NOTES
IMC Workgroup

June 5th 2019 | 1:30-3:00pm | Call-in only

By computer: https://zoom.us/j/911995757

By phone: +1 720 707 2699 • Access Code: 911 995 757

1:30 WELCOME & INTRODUCTIONS

1:45 DISCUSSION

- 6 month check-up – BHT
- SAMHSA Block Grant CAP: Non-Encounter Data – HCA
- Provider questions, new & outstanding – see following pages
- SERI Q&A follow-up - TBD
- Other discussion

2:45 NEXT STEPS

- Topics/items for next time

3:00 ADJOURN

Meeting Notes – begin page 2

Outstanding Questions – begin page 5

NOTES

Attendee organizations: BHT, HCA, Molina, Coordinated Care, Amerigroup, CHPW, Spokane Public Schools, Institute for Family Development, Xpio, Daybreak Youth Services, YFA Connections, Lutheran, SRHD, Pioneer, Children's Home Society, Excelsior, Spokane County Detention Services, New Horizons, CME, Spokane Counseling & Recovery Services, SPARC

CHECK UP & UPDATES

- Molina – MCOs are working together to compile best practice doc for provider rosters. Helpful hints to reduce delays in clarification/updates
- HCA documents update
  - Medicare and ITA, the Address Confidentiality Program, IMC Billing for dual-eligible clients
  - Reviewing comments from feedback period, expect to update & get out later this month
  - Also working on updating HCA Contact List and will share soon

SAMHSA/NON-ENCOUNTER DATA

- MCOs have heard questions from providers, so wanted to share the update
- An email update was sent out on Monday by HCA, sent to BHO, ASO, MCOs, asked to send out to provider network
- BHT will forward to group

SERI QUESTIONS

- BHT still working with HCA to get the list of questions answered (see list of questions on pg. 6-7)
- Will send out to group as soon as we have them!

PROVIDER QUESTIONS

1. Billing for multiple services/encounters on the same day (CHSW): Many times we have problems getting paid for providing multiple services, with the same CPT code, for a client in a day. They often are denied as duplicate billings. A good example is Code H0046. The therapist may contact two or four agencies in a day trying to arrange services for the client. Interns can only use H0004 for an individual or family session. If they do both individual and family therapy with the same client in the same day one of the H0004 encounters will likely be denied as a duplicate service. After we receive the denial, we send copies of each progress note and a paper HCFA for each service to the MCO to prove they are not duplicates. We use the 59 modifier to let the Insurer know that these are separate encounters and not duplicates. The 59 modifier is not in the SERI. Is there a better way to let the MCO know it is not a duplicate service? Can we use the 25 Modifier even though it is not with an E&M code and our therapists are not physicians? Finally, is there a limit on the number of services allowed per day per client?
   a. Molina – the challenge is that with these services that can be rendered multiple times in same day. Most MCOs are going to look for the multiple modifiers. Recommended HCA include some additional modifiers. Our hope is that it gets in SERI. Absent that, Molina has to share guidance about modifiers outside of SERI with providers. As far as combining services in single day, use SERI for reference on whether or not it can be done. Until then, we have to provide as additional info. Anything that comes into us as encounter/claims, we have systems in place to look for duplicates. Will have to see if we can share widely, but believe we'll be able to do that. Corey will touch base internally and get back
   b. Amerigroup – similar approach. MCOs met last week to discuss this issue and others around coding/modifiers. For H0004, you could use modifier 25. We also follow SERI in regards to rolling up services.

c. Children's Home Society – can we use 25 modifier even though its not with an E&M code and our providers are not clinicians?
    i. Amerigroup – believe yes, but need to check
    ii. Molina, Coordinated Care, CHPW – same
    iii. Amerigroup update 6/5 - yes, is allowable as appropriate
d. Can we continue to use 59, even thought not in new SERI?
    i. Molina – you can use 59
    ii. Amerigroup – yes, is allowable as appropriate
    iii. Other – will check
e. Follow-up from Molina 6/6:
    i. Attached is the CMS article that I have been sharing with providers about multiple-visit modifiers (25, 59, XE, etc.). Based on my interpretation of the article, I think XE is probably the most appropriate modifier for most of the scenarios we are being presented with (including the two described by CHSW). But 59 will work as well. [BHT note: the CMS article is also posted on the IMC webpage under "MCO Resource Roundup"]
    ii. Regarding the question about modifier 25, the answer for Molina is, yes, providers can use that modifier for same service/same day even when E&M codes are not involved. However, for Molina that is only true because we have suppressed that particular "correct coding" rule for IMC BH providers (essentially because HCA initially only included modifier 25). My recommendation is that providers use the other modifiers in those circumstances because that is "more appropriate" outside of SERI. However, 25 is currently acceptable and I understand why providers would want to use only what is included in the SERI guide. We will continue to try and reach better clarity for providers on this in the long term (by either including it in SERI or being very clear about the limits of the SERI guide).

2. Requests from Lexis Nexis, Better Doctor (CHSW): Just wanted to make sure this was on your radar for the next meeting. Our therapists are being inundated with requests. It appears that Lexis Nexis was recently contracted with Coordinated Care to do updating of rosters (see email from Coordinated Care under "Verify HCP Introduction"). Every clinician is getting an email with a form they have to fill out and return. I am also getting daily emails from Better Doctor asking for updates. They list Coordinated Care, United Health Care, and Amerigroup as plans they are collecting information for. It's getting out of hand. We already submit the MCO roster on a regular basis and these requests are duplicative. I asked our Coordinated Care Provider Rep if we could ignore the requests from Lexis Nexis and she said No. I don't understand why we would need to submit a roster AND fill out individual questionnaires for every therapist on staff?
    a. Amerigroup – these requests are not coming from the MCOs directly. Providers may receive quarterly. Believe it is through the HCA, not directly from MCO. Have a couple of links about the reasons for request, which are about the WA Health Plan Finder, will send to share:
        i. From Amerigroup 6/5: Here are the two links in regards to Better Doctors below. This is something that the provider may receive communication once a quarter (4 times a year). If the provider has concerns about completing this task they can outreach to the state directly. This fax is not coming from Amerigroup.
            - *https://www.wahbexchange.org/wp-content/uploads/2013/05/HBE_PN_190717_BetterDoctorDataCollection.pdf*
            - *https://betterdoctor.com/providers/washington-healthplanfinder/*
    b. Coordinated Care – Joey will look into and get an answer in writing.
3. New sFTP process for Amerigroup (LCSNW): I was continuing my search after my email to you yesterday regarding Amerigroup and their ask regarding their new sFTP process that they want implemented by end of May and this is what I found: The MCO's have worked together to have a similar reporting format and spreadsheet to simplify this process for WISe providers.
http://www.betterhealthtogether.org/bold-solutions-content/wise-resources?rq=MCO%20contact
I am not sure I have heard that all providers are using this and it would be challenging for our IT department to accommodate this request for all MCOs (or even just the one) by the end of May so I wanted to see if

maybe I missed something at the IMC meetings in an attempt to try and track down information. We are following up with a contract review as well but thought I would check in to see if this is a another new change that is being asked.

a. *Answer from Amerigroup 5/24: By the end of May was a target, with the vision that with some providers it may be June or July. If that provides relief from a timeline/IT resources – please let me know and we can stagger yours set up later. This remark about staggering applies to any WISe provider as we will work with them, some are going live in NS or configuring SERI, etc. Point being, sFTP is new process and we do have some flexibility of setting this up this summer.*
b. Lutheran – is this going to be required for other MCOs? Or a process specific to Amerigroup?
    i. Molina – we worked with providers before go-live on sFTP. Will need to check with specific providers to make sure they are set up in our system. For purpose of exchanging member-specific information and things like WISe rosters. Working across MCOs to make sure process is as similar as possible. Corey can put providers in touch with sFTP people on their end.
    ii. CHPW & Coordinated Care – will have to get back

4. Billing for Rehabilitation Case Mgmt (SPS) - I was emailed these questions yesterday. Not sure if they have been answered already. The main question seems to center around when a adolescent is incarcerated: 1) Are their Apple benefits suspended as mentioned in the above attachment? 2) Can a MH or SUD therapist provide services to a client who is either incarcerated or hospitalized? My thought was that they could bill for Rehabilitation Case Mgmt but is this only for discharge? Thanks
    a. HCA – need to check if suspension is also true for adolescents, but believe it is suspended for them as well
        i. From HCA 6/5: Outreach Services to individuals in jails or hospitals, including youth: Rehabilitation Case Management modality is outlined on page 65 of the SERI guide. https://www.hca.wa.gov/assets/billers-and-providers/SERI_v2019-1EffectiveJuly1_2019.pdf
        Per the SERI guide:
        Rehabilitation Case Management (RCM) can is the only service to be encountered when a client is in Jail/Prison, Juvenile Detention Facility, CLIP Facility, Evaluation & Treatment Facility, Medical or Psychiatric Inpatient Facility for the purposes of discharge planning and coordination of care. Services provided in a Skilled Nursing Facility are not covered in this modality, but can be reported in other modalities as appropriate. RCM may be used to provide mental health services when an individual is in a substance use disorder treatment facility.
        - *RCM provided in an IMD, jail/prison, or juvenile detention facility is funded as a non-medicaid service. This includes mental health services provided to individuals with Medicaid as the pay source.*
        - *All RCM services delivered in an IMD will be reported as non-medicaid services.*
        - *This modality may be provided prior to an intake.*
    b. Amerigroup – Yes you can bill Amerigroup for this service under Rehab Case Mgmt
    c. Molina, Cordinated Care, CHPW – need to take this one back and check on when/where rehab case mgmt. can be used
5. SERI play therapy (SPS) - SERI definition of "interactive complexity" for play therapy. Hoping to get more clarification on situations where you can use it. Can our providers who regularly use a modality of play therapy for very young children, versus when it's an investigative process with multi-system involvement (e.g. CPS)?
    a. Provider type? Mental health therapist working directly with the child for therapy? Yes
    b. HCA – will take this one back
6. AI/AN FFS (IFD) – Was looking into how our agency can become a provider for FFS for AI/AN youth in WISe. Wondering who to contact for help?
    a. Keller, Yvonne G (HCA) yvonne.keller@hca.wa.gov
    b. Mena-Tyree, Sandra (HCA) sandra.mena-tyree@hca.wa.gov

7. Reporting data breach - Who (if anyone) do we report data breaches to? Is there a format and/or timeline for the report. Under the BHO we were required to submit reports for any violation of HIPAA or 42CFR which was then forwarded to DBHR. I can't find any information about the process now.
    a. HCA response: You can send them at HCA HIPAA-HELP HIPAA-HELP@hca.wa.gov
    b. The requirement for reporting actually falls on the MCOs. https://www.hca.wa.gov/assets/billers-and-providers/ipbh_fullyintegratedcare_medicaid.pdf (See Exhibit G starting on page 347 – Section 7 talks about notifications – page 361). However, I would also recommend checking your provider contract, as they may have passed this down.
    c. *Follow-up from HCA:* so if it is NOT a managed care provider the response below is correct: The best way to report a data breach would be to contact our Privacy Officer, Matt King PrivacyOfficer@hca.wa.gov. The first email address (HIPAA HELP) I gave you would also get the right place but this one is more specific.

Outstanding questions

For MCOs to address/check into

1. Billing for multiple services/encounters on the same day: Many times we have problems getting paid for providing multiple services, with the same CPT code, for a client in a day. They often are denied as duplicate billings. A good example is Code H0046. The therapist may contact two or four agencies in a day trying to arrange services for the client. Interns can only use H0004 for an individual or family session. If they do both individual and family therapy with the same client in the same day one of the H0004 encounters will likely be denied as a duplicate service. After we receive the denial, we send copies of each progress note and a paper HCFA for each service to the MCO to prove they are not duplicates. We use the 59 modifier to let the Insurer know that these are separate encounters and not duplicates. The 59 modifier is not in the SERI. Is there a better way to let the MCO know it is not a duplicate service? Can we use the 25 Modifier even though it is not with an E&M code and our therapists are not physicians? Finally, is there a limit on the number of services allowed per day per client?
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    b. Children's Home Society – can we use 25 modifier even though its not with an E&M code and our providers are not clinicians?
        i. MCOs – believe yes, but need to check
            1. *Amerigroup 6/5 - yes, is allowable as appropriate*
    c. Can we continue to use 59, even thought not in new SERI?
        i. Molina – you can use 59
        ii. Other MCOs – will check
            1. *Amerigroup 6/5 - yes, is allowable as appropriate*
2. Question 3 above re: sTFP/WISe system - CHPW & Coordinated Care – will have to get back
3. Billing for Rehabilitation Case Mgmt (SPS) -The main question seems to center around when a adolescent is incarcerated: 1) Are their Apple benefits suspended as mentioned in the above attachment? 2) Can a MH or SUD therapist provide services to a client who is either incarcerated or hospitalized? My thought was that they could bill for Rehabilitation Case Mgmt but is this only for discharge? Thanks
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    b. Molina, Cordinated Care, CHPW – need to take this one back and check on when/where rehab case mgmt. can be used

Outstanding from last month:

4. Update MCO contact list – most recent is from February (available here)
5. Billing for case management: We operate an outpatient SUD facility. We have 1 case manager and 2 peer support that provide services to MCO covered clients. These three employees are not CDPTs or CDPs. We are just not beginning to put in our claims due to issues with getting set up through the MCOs. Those 3 individuals have been coding their services to case management (T1016) on our trackers but the SERI calls out that SUD case management must be provided by a CDP or CDPT (see below). My question is this: What code can we use and submit to an MCO for services provided by these individuals? They are providing services such as assisting clients with housing, clothing, food, work, workforce redevelopment and peer support. I am sending this question to you in hopes that you can help me determine the correct code to use.
6. How to handle money received from primary commercial insurance while in capitated MCO contract: We're in a capitated contract - outpatient services paid PMPM. We have a handful of members who also have private insurance for some reason. Under the BHO, we billed the private insurance company and they sent us the money and then we sent it to the BHO. We still go thru the process of billing the primary insurance. Feels like double billing, but we're required to bill the insurance. What should we do?

7. H-codes are not covered by primary commercial: Is there a way to streamline process so don't need denial? When we bill the primary insurance (commercial) with H-codes, insurance company sends back request for more info - progress note, explanation of the code, etc. Then they come back and deny that. Then you can finally bill the MCO. It's time intensive. Commercial in general doesn't cover H-codes. Way to streamline?

For HCA to address

Outstanding from last month:

8. Update HCA contact list – most recent we have is here.
    a. Working on. Coming soon!
9. SUD Peer: When will providers be able to begin billing for SUD peers?
    a. *HCA Answer 6/5: Providers will be able to begin billing for SUD peer services on July 1, 2019. SUD Peer Support will be added to the SUD modalities in SERI so there will be a code for this. However, SUD case management services under T1016 must be provided by a CDP or CDPT in order to be reimbursed under Medicaid.*
10. Potential for process/guidance doc for reactivating pharmacy benefits: see May notes for details

SERI questions

1. *(new)* SERI definition of "interactive complexity" for play therapy. Hoping to get more clarification on situations where you can use it. Can our providers who regularly use a modality of play therapy for very young children, versus when it's an investigative process with multi-system involvement (e.g. CPS)?
2. *(new)* Billing for multiple services/encounters on the same day: Many times we have problems getting paid for providing multiple services, with the same CPT code, for a client in a day. They often are denied as duplicate billings. We use the 59 modifier to let the Insurer know that these are separate encounters and not duplicates. The 59 modifier is not in the SERI. Can we continue to use 59 / will it be added to the SERI? Can we use the 25 Modifier even though it is not with an E&M code and our therapists are not physicians?
3. H2011: I would like to confirm that we can continue to use H2011 for crisis services that are NOT provided by the BHASO crisis line. We have used that code with the U8 modifier for WISe, for mental health professional crisis response to our families. It looks like we can still use it, as it has the U8 modifier as a possibility but the service itself is described under the 'BHASO only' section.
4. H2027: In the description, it states Provider Type 12- Other (Clinical Staff) but there is no definition as to who qualifies. Would a CDP or CDPT be able to use this code?
5. H0023: It mentions "targeted population". Are there some examples that we could get for the Engagement and Outreach H0023 on page 126 of SERI 2019? Would AI/AN be a "targeted population"?
6. As follow up to the IMC Workgroup meeting, H0023 is a state funded code, does that mean if for SUD, we would be able to use the SABG to pay for these?

    Note from Kurt Beilstein (Spokane BH-ASO), 05/08/19:

    The MCOs receive 30% of State GFS Non-Medicaid funds to pay for Non-Medicaid services for Medicaid Enrollees as identified in the SERI. During the next meeting, BHT may want to consider asking the MCOs:

    Do providers submit Non-Medicaid funded services to the MCOs for Medicaid eligible individuals the same way Medicaid funded services are submitted?

    SABG is not a funding source generally available for Medicaid clients, except in certain circumstances identified by the ASO, and included within the SABG Plan, as well as the SCRBH (ASO) contracts with behavioral health providers. The SCRBH (ASO) is using SABG to cover specific services for Medicaid Enrollees, and example of that is childcare for parents engaged in SUD treatment services.

    There are other carved out services that the SCRBH (ASO) pays for using GFS, CJTA, or MHBG funds with money provided to the ASO specifically for those special carved out services, such as Involuntary

Treatment Act evaluations or the SEER program provided by the Community Colleges of Spokane. Any of the carved out services are contracted out with specific behavioral health providers.

I hope this helps provide more information regarding this topic.

7. Engagement and Outreach H0023 - looks like this CANNOT be used for MCO Medicaid clients as it is State funded - is this true? Is there another code to use or do we stop providing this service to MCO clients?
    b. Same code also used for Rehab Case management - state funded service. Engagement & Outreach has been available for both Medicaid & State funded services.
    c. Gail - in that modality section, says that this is state funded only. Not available for federal funds match. Need to look into further to clarify
8. Care Coordination - H2021 - can only be used for people 21 and under - is there a code for Adults for Care Coordination with medical providers or do we use H2015 Comp Comm. Support Services?
    d. Need to look into further. Wonder if the limit is applicable only to the child & family team meetings, not to all H2021. Modifiers there are more than youth age.
    e. Follow-up question - if it is only for 21 and under, is there flexibility to have expansion?
9. Page 94 - SUD Assessment - states "H0001 or 0124" - what is 0124 -it's not listed anywhere that we can find.
    f. Couple places where when we were working with the MCOs. 0124 is a revenue code used for facility-based care. Offering the opportunity to use one or the other based on how the systems were programmed.
    g. Will remove 0124 from SERI
10. HH Modifier - under the BHO we did not use this code for COD services - we used mental health services codes. Our COD groups are run by CDP's and it appears now that they will not "count" as COD services because the CDP's are not mental health certified? This will under report COD services significantly.
11. COD Treatment (pg 124) - It appears from the Notes section that if a CDP/CDPT is also an Agency Affiliated Counselor - they are able to bill for these services using the HH modifier - is that correct?