BHA/MA/Beacon Health Options, Inc.
Provider Quality Committee Agenda

Beacon Health Options
1099 Winterson Road, Suite 200
Linthicum, MD 21090
Friday, February 10, 2017
10:00 am to 11:30 am

In attendance:

Telephonically:

Topics & Discussion

Minutes

BHA Update

Medicaid Update

Beacon Health Options Update

Provider Questions

1. **Medicaid Revalidations.** Providers have received validation letters for some, but not all, MA numbers. One provider was told to complete the revalidation process only for the MA numbers requested. Can you confirm that this is correct?

2. **Medicaid Revalidations.** Some revalidation letters sent to providers do not contain the MA number. What should a provider do under those circumstances?

3. **Request for Clarification About Change in Authorization Period.** No Provider Alerts were issued, but we understand that a change to the initial auth period was covered in the DLA-20 trainings. Auths for new clients will be 30 days to allow providers time to administer the DLA-20, which is now a requirement with every auth request except the initial. The next auth will be for 5 months, and all subsequent auths will be the usual six months, including grey zone auths. Is this correct?
    - Does the 1-month auth period operate like the 2 initial auths in the OMHC world?
    - Does an approved diagnosis still need to be completed with all of the other referral and required questions to get the initial auth?
    - What will be required to be entered into Beacon to obtain the 5-month auth? Will the entire DLA-20 be required? Can it be uploaded as a document?

4. **Request for Policy & Operations Change.** When submitting a PRP authorization request, providers must submit the name of the DLA-trainer and training date. Duplicated over tens of thousands of claims, this requires substantial more administrative time to complete the authorization process. Other methods – such as attestation and auditing – can achieve the same policy goals more efficiently, with less outlay of administrative staff time on providers' part. Have you explored these options as an alternative? If so, why were more efficient reporting options rejected?

5. **Status of Operational Update.** At the January Provider Council, you indicated that Beacon is adding Z03.89 for "no diagnosis" on assessments, slated for the end of January. What is the current anticipated go-live date for this change?

6. **Request for Clarification.** Could we get guidelines about when a psychiatric re-assessment can occur and be paid. Is this something that can happen once per year? Once per auth period? When a client is not in treatment for an extended period? (how long-90 days?) Coming from another provider-so new admission *but* had been in active treatment?

7. When will BHO Maryland start having the same COB information as EVS? This has been an issue in getting claims paid even after the consumer and the provider office call EVS to give the termed date of a consumer primary insurance. Now we are being told the consumer also has to call BHO Maryland to have information updated also after EVS updated their information 48 hours after getting the information. Is this correct?

8. Here is a question I have for the Provider Council meeting on 2/10/16: We are a small PRP and we are looking to expand. We would like to hire contractors as mental health therapists to see our clients and to participate in a collaborative treatment team meeting to achieve continuity of care. Is this allowed? If not, what would we need to do to make this possible? Also, I would be interested in learning more details about the PRP best practices subcommittee. Please let me know if any additional information is needed.

9. What is the reimbursement duration for uninsured individuals? Is it 60 or 90 days? Does this start on uninsured eligibility span date or on the start date of the authorization?

10. One of the speakers on the Beacon OMS Interview webinar last 1/24 stated that the providers' OMS data report have already been posted in Provider Connect. The OMS Data report for our facility is not yet available. Who can we contact to obtain our facility's OMS Data report?

11. **Medicare / Medicaid related questions:**
    - Please explain the current practice for billing Medicare. In the past, if an individual is being seen for IOP services or has **alcohol abuse diagnosis (ICD-10 F10.10)** has primary Medicare and secondary Beacon/MA, as long as the MA coverage is full (not SLMB or QMB), provider can bill Beacon directly. Is this still the current practice or can we now bill Beacon even if Beacon coverage is only partial (QMB or SLMB)?

- If an individual has primary Medicare and secondary full Medicaid/Beacon, was seen by a Medicare approved provider for an SUD assessment and was diagnosed with F14.21 (cocaine dependence), are we to bill Medicare or Beacon? We initially billed Medicare and payment was denied due to Medicare not reimbursing for F14.21 diagnoses. Since Medicare rejected the claim, can we bill Beacon since we obtained timely and accurate authorization?
- An individual has straight Medicare coverage; no secondary. We scheduled the individual's SUD assessment with a Medicare approved provider. Provider recommended no treatment and therefore patient had an R69 diagnosis. Payment was denied since Medicare does not pay for an R69 diagnosis? Is there a way around this situation?

12. Beacon offered different webinar schedule on providers transitioning to fee for service. Couple of our staff heard in one of the webinars that stated individuals with private insurance who have high deductible can qualify for uninsured? This information did not come up in the webinar I attended. Is this accurate? If yes, can you define or provide a range of what you consider as high deductible and describe the process of how this individual will then qualify as uninsured to receive SUD services?