



Alliance

BEHAVIORAL HEALTHCARE

Coordination of Care:
Licensed Independent Practitioners

Coordination of Care

- Arrangement of patient treatment needs between two or more individuals involved in the patients care
- Entities work together to provide a more comprehensive and inclusive treatment to the consumer

Coordination of Care

- As authorized by the consumer, it is required that there is documentation that coordination of care is occurring between providers involved with the individual
- ALL contracted LIP providers including physicians, nurse practitioners, physician assistants, licensed therapists and associate licensed therapists must offer coordination of care to their patients

Coordination of Care

- If the consumer refuses coordination of care, this should be documented within the chart
 - Provider can choose the way in which they wish to document this refusal
- For coordination of care pertaining to billing, see Attachment A of Clinical Coverage Policy 8C
 - Coordination of care activities are included in the administrative costs for this service and are therefore not billable

NC Division of Medical Assistance Clinical Coverage Policy 8C 7.2.2

Coordination of Care Activities

- Written progress or summary reports provided to other entities
- Telephone communication with other entities

Coordination of Care Activities

- Treatment planning processes
 - Individualized plan of care, service plan, treatment plan, or Person-Centered Plan (PCP), consistent with and supportive of the service provided and within professional standards of practice, required according to Subsection 7.3.4 below
 - When beneficiary receiving multiple behavioral health services in addition to the services in this policy, a PCP must be developed with the beneficiary, and outpatient behavioral health services are to be incorporated into the beneficiary's PCP

Coordination of Care Activities

- Coordination of care with the beneficiary's Community Care of North Carolina/Carolina ACCESS (CCNC/CA) care manager (if applicable) and primary care or CCNC/CA physician

Potential Care Coordination Partners

- Examples of individuals/entities that providers can coordinate care with:
 - Medical, psychiatric, other providers
 - Coordination in crisis or discharge planning
 - Participation in child and family teams
 - Treatment planning processes
 - Schools
 - Community agencies for resources for basic needs such as housing, clothing, food, etc.
 - Group home staff

Potential Care Coordination Partners

- This is not an all inclusive list as consumers can have multiple needs
- Please ensure that all necessary releases of information have been completed and signed by the consumer to release PHI to other individuals/entities

Resources

- Clinical Coverage Policy 8C