

NBH News

Fall 2005

Northeast Behavioral Health

Mission:

To provide a comprehensive array of superior behavioral health services that support safe, successful, and self-sufficient lives throughout our twelve counties.

New State Required Posters

NBH will be sending out posters in English and Spanish informing Medicaid consumers of their rights and responsibilities. The posters also provide consumers with information on the grievance procedures, notice of the NBH privacy practices, how to reach consumer and family advocates as well as the State Ombudsman. NBH requests that all providers and facilities hang these posters in their

reception areas as this is a State requirement

NBH will check reception areas for this information during audits. The posters are in removable laminate sleeves. This will allow you to remove old posters and replace them with updated versions as they become available. To request additional copies of the posters, please call Jason Brokaw at:

970-347-2307 or

jason.brokaw@northeastbho.org.

NBH Web Site

NBH is projecting that our web site will be ready to view in February. The web site will have information for consumers and providers. The Consumer Handbook, Provider Manual, forms, and many other items will be on this site. We also hope to have a link to the web based CCAR available by July 2006. The state will release the new version in July and NBH will provide training on the new CCAR. The web address is:

www.northeastbho.org.

Provider Manual

Updates

NBH will be sending out updates to your provider manuals soon. In your update you will find new forms for intakes and service plans that will be shorter and more user friendly.

Inside this issue:

Posters, Provider Manuals, web site	1
New case management code	1
What is case management?	1-2
Recovery based services	2-3
Education Committee	3
Medicare Part D	3
Third Party Insurance	3
Third Party Insurance Form	4
Contact Numbers	5

New case management code

As of January 1, 2006 NBH will be using a new code for case management which is T1016. You will see this code on all authorizations for services dated after January 1st. T1016 is case management in 15 minute increments. You may bill up to 4 increments in a day. You may continue to use 90882 through December 31, 2005. Contract addendums will be mailed out by the end of November.

What is case management?

There have been a lot of discussions regarding what constitutes billable case management services for Medicaid Consumers. The following is a description of case management and examples of allowable and unallowable services.

Case Management contacts can occur with significant others, parents, guardians, and other service agencies that are necessary to help the client succeed in meeting treatment goals. All individuals who are receiving case management services must have an Individual Service Plan which includes the individuals or agencies with whom case management contacts will occur.

All types of case management to be used to assist in achieving the clients' goals, which are related to the mental health diagnosis, must be identified as medically necessary.

Examples of case management activities:

Allowable Case Management Activities:

- Transportation for the purpose of linking clients to services from other agencies
- Liaison activities to any federal, state, or local agency providing medical, vocational, residential, social, or other supportive service essential to the well-being of the client.
- Locating and establishing a residential placement
- Talking with a client on the phone to monitor the client's status is a case management contact.

Unallowable Case Management Activities:

- Staff time spent traveling alone
- Administrative record keeping
- Ordering or picking up of prescriptions

- Transportation of a client to or from a facility for an NBH mental health service
- Group case management activities
- In-house agency treatment team meetings, staffing, consultations when the client is not present
- Writing service plan
- Crisis management with a client. Crisis management must be done with someone other than the client (see crisis management definition)
- Phone message left with client or other agency
- Writing letters regarding cancels and/or no-shows do not constitute case management contacts.
- A consultation with another staff member does not constitute a case management contact.

Medicare Part D

Drug Prescription Program

November 15 is the date that Medicare beneficiaries can start signing up with a Medicare Part D Drug Prescription Program. Individuals with Medicare who do not currently have a Medicare Advantage Plan or other health plan with good reasonably priced prescription drug coverage need to investigate the new plans offered and sign up for one before May 15, 2006.

Medicare will penalize qualified Medicare beneficiaries by charging higher premiums for a drug prescription program if they don't choose and sign up for a plan after May 15. Providers will need to be prepared for questions from understand how best to help consumers can be found at: www.nccbh.org. Additional web sites that may be helpful are www.socialsecurity.gov and

Junk is something you've kept for years
only to throw away
three weeks before you need it.

Education Committee

The Education Committee of NBH, consisting currently of representatives from Centennial Mental Health Center, Larimer Center for Mental Health, North Range Behavioral Health, and NBH, is in the process of developing a training plan to ensure development of a Provider Network that is knowledgeable in the NBH adopted Practice Standards that include recovery models.

NBH is seeking representation from its External Provider Network for this committee and invites interested providers to contact Carol Staples at 970-347-2367. The function of the group is to make a plan for specific training in four areas: Cognitive Behavioral Therapy (general and selected types), Dialectical Behavioral Therapy (DBT), Family Psychoeducation, and Recovery-Based Treatment.

The first NBH sponsored training is DBT a two-day training scheduled for Spring, 2006. The first training led by Alissa Ball, CMHIP Preliminary to the training, providers can access information about DBT at:

www.behavioraltech.com.

Recovery based services

Principles of recovery-based practice for adults and resiliency for children have been adopted by many mental health agencies and practitioners including NBH. Recovery services are based on the merging of recovery concepts and processes as defined by consumers with evidence-based or promising practices that promote and support the recovery process.

While there is no one definition of recovery, the concept involves a belief and renewed optimism about the outcomes of mental illness and hope for the future that living a meaningful and satisfying life in the mainstream of a community is possible in spite of having to deal with a mental illness.

It is generally agreed in the field that recovery means much more than treatment or reduction or removal of symptoms and improvement in functioning. It is also commonly understood that recovery does not necessarily mean that all suffering and symptoms are gone, or that a person is cured or that functioning is completely restored. The process of recovery includes hope, empowerment, taking responsibility, building on strengths, and persevering over time. The process also typically involves biological, environmental, psychological and often spiritual elements. Although similarities

can be found in the recovery journey traveled by each individual, it is important to remember that no two people experience recovery in exactly the same way. Making the journey does involve choice and individual responsibility.

Recovery concepts were first developed in various articles written in the 1980's by consumers who were living meaningful and satisfying lives after being told that the prognosis was bad for them and that they shouldn't expect too much. The recovery idea was strengthened by an important longevity research project studying patients thirty years after their release from a Vermont State Hospital and finding that over 65% of them were living meaningful and satisfying lives in the community, many without medications.

The term recovery in mental illness was coined by Patricia Deegan, PhD, a consumer professional in an article *Recovery, the Lived Experience of Rehabilitation*. In the 1990's Bill Anthony, PhD, Boston Center for Psychiatric Rehabilitation, contributed a seminal article, *Recovery from Mental Illness: the Guiding Vision of the Mental Health Service System in the 1990s Report on Mental Health* was the first widely distributed publication that discussed mental health issues and recovery.

Recovery based practice includes shifting attitudes and beliefs from maintenance for consumers to active support of future plans in partnership with consumers and families. It means to respect and support the individual recovery process as well as develop services that work for them. It means developing services that are evidence based and shown to have good outcomes as well as those that consumers report as being helpful to them.

Articles and resource materials on recovery and evidence based practices can be found on many national websites. Two useful websites are listed below.

www.mentalhealth.samhsa.gov/cmhs/communitysupport/toolkits

Sections under *Evidence-Based Practices: Shaping Mental Health Services Toward Recovery* contain basic information and toolkits (with workbooks for practitioners and consumers) for several of the Evidence-based Practices

www.mentalhealthpractices.org

There are sections on Illness Management and Recovery with overview and bibliography, Medication Management, Assertive Community Treatment, Family Psychoeducation, Supported Employment and Co-occurring Disorders and Integrated Treatment with bibliographies.

Third Party Liability (TPL)

As a condition for participation in the Medicaid program, all Members are required to assign their rights to any benefits to the Department and agree to cooperate with the Department in identifying third parties who may be liable for all or part of the cost for providing services to the Member. NBH, as the State Contractor, has the same rights as the Department for assignment of benefits from the Member.

NBH requires Providers to obtain this information from their clients at the time of client registration and verify periodically with the client as to changes in payor or addition of a third party payor. Providers are required to report this information to NBH and send claims to the third party payor before issuing claims to NBH for services provided. Providers are required to inform NBH when they learn of TPL from their clients. The enclosed for is the information the State of Colorado requires. This form should be completely filled out and faxed or mailed to NBH within 5 day of learning about the TPL.

**NORTHEAST BEHAVIORAL HEALTH
THIRD PARTY LIABILITY REPORTING**

**FORM #
036**

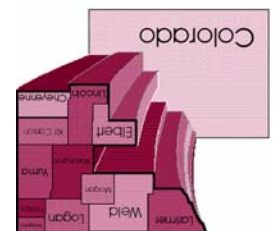
Client Name:			
Address: (Street, PO Box, City, State, Zip)			
Telephone:		Date of Birth:	
Medicaid ID:		Social Security #:	

Medicare Third Party Payor	
Medicare ID:	

Other Third Party Payor	
Relationship to Policyholder:	
Health Insurer: (Complete Name, Street, PO Box, City, State, Zip, Telephone)	
Policy ID:	
Policy Group:	
Policyholder Social Security #:	
Effective Date:	
Policy Member: (Complete Name, Street, PO Box, City, State, Zip, Telephone)	

- › All fields must be completed. Forms with blank fields will be returned for completion.
- › Form may be faxed (970-392-1354) or mailed to NBH at 1306 11th Avenue, Greeley, CO 80631.
- › Notification must be sent to NBH within five (5) business days of discovery.

Northwest Behavioral Health
1306 11th Avenue
Greeley, CO 80631



Important Contact Information:

Consumer Affairs:

Carol Staples
970-347-2367

Outpatient Coordinator:

Laura Martinez
970-347-2375

Inpatient/Intensive Services:

Anne Mitchell
970-347-2282

Provider Relations:

Libby Goode-Grasmick
970-347-2360

Claims Information:

Sylvia Job
970-347-2379

CCAR Coordinator:

Jason Brokaw
970-347-2307

OR Toll-free 888-296-5827

