Payment Reform Frequently Asked Questions 2nd Edition

1. *How does the DA notify and invoice DMH for Room and Board and Personal Expenses for children/youth receiving Intensive Home & Community Based Services in an out-of-home setting?*

   The DA does not need to submit anything in advance to DMH for children/youth receiving Intensive Home & Community Based Services in an out-of-home setting. The services are coded in the MSR under Cost Center 99 (IHCBS) and with service code for either Therapeutic Foster Care (H04) or Staffed Living (H02) for actual dates of service. The DA submits an invoice to DMH using the standard form. DMH pays the invoice and conducts retrospective review comparing invoice with service data when data is available the following month. DMH will communicate with DA to reconcile any discrepancies between MSR data and invoice.

2. *How are Medicare Crossover claims paid?*

   The crossover claim money was taken out of the MHPR case rate, these should be billed to Medicare and will be paid cash for any Medicaid portion.

3. *Should the DA's be coding different POS codes for Crisis Screenings?*

   The Emergency Services Directors and VCP are looking into the POS codes and making determinations on how to best create consistency in coding POS for the screenings. They will notify DMH about proposed changes. The two DA's with IRR's included in their case rate can code POS 56 for screenings done at the IRR.

4. *We had a treatment team meeting earlier in the month on a kid who receives school-based services, IFBS and outpatient. The event could count toward the DMH, IFBS and SBS case rates. As all three programs "fee for service" in the past, only one program would bill so as not to "double dip," but in the case rate world it's not as clear as to what we should do. I talked with the State Level IFBS folks and they're not sure either?*

   If a team meeting includes people with different specialties bringing different qualifications and expertise, then they all could bill. If we look from the point of view of the individual client, the services that are provided by the attendees of the meeting are separate and distinct. The meeting is held to coordinate those services; therefore, the meeting is supporting the client's separate and distinct needs for each program they are a part of.

5. *I have a question regarding guardianship evals. If we have a CRT client that we have done an eval on and we did it in March and we have not sent claims to Medicaid for this because our CRT population cannot get sent until April 1st – would we still put the rate of what we would have gotten paid for an eval since the claims had to go thru the MSR (not MMIS)?*

Because the evaluation was done In March, please do what you have always done with regards to billing Guardianship Evaluations for CRT clients. As of January 1, please continue to track the hours that it took to complete the evaluation and use the FFS rate sheet to calculate the overages. If there are reasonable overages above $800.00 the invoice and rationale should be sent to DAIL. The code to use for billing the services to MMIS is 90791.

6. *Can the MH case rate be billed concurrent to a DS waiver?*

   Yes, to the extent that the services are outside of what is indicated in the DS waiver. Please follow the concurrent billing guidelines on page 78 of the Mental health Provider Manual.

7. *Can we start using H2015 and how is it different that H2017?*

   Yes, H2015 is the code for Comprehensive Community Supports, it aligns with B01 in the MSR and can be used in the MMIS for MHPR Community Support Services.

8. *Can APRN's bill for therapy services?*

   Yes, APRN's can bill for all therapeutic services without using a MH/ Supervised Billing Modifier. Please continue to use MHPR modifiers (HA, HB, V1).

9. *Can you bill group therapy and individual therapy on the same day?*

   This issue is still being worked on with DXC, if you bill these services on the same day, one will pass and the other will deny. DMH Policy Unit will send out additional information as we know more.

10. *Can you please tell me if we have to submit the encounter claims under individual rendering provider numbers, (therapy codes 90837) Or is it ok to under group agency NPI and Taxonomy as rendering?*

    You would continue to bill services as you have in the past. Please follow the billing guidelines and the Supervised billing guidelines outlined in the VT Medicaid Provider Manual. http://dvha.vermont.gov/for-providers/manual?portal_status_message=Changes%20saved.

11. *We sent our first batch of CRT claims for dates of service 4/1/19 forward and some of the services are denying for:*
    - *Service is not covered for non-Medicaid beneficiaries*
    - *Service is non covered for VHAP Pharmacy beneficiaries*
    - *Provider not authorized for service*

    These issues have been resolved through *DXC.* These were old edits that were put into the system that no longer apply.

12. *Is there a list of codes that we can use during the "services prior to assessment" timeframe?*

    There are no limitations on services that can be provided during the 45-day (30 for CRT) window prior to the completion of the initial assessment.

13. *We are getting denials or suspended claims for Group Community Supports, how can we fix this?*

This issue has been resolved, there are no longer any limits on units for Group Community Supports. The utilization of these services will be monitored to identify if there have been any significant changes in service delivery.

14. *Now that we are in Payment Reform, do we still have only 45 hours of Service Planning and Coordination for discharge planning with clients in residential treatment programs?*

    This restriction is no longer in place, DMH encourages person centered planning and understands that clients are often in need of more intense collaboration while discharging from an out of home placement back into their community.

15. *The Billing Managers had a question about when CRT comes on line with MMIS- some codes like supported employment/ JOBS and that they may need additional procedure codes?*

    There are some CRT services that do not have MMIS procedure codes. Supported Employment, Staffed Living (Adult residential), and Day Services. The answer is that none of these are qualifying caseload count services, so it is currently okay that they are not in MMIS, as that system is serving only to count qualifying services at this time. We do hope to add them eventually to the MMIS but they will not be added by 4/1. They still will be reported only to MSR. This is currently the case for non-qualifying Children's services as well (JOBS, licensed foster homes, respite, etc.). It is important that you continue to code these service encounters to the MSR, because these services impact future case rate calculations.

16. *Could you please clarify the coding that needs to be done when a psychiatrist is completing part of the assessment. Would they need to bill the reassessment code, or can they bill the regular med. check code?*

    If the psychiatrist completed a reassessment, they should bill for this. If they did a med check, they should bill for this. The service the Psychiatrist provided should be billed accordingly. There are psychiatry codes indicating a medical service was accompanied with history and decision making based on the client's complexity and whether they are a new or established client. DMH cannot dictate the specific coding but please refer to the allowable procedure codes in Attachment E of the Mental Health Provider Manual.

17. *Clarification on CRT enrollment and assessments services, this is a culmination of a number of different questions that have come to the DMH Program Tech.*

    - Once a Medicaid eligible adult client is open to the agency, as of April 1 all eligible services must be billed to MMIS and will be counted toward the monthly case rate.
    - As of April 1, all currently enrolled CRT clients who receive an eligible service and the service can be reported to MMIS, must be billed monthly to MMIS. Regardless of AOP or CRT status, any adult can access the menu of services as determined by the DA and the IPC.
    - Currently, for all adults, residential services and supported employment services, are not reportable services to MMIS.

- For adults, not enrolled in CRT (in AOP), these services referenced above may be reported in MSR even though they are not qualifying case load services. Other qualifying mental health services will still be captured in the monthly case load count.
- For CRT enrolled clients, residential services and Supported Employment must continue to be reported only to the MSR until MMIS can accept this service at a later date. MMIS and MSR service reconciliation for CRT clients is done monthly in the interim.
- CRT enrollment forms can be submitted at any time during a month. However, Persons enrolled in the CRT program will be added to the CRT list as of the first of the month of enrollment.
- An Individual's CRT enrollment can be backdated (if they had a case load qualifying service) up to three months prior to the month of enrollment if the individual has no other source of coverage.