Request to Move to NC Medicaid Direct (Fee for Service) or LME-MCO: Provider Form

What is this form for?

This form is for you to request for an individual with Medicaid to stay in, or move to, NC Medicaid Direct (formerly known as Fee-for-Service or traditional Medicaid) or an Local Management Entity-Managed Care Organization (LME-MCO). While physical health services are the same for all individuals with Medicaid, some services for **people with an intellectual/developmental disability (I/DD), mental illness, traumatic brain injury, or substance use disorder** are only available in NC Medicaid Direct and/or through the LME-MCOs. It may benefit an individual to transition to NC Medicaid Direct and/or their LME-MCO if they need these services. These services are not in the new Standard Health Plans. This form can be filled out by a doctor, therapist or other I/DD, Mental Health, or Substance Use Disorder provider of the person enrolled in NC Medicaid.

Send this form to NC Medicaid by mail, fax, or online.

Mail
NC Medicaid
PO Box 613
Morrisville, NC 27560

Fax
1-833-898-9655

Online
ncmedicaidplans.gov

What happens next?

NC Medicaid will review the information on the form and will contact the doctor, therapist or other behavioral health provider who completes this form if more information is needed.

If the request is approved, we will send a letter to the individual with Medicaid to let them know that they will continue getting, or begin to get, their Medicaid services through NC Medicaid Direct and/or an LME-MCO.

If the request is not approved, we will send a letter to the individual with Medicaid to let them know that they will continue to be enrolled, in one of the new Health Plans. The letter will also tell them how they can appeal if they do not agree with our decision.

NC DEPARTMENT OF
HEALTH AND
HUMAN SERVICES
Division of Health Benefits

Request to Move to NC Medicaid Direct (Fee for Service) or LME-MCO: Provider Form

Check here if this request is for an individual seeking admission to SACOT or SAIOP. If there is not a SACOT or SAIOP request, please continue completing the form and refer to *Section 3. Reason for Submitting Request*.

☐ **Request for Substance Abuse Comprehensive Outpatient Treatment (SACOT)**

☐ **Request for Substance Abuse Intensive Outpatient Program (SAIOP)**

1. Beneficiary Demographic Information

Fill out the beneficiary demographic information and guardian/legally responsible person contact information.

Beneficiary Name (Last, First, M.I.)	
Date of Birth (Month/Day/Year)	
NC Medicaid ID Number	
Guardian/Legally Responsible Person	
Guardian/Legally Responsible Person Phone number	

2. Provider Submitting this Form

Fill out the provider information.

Provider Name (Last, First, M.I.)	
Telephone Number	
Provider Agency (if Applicable)	
NPI/Provider Identifier	
Provider email	

3. Reason for Submitting Request

Beneficiaries may be eligible to return to NC Medicaid Direct and/or their LME-MCO if they meet one of the criteria below. Check all reasons that apply and provide the requested information:

☐ Has used, or has a current need for, a Medicaid service that is only available through NC Medicaid Direct and/or an LME-MCO or a State-funded service. **A full list of Medicaid services only available through NC Medicaid Direct and/or the LME-MCOs and State-funded services is attached to this form.** Please note the service(s) needed.

_____

_____

☐ Has an intellectual or developmental disability (I/DD), serious mental illness, serious emotional disturbance, qualifying substance use disorder, or is a child aged 0-3 with or at risk for, developmental delay or disability. Please provide the DSM 5 or ICD 10 Diagnosis Code/Description and the functional impairment related to the diagnosis:

ICD 10 Diagnosis Code	
Description	
Related Functional Impairment	

☐ Has survived a traumatic brain injury and is receiving traumatic brain injury services or has a traumatic brain injury that is otherwise a knowable fact. Please provide the ICD 10 Diagnosis Code/Description and the functional impairment related to the diagnosis:

ICD 10 Diagnosis Code	
Description	
Related Functional Impairment	

☐ Has had one involuntary commitment to a State Facility within the past 18 months.

☐ Has had two or more of the following within the past 18 months:

- Psychiatric hospitalizations
- Visits to the emergency department due to a behavioral health diagnosis use of behavioral health crisis services (Mobile Crisis Management, Facility Based Crisis Services for Children and Adolescents, Professional Treatment Services in Facility Based Crisis Program)

Please provide facility name and date of service below:

Facility/Agency Name	Date(s) of Service

☐ For State Operated Health Facility staff only (DSOHF): The Provider submitting this form is a State Operated Health Facility.

☐ Other reason the beneficiary should remain in NC Medicaid Direct and his/her LME-MCO (please describe).

_____

_____

_____

_____

☐ Optional: Please check if the beneficiary is a youth involved in the juvenile justice system. (Note: Juvenile Justice system involvement is a sign that a beneficiary has high support needs for their mental illness, substance use disorder, I/DD or traumatic brain injury).

_____

_____

_____

_____

☐ Check if member or service requested is Substance Use Disorder covered under 42 CFR Part 2.

- If yes, please have the beneficiary complete Section 7: Substance Use Disorder Consent at the end of this form.

4. Provider Signature

I attest that the information presented in this form is accurate to the best of my knowledge. This request is being submitted for the benefit of the beneficiary and not for the benefit of the beneficiary's enrolled health plan or service provider. I understand this form may be subject to audit.

Signature **Date**

Printed Name **Plan/Provider Affiliation**

5. Care Coordinator/Care Manager Signature

I attest that the information presented in this form is accurate to the best of my knowledge. This request is being submitted for the benefit of the beneficiary and not for the benefit of the beneficiary's enrolled health plan. I understand this form may be subject to audit.

Signature **Date**

Printed Name **Plan/Provider Affiliation**

6. Beneficiary Attestation:

Have the beneficiary (or legally responsible person) read and sign the beneficiary attestation.

By signing below, I acknowledge that I am requesting to transition to NC Medicaid Direct and/or LME-MCO, rather than remain enrolled in a Standard Health Plan. I have been fully informed of the differences between NC Medicaid Direct/LME-MCO and a Standard Health Plan. I acknowledge that this request will be considered by NC Medicaid and/or the LME-MCO or its agent and may be denied based upon my individual circumstances.

By signing below, I am agreeing that NC Medicaid and/or the LME-MCO and its vendors may contact the doctor, therapist or other behavioral health provider listed above to obtain medical records, which may include records of the following: intellectual or developmental disability (IDD), mental illness, or traumatic brain injury. I expressly consent to NC Medicaid and/or LME-MCO receiving any or all such records. I also give permission to NC Medicaid and/or LME-MCO and its vendors to share this request form with both my current Standard Plan Health Plan and my intended LME/MCO.

I understand that if this request is approved, I will be moved to NC Medicaid Direct and/or LME-MCO. If I have been assigned to a Standard Health Plan, I understand that I will no longer be enrolled in that plan.

Signature of Person Enrolled in NC Medicaid Or Legally Responsible Person **Date**

Printed Name

7. Beneficiary Substance Use Disorder Attestation

I [name of member/patient or legally responsible person] _____ hereby authorize NC Medicaid to share this request with its Enrollment Broker (MAXIMUS) and the Health Plan and LME-MCO checked below. I authorize NC Medicaid and its Enrollment Broker to contact my SUD treatment providers: _____ and obtain my Substance Use Disorder Records for the purposes of care coordination and/ or case management. I also give NC Medicaid, its Enrollment Broker and the Health Plan and LME-MCO checked below permission to talk to each other and share information about prior authorizations, clinical assessment(s), treatments and care plans for the purposes of care coordination and/or case management. I understand that I may revoke this permission at any time for any future disclosures and that this permission will expire in one year or upon completion of care coordination and case management activities by NC Medicaid and its Enrollment Broker, whichever occurs first, unless I withdraw my permission earlier unless I withdraw my permission earlier.

My Current Health Plan Is (check one)	My LME/MCO will be (check plan)
☐ AmeriHealth Caritas	☐ Alliance Health
☐ Carolina Complete Health	☐ EastPointe
☐ Healthy Blue	☐ Partners Health Management
☐ United Healthcare Community Plan	☐ Sandhills Center
☐ WellCare	☐ Trillium Health Resources
	☐ Vaya Health

Signature of Person Enrolled in NC Medicaid Or Legally Responsible Person **Date**

Request to Stay in NC Medicaid Direct or LME-MCO: Appendix

Medicaid Behavioral Health Services excluded from the Health Plan Benefit. These services are only available in NC Medicaid Direct and through the LME-MCOs

- Residential treatment facility services for children and adolescents
- Child and adolescent day treatment services
- Intensive in-home services
- Multi-systemic therapy services (MST)
- Psychiatric residential treatment facilities (PRTF)
- Assertive community treatment (ACT)
- Community support team (CST)
- Psychosocial rehabilitation (PSR)
- Substance abuse non-medical community residential treatment
- Substance abuse medically monitored residential treatment
- Substance Abuse Intensive Outpatient (SAIOP)
- Substance Abuse Comprehensive Outpatient Treatment (SACOT)
- Intermediate care facilities for individuals with intellectual disabilities (ICF/IID)
- Innovations Waiver services*
- Traumatic Brain Injury Waiver services*
- 1915(b)(3) services
- State-Funded Behavioral Health and Intellectual and Developmental Disability Services

**Please note that waiver services are only available to individuals enrolled in the waiver.*

1915(b)(3) Services

- Respite
- Supported Employment/Employment Specialist
- Individual Support
- One-time Transitional Costs
- NC Innovations Waiver Services (funded by (b)(3)) (Deinstitutionalization Services)
- Community Navigator
- In-home Skill Building
- Transitional Living Skills
- Intensive Recovery Support

State-Funded Behavioral Health and I/DD Services

Certain behavioral health and I/DD services are available for individuals who are uninsured or who do not have adequate insurance and are supported by state and federal funds. These services are available through LME-MCOs and vary by LME-MCO.

Examples of these services include substance use halfway house, developmental therapy, and residential supports. The full state-funded services list is accessible at: https://files.nc.gov/ncdhhs/State-Funded%20MHDDSAS%20Service%20Definitions%202003-2017%20effective%207-1-17.pdf

The state-funded services available through the beneficiary's LME-MCO are accessible at:

- Alliance Health - https://www.alliancehealthplan.org/wp-content/uploads/Non-Medicaid-Benefit-Plan-2.pdf
- Eastpointe - http://www.eastpointe.net/provider/authorization-um-and-benefits-packages-2/#1559750317947-1e958130-3c23
- Partners Health Management - https://providers.partnersbhm.org/benefit-grids/
- Sandhills Center - https://www.sandhillscenter.org/for-providers/resources/
- Trillium Health Resources - https://www.trilliumhealthresources.org/for-providers/benefit-plans-service-definitions
- Vaya Health - https://providers.vayahealth.com/service-authorization/coverage-info

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES
Division of Health Benefits

Behavioral Health Intellectual Developmental Disability (BH/IDD) Service Authorization Request Form

Authorization approves the medical necessity of the requested service only. It does not guarantee payment, nor does it guarantee that the amount billed will be the amount reimbursed. The beneficiary must be NC Medicaid or NC Health Choice eligible on the date of service or date the equipment or prosthesis is received by the beneficiary.

▶ **To learn how to fill out this form, go to the end of the form for the Instructions for completion.**

1. General information. To be completed by the provider requesting the prior authorization.

1. Name of the Prepaid Health Plan (PHP) or Prepaid Inpatient Health Plan (PIHP)

2. Beneficiary or recipient name (Last, First, M.I.)	3. Date of birth

4. Address (Street, City, State, ZIP Code)

5. NC Medicaid ID Number or CNDS Number	6. Diagnosis code

7. Diagnosis description

8. Name and address of facility where services are to be rendered, if other than home or office

2. Service information

Reference number 1			**FOR PLAN USE ONLY**
9. Procedure code	10. From date	11. Through date	☐ Approved ☐ Denied
12. Description of service or item		13. Qty or units	Amount allowed if priced by report: $

14. Detailed explanation of medical necessity for services/equipment/procedure/prosthesis (Attach additional pages if necessary).

2. Service information (continued)

Reference number 2			FOR PLAN USE ONLY
9. Procedure code	10. From date	11. Through date	☐ Approved ☐ Denied
12. Description of service or item		13. Qty or units	Amount allowed if priced by report: $
14. Detailed explanation of medical necessity for services/equipment/procedure/prosthesis (Attach additional pages if necessary).			

Reference number 3			FOR PLAN USE ONLY
9. Procedure code	10. From date	11. Through date	☐ Approved ☐ Denied
12. Description of service or item		13. Qty or units	Amount allowed if priced by report: $
14. Detailed explanation of medical necessity for services/equipment/procedure/prosthesis (Attach additional pages if necessary).			

Reference number 4			FOR PLAN USE ONLY
9. Procedure code	10. From date	11. Through date	☐ Approved ☐ Denied
12. Description of service or item		13. Qty or units	Amount allowed if priced by report: $
14. Detailed explanation of medical necessity for services/equipment/procedure/prosthesis (Attach additional pages if necessary).			

2. Service information (continued)

Reference number 5			FOR PLAN USE ONLY
9. Procedure code	10. From date	11. Through date	☐ Approved ☐ Denied
12. Description of service or item		13. Qty or units	Amount allowed if priced by report: $
14. Detailed explanation of medical necessity for services/equipment/procedure/prosthesis (Attach additional pages if necessary).			

Reference number 6			FOR PLAN USE ONLY
9. Procedure code	10. From date	11. Through date	☐ Approved ☐ Denied
12. Description of service or item		13. Qty or units	Amount allowed if priced by report: $
14. Detailed explanation of medical necessity for services/equipment/procedure/prosthesis (Attach additional pages if necessary).			

Reference number 7			FOR PLAN USE ONLY
9. Procedure code	10. From date	11. Through date	☐ Approved ☐ Denied
12. Description of service or item		13. Qty or units	Amount allowed if priced by report: $
14. Detailed explanation of medical necessity for services/equipment/procedure/prosthesis (Attach additional pages if necessary).			

2. Service information (continued)

Reference number 8			FOR PLAN USE ONLY
9. Procedure code	10. From date	11. Through date	☐ Approved ☐ Denied
12. Description of service or item		13. Qty or units	Amount allowed if priced by report: $
14. Detailed explanation of medical necessity for services/equipment/procedure/prosthesis (Attach additional pages if necessary).			

Reference number 9			FOR PLAN USE ONLY
9. Procedure code	10. From date	11. Through date	☐ Approved ☐ Denied
12. Description of service or item		13. Qty or units	Amount allowed if priced by report: $
14. Detailed explanation of medical necessity for services/equipment/procedure/prosthesis (Attach additional pages if necessary).			

Reference number 10			FOR PLAN USE ONLY
9. Procedure code	10. From date	11. Through date	☐ Approved ☐ Denied
12. Description of service or item		13. Qty or units	Amount allowed if priced by report: $
14. Detailed explanation of medical necessity for services/equipment/procedure/prosthesis (Attach additional pages if necessary).			

3. Provider requesting prior authorization

15. Provider name	16. NPI

17. Address

18. Telephone number	19. Fax number

20. Email

By submitting this form, the provider identified in Section 3 certifies that the information given in Sections 1, 2, and 3 of this form is true, accurate, and complete.

21. Signature	**Date**

4. Performing practitioner

This section must be completed for the performing practitioner when the provider in Section 3 is a clinic or group practice. Check your provider manual for additional instructions.

22. Name

23. Telephone number

24. Address

Instructions for completion

1. **General Information**

   To be completed by the provider requesting the prior authorization.

   1. **Name of the Prepaid Health Plan (PHP) / Prepaid Inpatient Health Plan (PIHP):** Enter the name of the PHP/PIHP in which the beneficiary/recipient is enrolled or receiving services. (PHP refers to Standard & Tailored Plans while the PIHP refers to the LME/MCO)
   2. **Name:** Enter the beneficiary/recipient name. If the individual has Medicaid, enter their name as it appears on the NC Medicaid Identification Card.
   3. **Date of birth:** Enter the beneficiary/recipient date of birth.
   4. **Address:** Enter the beneficiary/recipient address, city, state, and zip.
   5. **NC Medicaid number or Common Name Data Service (CNDS) number:** Enter the beneficiary/recipient NC Medicaid Identification number as shown on the NC Medicaid Identification card or county letter of eligibility, or the CNDS number.
   6. **Diagnosis code:** Enter the diagnosis code(s).
   7. **Diagnosis description:** Enter the diagnosis description. If there is more than one diagnosis, enter all descriptions appropriate to the services being requested.
   8. **Name and address of the facility** where services are to be rendered, if service is to be provided other than home or office.

2. **Service information**

   Reference number is a unique designator (1-10) identifying each separate line on the request.

   9. **Procedure code:** Enter the procedure code(s) for the services being requested.
   10. **From date:** Enter the from date that services will begin if authorization is approved (mm/dd/yy format).
   11. **Through date:** Enter the through date that services will terminate if authorization is approved (mm/dd/yy format).
   12. **Description of service or item:** Enter a specific description of the service or item being requested.
   13. **Qty or units:** Enter the quantity or units of service/item being requested.
   14. **Detailed explanation of medical necessity of the service**, equipment/procedure/prosthesis, etc. Attach additional page(s) as necessary.

       For Behavioral Health services, attach current Comprehensive Clinical Assessment (CCA), Diagnostic Assessment (DA), Level of Care Utilization System (LOCUS) / Child & Adolescent Level of Care Utilization System (CALOCUS) score and other clinical or psychiatric evaluations. For State-funded requests for Intellectual & Developmental Disability (I/DD) services, attach the North Carolina Support Needs Assessment Profile (NC SNAP). For Substance Use Disorder (SUD) services, attach American Society of Addiction Medicine (ASAM) Level of Care determinations. These items should be submitted as required by service definition.

       Do not use another Prior Authorization Form.

3. **Provider requesting prior authorization**

   15. **Provider name:** Enter the requesting provider information. If a clinic or group practice, also complete Section 4.
   16. **National Provider Identifier (NPI):** Enter the requesting provider NPI
   17. **Address:** Enter the complete mailing address in this field.
   18. **Telephone number:** Enter the requesting provider telephone number.
   19. **Fax number:** Enter the requesting provider fax number including area code.
   20. **Email:** Enter the requesting provider email address.
   21. **Signature:** Sign the form and enter the date.

4. **Performing practitioner**

   This section must be completed for the performing practitioner when the provider in section 3 is a clinic or group practice. Check your provider manual for additional instructions.

   22. **Name:** Enter the name of the performing practitioner.
   23. **Telephone number:** Enter the performing practitioner telephone number including area code.
   24. **Address:** Enter the address, city, state, and zip code.