Behavioral Health Provider Training: BHSO updates
Agenda

- Diagnosis Code 799
- Laboratory Work
- CPT Code Q3014- Telehealth
- BHSO Claims submission Process
- Targeted Case Management
Diagnosis Codes
Diagnosis Code 799

- Diagnosis Code 799 is Other ill-defined and unknown causes of morbidity and mortality

- At this time Passport does not reimburse for this diagnosis
Laboratory Services
Laboratory Services

- Laboratory services are not reimbursed via the behavioral health benefit.

- Claims for lab services are paid as a medical benefit.

- **Electronic Claims Submission**
  Emdeon (formerly WebMD)
  1-800-845-6592
  Passport Health Plan electronic payer identification number is 61129.

- **Claims Submission**
  Passport Health Plan
  P.O. Box 7114
  London, KY 40742
TeleHealth Services
Telehealth Services

• Kentucky faces significant challenges in ensuring care is available to individuals across the state.

• Providers can provide care using telehealth technology (HIPAA compliant, web-based communication system).

• Provider must be an approved provider through the Kentucky Telehealth Network and comply with the requirements of the Kentucky Telehealth Board in order to seek Medicaid reimbursement for telehealth services.
Telehealth Services

• When you begin billing with the GT modifier, you are attesting that you have gone through the proper certification process with the Kentucky Telehealth Board.

• Currently Passport does not reimburse for code Q3014.
Telehealth Services Cont’d

• To ensure that your claims for providing telehealth services will be paid, be sure to bill with the appropriate CPT code for the service provided, along with your behavioral health provider-type modifier, and the telehealth modifier: GT.
Targeted Case Management
Targeted Case Management

Targeted Case Management is an available service for Individuals with:

- Substance Use Disorders (SUD)
- Co-Occurring Mental Health Disorders for Chronic or Complex Physical Health Conditions (CCC)
- Severe Emotional Disability (SED)
- Severe Mental Illness (SMI)

Billable code for TCM is T2023. This code is billed as a monthly service.

Targeted case management can be provided by enrolled Kentucky Medicaid providers that meet Kentucky criteria for providing case management in the 907 KAR 15:050.
Targeted Case Management

Authorization Requirements:

• Substance Use Disorder Targeted Case Management, Co-Occurring Mental Health Disorders for Chronic or Complex Physical Health Conditions Targeted Case Management, and Targeted Case Management for Adults with Severe Mental Illness (SMI) or Children with Severe Emotional Disability (SED) require prior authorization.

• Please complete an e-Services Outpatient Request Form within the 14 calendar days of the service.
Targeted Case Management
Modifier Types

**Modifier Types:**
- HF: Substance Use Disorder
- TG: Co-Occurring Mental Health Disorders for Chronic or Complex Physical Health Conditions
- UA: Children with SED
- HE: Adults with SMI

Provider must include modifier Type of the rendering provider providing the service, such as U4 to indicate the Certified Social Worker Provider Type.

Please include the modifier to indicate whether the service was provided to a child or an adult for the Substance Use Disorder Targeted Case Management and Co-Occurring Mental Health Disorders for Chronic or Complex Physical Health Conditions Targeted Case Management only:
- HA: Child or Adolescent
- HB: Adult

For example, your submission for Targeted Case Management for a Substance Use Disorder provided by a Licensed Clinical Social Worker for a child would look like: T2023-HF-AJ-HA
Resources

• Website: www.passporthealthplan.com

• Provider Manual
  – The most recent edition is online.
  – An updated version will be posted soon.

• eNews
  – To register and view recent eNews:
    http://passporthealthplan.com/providers/provider-communications/
Clinical Discussion

- Authorization process
- Level of Care Criteria
- Individualized care
- Treatment curriculum
- All decisions are based on medical necessity criteria per the regulations:
  - 907 KAR 17:025 and 907 KAR 3:130
Authorization process

- Provider contacts the BH hotline within 1 business day of admission
- Provider will request a review of clinical information for a specific level of care
- Utilization reviewer will ask for clinical information specific to the level of care requested, including current symptoms as well as treatment and discharge planning
- Providers should be fully aware of medical necessity criteria, regulations and the state plan amendments
Level of Care Criteria

- Level of Care Criteria are based on industry standards for care
- Programming should be evidence-based
- Every member is expected to have a treatment plan specific to their individual treatment needs
- If treatment progress is not seen from one review to another, we anticipate a treatment plan to change to address member needs
Individualized Care

• Passport authorizes medically necessary services based on the member’s symptoms and current clinical needs
• Passport seeks to ensure the effective delivery of treatment in the least restrictive environment possible to meet the identified needs of the member
• We do not authorize services based on average program length of stay – authorizations are based on the clinical information presented at the time of the review
Treatment Curriculum

• If your agency will focus on substance use disorder, we may request information about your treatment curriculum.

• Our level of care criteria is based on the American Society of Addiction Medicine (ASAM) criteria. Clinical Opiate Withdrawal Scale (COWS) scores will be requested if the member is experiencing opiate withdrawals. Clinical Institute Withdrawal Assessment (CIWA) scores should also be available dependent upon the member’s drug of choice.
Decision making

• Authorization decisions are based on clinical information presented at the time of the review.
• Periodically a case will be sent to the Physician Advisor for review. The PA may contact the provider to gather more information to make a decision.
• Providers are notified within 24 hours whether an inpatient stay is authorized.
Service Delivery

Passport is committed to a recovery and resiliency approach to behavioral health treatment.

Providers must be sensitive to the unique cultural and diversity needs of Passport members and ensure access to services for members with special needs such as physical disabilities or language needs. As per Title VI, providers are required by federal law to provide appropriate accommodations to meet the needs of members, including translation services.

Inpatient providers must ensure that members are discharged with an aftercare appointment within 7 days of discharge. Passport can assist with this process.

Passport may review/audit treatment records as part of our quality program and/or to conduct outlier management activities.

Providers are encouraged to report suspected fraud and abuse to Passport.
Access and Availability

• Members must have access to ensure that the Medicaid Managed Care Participation standards are met.
• Behavioral Health providers require no referral when members request an appointment.
• Although answering services are allowed, a member must receive a callback promptly and not be put on hold for an extended time.
• If provider information changes (phone number changed or terminated, moved to another location, no longer accepting patients, etc.), inform Passport within 30 days so that members will be able to make appointments.
• If a provider requested is no longer at the practice, please assist member in finding another suitable clinician.
Behavioral Health Care Standards

• Care for non-life threatening emergency within **6 hours**.
• Emergency Care with Crisis Stabilization are available within **24 hours**.
• Urgent Care appointments are available within **48 hours**.
• Services Post-Discharge from Acute Psychiatric appointment within **7 days**.
• An appointment for routine office visit within **10 business days**.
• All other service appointments are available within **60 days**.
• Missed Appointment Follow-Ups are rescheduled within **24 hours**.
Working with Passport Behavioral Health
Utilization Management
Utilization Management

• The Passport Behavioral Health Program uses a proprietary, Kentucky-specific medical necessity criteria that complies with regulatory mandates.

• We provide utilization management for inpatient, outpatient and community support services using level of care (LOC) criteria.

• This LOC criteria is available to Passport network providers through eServices. Please go to https://provider.beaconhs.com/ and choose the Provider Materials link to review the criteria. You can also call the Behavioral Health hotline at 1-855-834-5651.

• Our application of LOC criteria and authorization procedures represent a set of formal techniques designed to monitor the use of, and/or evaluate the medical necessity, appropriateness, and efficacy of behavioral health care services.

• Depending on the service request, providers may use eServices to submit their requests.
UM Authorization Process for Outpatient Services

No authorization required for:

<table>
<thead>
<tr>
<th>Medication management</th>
<th>Service Planning</th>
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<tbody>
<tr>
<td>Injection Administration</td>
<td>Crisis Services</td>
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<tr>
<td>Comprehensive Medication Services</td>
<td>(including Therapy, Emergency Intervention, and Mobile Crisis)</td>
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<tr>
<td>Diagnostic Interview / Evaluation</td>
<td>Psychoanalysis</td>
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<tr>
<td>Mental Health/Substance Abuse Assessments and Screenings</td>
<td>Narcosynthesis for Psych Diagnosis</td>
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<tr>
<td>Screening, Brief Intervention and Referral to Treatment (SBIRT)</td>
<td>Biofeedback</td>
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<tr>
<td>Peer Support</td>
<td>Alcohol and/or Drug Services, brief intervention</td>
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<tr>
<td>Group Therapy</td>
<td></td>
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<tr>
<td>Health &amp; Behavioral Assessment, Group and Intervention</td>
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<tr>
<td>Substance Abuse Prevention Services</td>
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</tbody>
</table>
UM Authorization Process for Outpatient Services

For individual and family therapy:

- Providers may see the member for 30 visits without prior authorization.
- Submission of electronic Outpatient Request Form (eORF) is required by 30th visit.
- eORF form can be downloaded at https://provider.beaconhs.com, under “Provider Tools” and can be submitted directly through eServices or faxed to 781-994-7633.
UM Authorization Process for Outpatient Services through EPSDT Benefit

- Prior authorization is required for services provided by non-licensed clinicians who are providing services outside of a licensed organization through the EPSDT Special Services Benefit through June, 2015 to facilitate changes in state regulations. Currently, Provider Type 45 is the only provider approved for the following services outside of licensed organizations:

  - Targeted Case Management for Children
  - Collateral Services (age 21 and under)
  - Comprehensive Community Support Services
  - Partial Hospitalization Program
UM Authorizations for Inpatient Services

### INPATIENT AUTHORIZATIONS

Telephonic Prior Authorization is Required for the following:

- Inpatient Mental Health
- Extended Care Unit (EPSDT Residential)
- Psychiatric Residential Treatment Facility (Level I and II)
- Substance Abuse Detoxification (in IMD and/or psych unit)
- Inpatient SA Rehabilitation
- Residential Services for Substance Abuse
- EPSDT Residential for Specialized Children Services
- Crisis Stabilization Unit
- ECT

FOR AUTHORIZATIONS CALL: 855-834-5651
UM Authorizations for Community Support Services

<table>
<thead>
<tr>
<th>COMMUNITY SUPPORT SERVICES</th>
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<tbody>
<tr>
<td><strong>Telephonic Prior Authorization</strong> is Required for the following:</td>
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<tr>
<td>- Partial Hospitalization</td>
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<td>- Intensive Outpatient</td>
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<tr>
<td>- Assertive Community Treatment</td>
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</tbody>
</table>

| **eServices Authorization** is required within 2 weeks of initial date of service: |
| - Day Treatment |
| - Therapeutic Rehabilitation Program |
| - Mental Health Service NOS |
| - Alcohol / Drug Service NOS |
| - Targeted Case Management – Adult and Children |
| - Comprehensive Community Support Services |
| - Skills Development & Training |

FOR AUTHORIZATIONS CALL: 1-855-834-5651
UM Appeals

• Appeal requests may be made by calling 1-855-834-5651, or by mail to:

  Passport Health Plan Appeals
  Attn: Beacon Health Strategies
  500 Unicorn Park Drive
  Woburn, MA 01801

• Once providers have received a final determination from Beacon, they may request an external appeal or State Fair Hearing with the Commonwealth of KY dependent upon the type of appeal submitted.
BHSO Claims Submission Process
Claims

- All BHSO claims must be submitted on a CMS 1500 professional services claim form.
- Claims may be submitted electronically through our Electronic Data Interchange (EDI) or via eServices.
BHSO Claims Submission Process

As of January 1, 2014 Providers must include:

• NPI number and taxonomy for the billing provider.
• NPI number and taxonomy for the rendering provider.

If a service is provided by a clinician under supervision, the supervisor’s NPI number and taxonomy is placed in the rendering provider area, and the clinician’s modifier is billed with the service to indicate that a clinician under supervision conducted the service.
eServices
eServices

This is a free service for all contracted and in-network Passport providers. The goal of eServices is to make clinical, administrative, and claims transactions easy to do. By using eServices you will be able to:

- Submit requests for authorization
- Submit claims
- Verify member eligibility for Passport Health Plan
- Confirm authorization status
- Check claim status
- View claims performance information
- Access to provider manuals, forms, bulletins and mailings
- View or print frequently asked questions (FAQs)

Screen shots from the eServices website appear on the following slides.
Welcome to eServices, Beacon’s web tool for providers.

All eServices functions are provided free to Beacon contracted providers and are aimed at enabling easy and secure access to a host of clinical, administrative and patient information, as well as all provider business transactions with Beacon. eServices allows providers to:

- Verify member eligibility quickly and easily
- Request authorizations – eAuthorizations receive priority review!
- Confirm the status of authorizations and print all authorization details, including the number of units utilized
- Submit claims, including reconsiderations
- Check the status of claims
- View and print explanation of benefit (EOB) information
- View and print claims performance information
- View, update and print provider demographic and directory information
- View, print and download provider documentation such as manuals, forms, bulletins, mailings etc.

If you are not registered for eServices, simply click the Register link on this page to start!

EFT (Electronic Funds Transfer) begins September 22, 2011 as a payment option for providers in CA, FL, MA, NY, RI and WI.

- For payments AFTER 9/22/11, EOBs will still be mailed to providers who opt out of EFT, and electronic EOBs can be downloaded at www.payspanhealth.com.
- However, these EOBs will not be posted on eServices. EOBs for payments BEFORE 9/22/11 and for Touchstone claims with dates of service before 10/1/10 only, will remain available on Beacon’s eServices.
- Register for EFT and to access electronic EOBs by calling the PaySpan Health Provider Hotline at 877.331.7154.

eServices home page
eServices is simple to log into and use. You create your own username and password.
Once the account is activated, there are a host of clinical functions available. Beacon prefers that authorization requests be sent via eServices.
Submit an authorization is just a few key steps away!
Simply use the Member Search to find the member for which you are wanting an authorization. We now require three unique member identifiers for a Member Search. You will need: Passport Member ID or Medicaid (Alternative) ID, Member Date of Birth and Member Last Name.
Choose the type of service from the drop down menu.
Once you have entered all of the required fields, you may submit your request.
After you have successfully submitted your request, you will receive a reference number for your records.
Once you have an authorization in place, you may submit a claim via eServices. Inpatient and outpatient claims can be submitted via eServices.
Submitting a claim electronically takes less time and is more efficient than a paper claim. Once the fields are entered just hit submit!
Now that your claim has been submitted, you will receive a transaction number. You may also print the page for your records.
Claim reconsiderations may be done online, for claims that were submitted and denied and require an in depth review.
eServices

Once you have entered your claim info and explanation you can submit a reconsideration request.

Use the free text box to enter your explanation.

Always make sure to enter the original claim's RecID.
eServices

Claims that may have denied for an incorrect procedure code or diagnosis code may also be re-submitted electronically.
Once the claim has been chosen, click on the resubmit link.
After you have clicked on re-submit, the information will automatically fill-in from the previous submission. You can then make corrections and re-submit. Re-submissions must be made within the timely filing limit of 24 months.
Claims
Electronic Data Interchange (EDI)

- EDI is the preferred method for receiving claims. We accept the standard HIPAA 837 format and provide 835 transactions.

- Beacon also uses 270/271 transactions for eligibility purposes.

- Beacon does allow EDI claims to be submitted from a Clearing House or Billing Agency.

- EDI claims may also be submitted to Beacon via Emdeon. Beacon’s Emdeon payer ID is 43324. Please note payer ID 61126 is incorrect for behavioral health, as it is for medical only.

- Passport Health Plan’s ID is: 028.

- All EDI claims submitted via Emdeon must include the member’s Passport “Plan ID” and Beacon’s Emdeon payer ID. Using just one or the other will cause claims to reject.

- EDI registration forms are on the Beacon web site at www.beaconhealthstrategies.com/private/pdfs/forms/EDI_Trading_Partner_Setup.pdf. Submit the EDI Registration forms and schedule test submissions with the EDI team.

- After test submissions have been completed, contact EDI Operations to request a production setup. They can be reached at 781-994-7500, or via email at edi.operations@beaconhs.com.
Important Claim Reminders

• All claims must be received within Passport’s timely filing limit of 180 days.

• All clean claim submissions (meaning no missing or incorrect numbers or information) will be processed and paid within 30 days.

• The top denial reasons for behavioral health claims submitted are:
  
  • Timely filing (claim denied as it was not received within 180 days).
  
  • Missing or incorrect NPI number. (All claims must list the rendering clinicians individual NPI number, along with the site NPI number. If either of these numbers are missing or entered incorrectly, the claim will deny.)
  
  • No authorization. (If the member has no authorization to see the provider, or the authorization has expired the claim will deny. It is important to make sure the member has an authorization in place, or has initial benefit visits remaining, before seeing them.)
Billing Multiple Hours of 90837

- 90837 Psychotherapy 53-60 minutes for the first hour.

- DMS will allow behavioral health providers to bill 99354 90-120 minutes for the second hour.

- For the third hour of services, behavioral health providers may utilize code 99355 150-180 minutes for the third hour.

<table>
<thead>
<tr>
<th>Minimum Length of Psychotherapy</th>
<th>Code</th>
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<tbody>
<tr>
<td>53-60 minutes (1st hour)</td>
<td>90837</td>
</tr>
<tr>
<td>90-120 minutes (2nd hour)</td>
<td>99354</td>
</tr>
<tr>
<td>150-180 minutes (3rd hour)</td>
<td>99355</td>
</tr>
</tbody>
</table>
Use of Modifiers

• All claims must be submitted with the appropriate modifier or the claims will deny.

• Please refer to the 10/06/14 eNews entitled “Modifications to Behavioral Health Claims Submission Process” for a list of modifiers and an example of a CMS 1500 claim form.
  
Additional Info: Waivers, Reconsiderations, Resubmissions

- All claim resubmissions must include the Rec ID from the original claim to prevent unnecessary timely filing denials.

- Waiver requests (for timely filing) may be submitted within 24 months from the qualifying event and must be accompanied by a claim form (available on www.beaconhealthstrategies.com).

- Qualifying events include: retroactive member eligibility; retroactive authorization and retroactive provider eligibility. If your request is not for one of these reasons, it will be denied and you must follow the procedure for reconsiderations.

- Once you have exhausted all other avenues, you can submit a request for reconsideration of the 24 month timely filing limit.

- Reconsiderations must include:
  - Copy of claim form with a cover letter explaining why claims were not filed in a timely manner, along with supporting documentation.
  - Screen prints of billing ledgers, certified mail receipts or documentation that claims were sent to a clearinghouse are not considered proof of timely filing.
Contact Information
Contact Numbers

• Passport’s Behavioral Health Hotline: (855) 834-5651
• Main fax number: (781) 994-7633
• TTY Number (for hearing impaired):
  (781) 994-7660 or (866) 727-9441
• Claims Hotline: (888) 249-0478
• eServices Helpline: (866) 206-6120 Provider Relation Representatives
do not have access to eServices. Therefore you must contact this number if you need
assistance.
• IVR: (888) 210-2018
• Psychiatric Decision Support Line for PCPs: (866) 647-2343

All departments may be reached via the Passport Behavioral
Health Hotline at (855) 834-5651
Contact Numbers

Enrollment Department
(502) 588-8578  Passport.Credentialing@passporthealthplan.com

For behavioral health questions, please contact the Behavioral Health Mailbox
Passport Behavioral Health Mailbox
Passportbehavioralhealth@passporthealthplan.com

Liz McKune, Ed.D.
Passport Director of Behavioral Health
(502) 585-7988  Liz.McKune@passporthealthplan.com

Brigid Adams Morgan
Beacon Health Strategies, Program Director for Passport
(502) 588-8572  Brigid.AdamsMorgan@beaconhs.com

Passport Health Plan’s mission is to improve the health and quality of life of our members.
Contact Numbers Cont.

Cindy Bundy  
Provider Relations Specialist  
(502) 213-8939  
cindy.bundy@passporthealthplan.com

Micah Cain  
Provider Relations Specialist  
(502) 357-8887  
micah.cain@passporthealthplan.com

Taquitta Porter  
Provider Relations Specialist  
(502) 357-8872  
taquitta.porter@passporthealthplan.com

Passport Health Plan’s mission is to improve the health and quality of life of our members
Questions & Answers
We will take a 10 minute break to compile questions.
Thank you for helping us with our mission of improving the health and quality of life of our members.