Payment Reform Frequently Asked Questions 1st Edition

1. *Can we bill for Interpreter Services?*

   Yes, you can bill T1013 for these services. This is not a case load qualifying service, the service that requires T1013 would be the case load qualifying service. Please be sure to add the HA, HB or V1 modifier as well.

2. *If we have back billing from July 2018 through December 31st, 2018 can we still send in claims with the previous procedure codes, modifiers, and provider numbers?*

   Yes, any billing that needs to be done prior to 1/1/2019 should use the same format you used prior to 1/1/2019. DXC made the changes for Payment Reform based on a start date so any claims previous to that will still be honored based on the previous provider numbers and codes/ modifiers.

3. *When a DA has a residential program, how should we bill, and which areas of their programming is case rate qualifying?*

   If a DA has a residential program embedded in their program, they should report the bed day in MSR for the client however this is not a case rate qualifying encounter. The services that are provided to the client while they reside in the program (community skills, therapies, service planning and coordination) should be billed and are considered case rate qualifying encounters.

4. *How long do we have to complete an Assessment after the client has been opened to our agency?*

   The DA's have 45 days after opening a client to their agency to complete the assessment for all clients EXCEPT for CRT clients who have 30 days to complete the assessment. The 45 day timeline has been an established expectation for children's services as noted in the Minimum Standards Chart Review and the 30 day timeline has likewise been previously established for the CRT population. DMH will be bringing this proposed change to the Adult Outpatient Program through the manual change process that is currently being finalized.

5. *Can we provide any billable services to a client prior to completing the assessment?*

   DMH has a draft proposal that will be vetted in the coming weeks with DA compliance and VCP. DMH will be bringing this proposed change through the manual change process that is currently being finalized. We intend on adding this to the Mental Health Provider Manual in the next revision period.

6. *Can we still use the procedure code/ modifier combinations we have always used?*

   No, the updated approved procedure code modifier combinations that have been agreed upon for payment reform are included on pages 93-97of the manual that is posted on-line. Here is the link: https://mentalhealth.vermont.gov/sites/dmh/files/documents/Manuals/Mental_Health_Provider_Manual.pdf

7. *We were told that place of service is no longer an issue, but we have had claims denied based on POS?*

   That is correct, Place of service is no longer an issue with payment reform and the agreed upon procedure codes for payment reform have been edited to allow more flexibility with the where the services are being provided. The changes to Place of Service for claims billing has been sent to the billing managers.

8. *Why are we being paid for claims that are being submitted and who is responsible for recouping those dollars?*

   There were errors made in the initial implementation of procedure codes and modifier permutations for payment reform, we are in the process of creating edits with DXC to ensure that claims will either be paid "0" or will be denied if they are not being billed correctly. The DA's are responsible for recouping the money that has been paid out through DXC.

9. *Will we be responsible for back billing CRT services in the MMIS?*

   DMH and DVHA are currently working with DXC on expediting this edit in the system so we can begin allowing CRT billing as soon as possible. We will continue having dialogue with the DA's and VCP on what the best next steps are for reporting, billing, and holding the claims information in one location. In our most recent discussion, we are hoping that DA's can begin CRT billing in MMIS starting 3/1/2019. DMH is also exploring whether it makes sense to back bill from 1/1/2019 through 2/28/2019.

10. *How do we bill guardianship evaluations?*

    DMH evaluations for persons in need of guardianship without developmental disabilities is a mental health adult case rate qualifying service. This service should be coded as a "0" paid claim with procedure code 90791, modifier HB and any other related mental health or supervised billing modifiers. Any uncompensated reasonable expenditure exceeding $800.00 should continue to be billed for DAIL for compensation.

11. *If a client is in a private residential program can we still keep them open or should we close them* until they are coming out of the program?

    DMH expects clients to be kept open throughout their treatment stay in the residential program as a best practice. There continues to be the expectation that the DA is providing discharge planning coordination and collaboration with the residential program. Claims can still be sent for service planning and coordination and this is a case rate qualifying service even with the client being in a residential program.

12. *When a client is admitted into our DA's crisis bed, how do we code that?*

    If a client is being screened for a crisis by a crisis clinician, that time should be coded H2011 at whatever location they are being screened. Once the client is admitted to the crisis bed and completes the intake, the should code H0046 for that day AND every subsequent day the client is in the crisis bed.

13. *Are there any cost center 99 updates?*

Cost center "99" is a newly created cost center through Payment Reform. This cost center has been added as a way to track services for individuals that would have been eligible for what we formerly referred to as Waiver or EFT/ ISB services. These services were formerly billed under cost center "22" but this has been retired as of 12/31/2018. Cost center "99" should be used for any Intensive Home and Community Based Services (IHCBS) which are outlined on pages 8 and 9 of the Mental Health Provider Manual.

14. *Is there an update on Cross over claims?*

The language in the Provider Manual still applies, however, the date that CRT encounters may start to be submitted is under current discussion and may start sooner than the 4/1/2019 date currently described. See also question 9, above.

"The DA/SSA rate and caseload calculations include dual eligible members and crossover claims. The DA/SSA may submit a case rate claim for dual eligible members. For CRT, MMIS encounter claims may not be submitted until April 1, 2019. For Medicare-only CRT participants, the DA/SSA must bill Medicare for all Medicare eligible covered services. If all services provided by DA/SSA are covered by Medicare, then no claim should be submitted for that beneficiary for reimbursement under the monthly case rate. However, if a CRT service allowable under the Global Commitment to Health Medicaid demonstration is delivered to an eligible CRT member in any month and is not covered, or is only partially covered, then the case rate may be billed in the month that service is provided starting April 1, 2019".

15. *What happens if the DA's want to make a change to the Provider Manual?*

DMH in partnership with the DA's and VCP have come up with an operational protocol for manual changes that we have posted online entitled "Mental Health Provider Manual DRAFT Revision Protocol and is located here: https://mentalhealth.vermont.gov/sites/dmh/files/documents/Manuals/Mental_Health_Provider_Manual_Revision_Protocol_2019.pdf

16. *Is there any language carried over from previous manual about balance billing?*

For Medicaid recipients please refer to the DVHA Provider Manual page 80 Section 4.4 on Member Cost Sharing/ Co-Pays and Premiums. For non-Medicaid recipients please refer to the language from the Medicaid Fee for Service Manual pages 12-13, Section 1.8.6 Payment and Conditions of Reimbursement. DMH will be adding this language to the Mental Health Provider manual for future reference.

17. *How has payment reform affected IFS regions and other programs like Success Beyond Six and Reach Up?*

Payment Reform applies to IFS regions, they have some areas that are still included in their PMPM rate that are not included with the other DA's in Non-IFS regions. Success beyond Six and Reach Up continue to be out of the PMPM rate and should be billed separate of the Case Rate. Success Beyond Six and Reach Up will have their own sections of the Mental Health Provider Manual in the coming months.

18. *We need some clarification on Personal Care Services (PCA), what if this is the only service a client receives in a month?*

    Personal Care Services is included in the PMPM case rate for IFS regions only. If this is the only service being provided to a client in an IFS region, this should be coded as T1028 and it can be considered a case rate qualifying code for IFS regions only.

19. *Should we be billing ABA services to the DMH Payment Reform Billing provider numbers?*

    No, ABA services should continue to be billed directly to DVHA as they have been prior to Payment Reform.

20. *We need some clarification on the minimum duration for individual therapy being a qualifying encounter as its written differently in two spots in the manual?*

    Thank you for pointing this out, we will be editing the manual to reflect the appropriate minimum duration which is 16 minutes for individual therapy to be considered a case rate qualifying service.

21. *Can an LADC bill for services other than specific substance abuse services? Ex. Can they bill for individual therapy?*

    An LADC can provide any service under their scope of practice without the need for a Supervised billing modifier (AJ Modifier). According to The office of Professional Regulation for LADC's : LADC licensure entitles the bearer to provide alcohol and drug counseling to clients. If The Person who holds an LADC is providing a counseling service outside their scope of practice, they will need to bill this service under a clinician with a license to provide that scope of work.

22. *if we have a client that has a primary insurance (or 2) and they pay the service in full – do we still have to send them claim in to DXC as a shadow claim? Or since primary paid in full does it stop there?*

    For individuals who have private coverage, third party payers must be billed for all services covered in the commercial payers covered benefit plan. If all services provided by DA/SSA are covered by the third party, then, no claim should be submitted for that beneficiary for reimbursement under the monthly case rate. However, if a service allowable under the Global Commitment to Health Medicaid demonstration is delivered to an eligible Medicaid beneficiary in any month and is not covered or is only partially covered under the beneficiary's private coverage benefits package, then the case rate may be billed in the month that service is provided.

23. *We have a 22 year old client that is receiving services from the JOBS program, can we bill the children's cost center for clients over 22?*

    JOBS services are tracked through the MSR and do not require billing through the MMIS. JOBS services are provided to clients age 16 through 22 Any provided services prior to the individual's23rd birthday should be recorded in the MSR under Children's services. Under Payment Reform, any individual can receive Supported Employment services if the agency has the resources after meeting the needs of their priority population (JOBS and CRT).

    Therefore, Supported Employment services provided to eligible youth ages 16-22 through JOBS should be coded as HA (child case rate) Supported Employment services provided to eligible adults

ages 18+ through CRT should be coded using the HB modifier. If available resources exist at the agency, any supported employment service provided to an individual who is not eligible for JOBS or CRT needs to be coded based on age: 18 years or over is HB; under 18 years is HA.

24. When a youth is in residential treatment does there have to be a monthly service and if so does it have to be face to face?

It continues to be expected that the DA stay involved in the youth's care for discharge planning and coordination purposes. There should be at least a monthly service for participation in treatment team meetings or care coordination. This should be billed as a "0" paid claim for Service Planning and Coordination. Please read the definition of service coordination in the Mental Health Provider Manual for additional detail. This can be found here: https://mentalhealth.vermont.gov/sites/dmh/files/documents/Manuals/Mental_Health_Provider_Manual.pdf

25. For clients that have received ISB's prior to payment reform, how do we get paid for what used to be the "below the line" services that are not Medicaid billable items?

DCF has been in communication about the structure of their process for payment of former "below the line" services with DMH, we will provide updates as we know more.