



**Q&A about Smoky Mountain Center's
Revised Southern Region MH/SA State Benefit Plan
February 8, 2008**

	Question	Answer
1	How do the Packages for Individual and Family Therapy authorizations work?	Because there are a variety of individual and family therapy services included in the plan, services are grouped and authorized by packages of either CPT codes or H codes. Providers must select <u>either</u> the CPT code package <u>or</u> the H code package when requesting authorization.
2	How much individual and family therapy can be authorized?	The amount of service than can be authorized varies by the Age/Disability Group and the Levels of Care within those groups. The number of sessions or units shown in the plan for an authorization period is the total number of individual and/or family sessions combined that may be authorized in that period.
3	Will SMC authorize individual and family therapy alone without Community Support?	Individual and family therapy may be authorized without Community Support for some Age/Disability Groups and Levels of Care, but not for others. Adult Mental Health, Level of Care B; Adult Substance Abuse, Levels of Care A & B; and Child Mental Health/Substance Abuse Level of Care B allow stand-alone individual and/or family therapy without Community Support. Individual and family therapy may be authorized for Adult Mental Health Levels of Care C & D, and for Child Mental Health and Substance Abuse Levels of Care C & D only when integrated with Community Support unless the approved PCP demonstrates that integration with Community Support is clinically contraindicated.
4	What are the requirements for providing Group Therapy under this benefit plan?	Group Therapy may be provided by appropriately trained and licensed clinicians where that service is clinically/medically necessary and included in an approved PCP. Group Therapy does not require authorization, but post payment reviews of paid claims for Group Therapy found not to meet those requirements is subject to recoupment of payments

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5	What services may be authorized for Adults dually diagnosed with Mental Health and Substance Abuse disorders?	For dually diagnosed adults, the primary diagnosis dictates the appropriate benefit plan. For consumers in which neither MH nor SA is the primary focus of treatment, providers may choose either the MH or SA plan, but may not use both.
6	Why am I unable to enter Individual and Family Therapy Package codes in BUI when requesting authorization?	Omit the hyphen in the package code when entering an authorization request. E.g., enter “P690806”, <u>not</u> “P6-90806.” Also, be certain to use the numeral zero (“0”) and not the letter “O” when requesting authorization of these packages. Additionally, all other requirements (e.g., current, valid target population) must have been entered into BUI to allow authorization of any service.
7	Do the Individual & Family Therapy Packages include Community Support?	No, Community Support is authorized with separate service codes.
8	Does this benefit plan allow providers to provide individual, family or group therapy for Adult MH/SA consumers in Haywood, Jackson and Cherokee Counties?	No—all state-funded Adult MH/SA consumers in these three counties are referred only to Meridian’s Recovery Education Centers or to higher level services (e.g., ACTT) with Meridian Behavioral Health (unless the LME determines that the REC is clinically contraindicated for an individual consumer).
9	What does an “X” mean and what does a blank space mean in cells of the benefit plan?	An “X” indicates that that service may be provided during that period of time, and a blank means that that service may not be authorized during that period. The Assessment Period is shown as being 30 days in the plan, but it may be briefer or longer depending on the time required to complete the assessment and develop the PCP.
10	Is there any flexibility in the covered services that may be authorized?	Yes. The services and the intensity listed in the plan are intended to meet the needs of the majority of consumers. However, where the service intensities are determined to be inadequate, providers may submit other requests for review by a Care Manager. Where clinical/medical necessity is found for greater service intensity and where funding is available, a Care Manager may authorize services at a greater intensity.
11	Do Community Support and Basic Benefit services for the same consumer have to be provided by the same agency?	No, but in most situations they should in order to ensure that all services provided to a consumer are integrated and coordinated. An example in which two different agencies might appropriately provide the services is a consumer receiving Community Support or other Clinical Home services from Agency A who needs a specialized service that is available only from Agency B. Remember, all services provided to a consumer must be included in a single PCP developed by the Clinical Home.