:** An advisory body to Cardinal Innovations comprised of elected provider representatives, member representatives and Cardinal Innovations staff.

**Network Provider:** A provider of behavioral health services that meets Cardinal Innovations criteria for enrollment, credentialing and/or accreditation requirements and is under written agreement to provide services.

**No Reject:** A policy whereby Cardinal Innovations providers agree to accept all referrals meeting criteria for the needed/requested service. Providers must have a no reject policy; however, a provider’s capacity to meet individual referral needs will be considered and, when necessary, negotiated between Cardinal Innovations and the provider.

**Non-paneled staff:** Staff who provide services that are not approved for billing by the member’s third party insurer or Medicare.

**Out-of-Plan Services:** Health care services which Cardinal Innovations is not required to manage or provide under the terms of its contract with the DMA. The services are Medicaid-covered services reimbursed on a fee-for-service basis. Per 10A NCAC 22L .0203, the DMA shall pay for all out-of-plan services provided in accordance with Medicaid policies.
**Out-of-Network Provider**: Any provider entity which provides services but does not have a written provider agreement with Cardinal Innovations, and is, therefore, not included or identified as being in Cardinal Innovations’ Provider Network. Out-of-Network providers that receive member-specific agreements are not considered to be members of the Cardinal Innovations Provider Network, and they are not offered as a choice to Cardinal Innovations members.

**Outlier**: An event that falls outside a particular range (e.g., an average length of stay that is significantly greater or lower than the norm).

**Peer Reviewer**: A licensed Psychiatrist or Psychologist (PhD level) whose duties include, but are not limited, to conducting reviews for requests for authorization of services for the LME/MCO. These individuals are employed by the LME/MCO/Health Plan and must be licensed in the state where they reviews occur. Only an MD Psychiatrist or PhD Psychologist can render a denial or reduction for a request for service. Peer Reviewers (PRs) also review cases under appeal, provide training and monitor quality of care, adherence to clinical policy and best practice.

**Penetration Rate**: The degree to which a defined population cohort is served.

**Person-Centered Planning**: A process for planning and supporting the individual receiving services that builds upon the individual's capacity to engage in activities that promote community life and that honor the individual's preferences, choices and abilities. The person-centered planning process involves the individual, family members, friends and professionals as the individual desires or requires. The resulting treatment document is the person-centered plan, which outlines strengths, needs, goals and other relevant information regarding the individual's proposed course of treatment.

**Population Health**: “The health outcomes of a group of individuals, including the distribution of such outcomes within the group" (Kindig & Stoddart, 2003). Cardinal Innovations uses a population health model, employing data and predictive analytics to monitor and improve the health of member populations. Additionally, Care Coordination’s Population Health staff have implemented predictive, analytic-driven telephonic support for members. This support helps to ensure outpatient treatment engagement, self-management plan utilization, and medication adherence with the goal being to ultimately avoid crisis events.

**Post Payment Review**: An audit conducted by Cardinal Innovations to assess the presence of appropriate documentation in support of claims submitted to Cardinal Innovations for payment.

**Prepaid Inpatient Health Plan (PIHP)**: A type of managed care entity recognized by Federal Managed Care regulations at 42 CFR 438. Per the Centers of Medicare and Medicaid services, this type offers a “limited benefit package that includes inpatient hospital or institutional services (example: mental health).” Cardinal Innovations Healthcare is categorized as a PIHP.

**Primary Clinician**: Professional assigned after the initial intake that is ultimately responsible for implementation and coordination of the Treatment Plan/Person-Centered Plan.

**Principal Diagnosis**: The most important or significant condition of an individual at any time during the course of treatment in terms of its implications for the individual’s health, medical care and need for services, which is the main focus of attention or treatment.

**Prior Authorization**: The act of approving specific services before they are rendered.

**Priority Populations**: Individuals with the most severe type of mental illness, severe emotional
disturbances, and substance use/addiction disorders with complicating life circumstances conditions, and/or situations that impact the person’s capacity to function, often resulting in high risk behaviors.

**Protected Health Information (PHI):** Individually-identifiable health information, in any form, which is created, maintained or transmitted by Cardinal Innovations or its Business Associates.

**Provider Concern:** An actual or potential issue with a network provider, separate and apart from a grievance or an adverse benefit determination. The scope of a Provider Concern may include, but is not limited to:

- The accessibility/availability of services and sites
- Compliance with Procurement Contract
- Provider submission of Treatment Authorization Requests and/or claims
- Clinical practices and/or documentation
- Regulatory concerns regarding maintenance of provider licensure, licensure violations, billing audits and/or paybacks
- Timeliness and access to care

**Provisional Status:** Status of a provider entity which requires increased monitoring of the provider and its contract status by Cardinal Innovations. A provider may be designated with this status because it is a newly contracted entity, has not achieved the performance or quality threshold set by established monitoring processes, or following the occurrence of a significant event.

**Prompt payment guidelines:** State-mandated timelines LME/MCOs must follow when adjudicating and paying claims.

**Provider:** In the context of the Medicaid program, the term means: (a) any individual or entity rendering services under an agreement with a Medicaid agency; or (b) any individual or entity that is engaged in the delivery of health care services and is legally authorized to do so by the state in which it delivers said services.

**Qualified Professional (QP):** Any individual with appropriate training, education, and experience as specified by the North Carolina General Statutes or by rule of the North Carolina Commission on Mental Health, Developmental Disabilities, and Substance Abuse Services in the fields of mental health or developmental disabilities or substance use treatments or habilitation. QPs may include physicians, psychologists, psychological associates, educators, social workers, registered nurses, certified fee-based practicing pastoral counselors and certified counselors (NC General Statute 122C-3).

**Quality Improvement Program (QIP):** This program, in conjunction with the Quality Improvement Committee structure, is responsible for planning, developing, prioritizing and supporting quality improvement initiatives and activities designed to ensure the accessibility of services, availability of the network and the quality and appropriateness of the behavioral health services that Cardinal Innovations provides to its members.

**Reconsideration Review:** A process by which a member who does not agree with Cardinal Innovations’ decision to deny, reduce, suspend, or terminate Medicaid services can have the decision reviewed. This process is allowed under the NC MH/DD/SAS Health Plan (1915(b) waiver) and the NC Innovations Waiver (1915(c) waiver). For specific details about this process, including relevant time frames for the process, see Section V, Member Rights and Empowerment at Paragraph I.
**Re-Credentialing:** A periodic review process repeating the same applicable screening, verifications, determinations and processes previously conducted for the initial credentialing in order to determine whether a provider and/or clinician continues to meet the criteria and eligibility for inclusion as a Cardinal Innovations Network Provider.

**Restrictive Interventions:** An intervention procedure which presents a risk of mental or physical harm to the client and, therefore, requires additional safeguards. Such interventions include the emergency or planned use of seclusion, physical restraint (including the use of protective devices for the purpose or with the intent of controlling unacceptable behavior), isolation time-out, and any combination thereof.

**Routine Need – Mental Health:** A condition in which the person describes signs and symptoms resulting in impaired behavioral, mental or emotional functioning which has impacted the person’s ability to participate in daily living, and/or markedly decreased the person’s quality of life.

**Routine Need – Substance Use/Addiction:** No substance use-related call or condition should be considered routine. See the definition for “Urgent Need – Substance Use/Addition.”

**Service Location:** Any location at which a member may obtain any covered service from a Network Provider.

**Severe Mental Illness (SMI):** Refers to people
- Age 18 or older;
- With substantial disorder of thought or mood that significantly impairs judgment, behavior, capacity to recognize reality, or the ability to cope with the ordinary demands of life; and
- Who have had one or more psychiatric hospitalizations or crisis home admissions in the last year.

**Severe and Persistent Mental Illness (SPMI):**
Refers to people
- Age 18 or older;
- With substantial disorder of thought or mood that significantly impairs judgment, behavior, capacity to recognize reality, or the ability to cope with the ordinary demands of life; and
- Who have had three or more psychiatric hospitalizations or crisis home admissions in the last year.
- The term includes all persons diagnosed with
  - Bipolar Disorders: 296.00-296.96
  - Schizophrenia: 295.20-295.90
  - Major Depressive Disorders: 296.20-296.36

**Special Needs Population:** Population cohorts defined by diagnostic, demographic and behavioral characteristics that are identified in a Managed Care Waiver. The LME/MCO responsible for waiver operations must identify and ensure that these individuals receive appropriate assessment and services.

**Specialty Service:** An area of practice that requires additional training, certification, or clinical specialization beyond what a comparable area of practice requires.

**Spend Down:** Medicaid term used to indicate the dollar amount of charges a Medicaid member must incur before Medicaid coverage begins during a specified period of time.

**State Fair Hearing:** A formal proceeding before an Administrative Law Judge of the North Carolina Office of Administrative Hearings in which parties affected by an adverse benefit determination of PIHP or an action taken by DHB shall be allowed to present testimony, documentary evidence and argument as to why such adverse benefit determination or action should or should not be taken.
Support Plan: A component of the Person-Centered Plan or the Individual Support Plan that addresses the treatment needs, natural resources, and community resources needed for the member to achieve personal goals and to live in the least restrictive setting possible.

Treatment Authorization Request (TAR): A form or other process by which a provider submits pertinent biographical and clinical information about a member to Cardinal Innovations in order to receive permission to render appropriate services to that member. This process is a prerequisite to payment for many Medicaid-funded services.

The Joint Commission: The Joint Commission is the national accrediting organization that evaluates and certifies hospitals and other healthcare organizations as meeting certain administrative and operational standards.

Third-Party Billing: Services billed to an insurance company, Medicare or another agency.

Treatment Planning Case Management: A managed care function that ensures that members meeting Special Needs Population criteria receive needed assessments and assistance in accessing services. Cardinal Innovations Care Coordinators carry out this function working with Providers if the member is already engaged with providers, or assisting in connecting and engaging the member with providers that will provide the necessary services to meet his/her needs. Activities may include:

- Referral for assessment of the eligible individual to determine service needs
- Development of a specific care plan
- Referral and related activities to help the individual obtain needed services
- Monitoring and follow-up

Urgent Need – Mental Health: A condition in which a person
- Is not actively suicidal or homicidal;
- Denies having a plan, means or intent for suicide or homicide, but expresses feelings of hopelessness, helplessness or rage;
- Has the potential to become actively suicidal or homicidal without immediate intervention; and
- Displays a condition which could rapidly deteriorate without immediate intervention; and/or without diversion and intervention will progress to the need for emergent services and care.

Urgent Need – Substance Use/Addiction: A condition in which a person is not imminently at risk of harm to self or others or unable to adequately care for self but by virtue of their substance use, is in need of prompt assistance to avoid further deterioration in the person’s condition which could require emergency assistance.

Utilization Review: A formal review of the appropriateness and medical necessity of behavioral health services to determine if the service is appropriate, if the goals are being achieved, or if changes need to be made in the Person-Centered Plan or services/supports provided.

Whole-Person Care: The coordination of physical health, behavioral health, and social services in a patient-centered manner with the goals of improved health outcomes and more efficient and effective use of resources. Integrated Care supports the outcome of whole-person care.
ADDENDUM

Section I – Introduction and Welcome

• Reviewed by Communications and OGC – No edits.

Section II. Governance and Administration (ID #60, #56, #51, #46, #40, #38, #29))

• Added a short sentence and link to our Provider Orientation Companion. (60)
• Changes made to subsections J and M. (56)
• Subsection H: Information Technology – Updated Provider Direct System Administrator section to include notifications in addition to audit requests that are received during the year. These were also shared earlier in the year via a communication bulletin. (51)
• Subsection H: Information Technology – Phone numbers and email addresses changed. (46)
• Clinical Operations edits to Subsection B (40)
• Subsection 2 D - Quality Management. Paragraph D. (38)
• Regulatory Affairs edits to subsection L – Stakeholder Involvement in Cardinal Innovations System Management (29)

Section III. Provider Network (ID #69, #68, #67, #66, #64, #58, #57, #48, #47, #45, #37)

• Updates to Subsection A – False Claims Act and Certificates of Insurance (69)
• Updates to Subsection E – Provider Communication (68)
• Updates to Subsection K- Reconsideration Reviews (67)
• Revised the below to provide updated contact information (66)
• Report matters involving suspected Medicaid fraud, waste or abuse through any of the following options:
  o Cardinal Innovations’ Fraud and Abuse line at 1.800.357.9084
  o Cardinal Innovations’ Online Fraud Form at https://www.cardinalinnovations.org/Contact/Report-fraud-abuse (64)
• Network Management, Provider Network – Insurance requirements not in its own section at prior pages 29, 30-32. (58)
• Subsection C. Types if Network Providers: Communications changed alternative in the "d. Alternative Family Living Providers" to be in bold font and underlined to match the rest of this label. Also, added (IRS) after Internal Revenue Service reference to show acronym. (57)
• Quality Management review with changes to Subsection L – Provider Monitoring and/or Site Reviews (48)
• Quality Management review with changes to Subsection D. – Quality of Care (47)
• Network Management reviewed Subsection F – Network Councils and Subsection G – Changes in Status (45)
• Cultural Competence Department reviewed Provider Network – Cultural Competency of the Network (37)

Section IV. Benefit Packages (ID #53, #42, #39, #30)
• Changes to Subsection E – Eligibility and Enrollment Requirements (53)
• Clinical Operations had multiple edits throughout this section (42)
• Access Department made edits to Subsection E, pages 53-54 (39)
• Regulatory Affairs edits to subsection H – Service Array (30)

Section V. Member Rights and Empowerment (ID #66, #67, #54, #50, #43, #41)
• Minor grammatical changes to Subsection A on Member Rights
• Reviewed Subsections A-F, minor changes to Subsection A - Member Rights (54)
• Reviewed by Compliance/SIU – minor edits throughout (50)
• Reviewed by Clinical Ops – multiple edits made throughout the section (43)
• Member Rights – edits made to Reconsideration Review and State Fair Hearing (41)

Section VI. Clinical Design Plan (ID #65, #62, #55)
• Section VI, item 6, third paragraph edits, starting "Clinical practice guidelines, are adopted as recommended..." (65)
• No new content, only updated the link to our external website to the new Clinical Practice Guidelines web page: https://www.cardinalinnovations.org/Providers/Clinical-Practice-Guidelines?sort=0 (62)
• Changes to Subsection O (55)

Section VII. Access, Enrollment & Authorization of Services (ID #35, #31, #27, #26)
• Access edits to Section 7, Sub-Sections C, 2 (Urgent Referral Process) Part A, D and G (35)
• Regulatory Affairs edits to Opening Paragraph and Bullets as well as Initial Authorization (31)
• Access Department edits to subsections A-E (27)
• Access Department edits to subsections A, D 1-3 (26)

Section VIII. State and Medicaid Service Definitions (ID #32)
• Regulatory Affairs edits to subsections A and B - added information about Alternative and In Lieu of Services (32)
Section IX. Resources for Providers (ID #61, #33, #28)

- Add a sentence and link to the Provider Orientation Companion which is currently on the website. (61)
- Regulatory Affairs reviewed section for edits. (33)
- Access Department edits to subsections B-K (28)

Section X. Getting Paid – Finance Requirements (ID #70, #63, #52 #36, #25, #24)

- Updated Subsection G on Coordination of Benefits – Added a sentence informing providers of possible requests for self-audits as a result of trends determined during COB Reviews. (70)
- Section 1: Changed email address to contact SIU to: fraud-abuse@cardinalinnovations.org.
- Section 2: Removed first paragraph. And added/revised third paragraph to read:
  o Investigations into allegations of provider fraud, waste and/or abuse may include an announced or unannounced on-site Provider visit, desk review, interviews, or other appropriate investigative methods. Investigation findings form the basis for a determination as to whether the alleged fraud, waste and/or abuse requires referral to appropriate authorities to DHB or law enforcement officials. If Cardinal Innovations determines that the allegation rises to the level of a credible allegation of fraud, a referral to DHB will be made within five (5) business days of the determination. (63)
- Changes to Sub-section E; Section 10, Sub-section N, 2. Claim Denial and 3. Review and Determination Request (52)
- H. 2. Process to Evaluate the Sliding Fee (36)
- Service Center edits to subsection G on Coordination of Benefits – This change was sent to providers in February 2019 via a communication bulletin. (25)
- Editing test – no changes (24)

Section XI. Quality Management and Compliance (ID #49)

- Reviewed by Quality Management. (49)

Section XII. Reconsideration Review Process for Providers (ID #59)

- Minor grammatical edits.

Section XIII. Official Communication

- Minor grammatical edits.
Section XIV. Glossary of Terms (ID #44, #34)

- Added: Local Appeal – If the MCO denies, reduces, suspends or terminates a non-Medicaid service, the member/guardian may request a Local Appeal to review the decision. For specific details about this process, including relevant time frames for the process, please see Section V, Member Rights and Empowerment. (44)
- Regulatory reviewed edits (34)

Section XV. Addendum

- This is this section – entirely new