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

Beacon Health Options
1099 Winterson Road, Suite 200
Linthicum, MD 21090
Friday, June 9, 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. When counselors perform an OMS interview, how are we supposed to document and bill such interview?

2. Please explain why do you not reimburse individual office-based providers for injections of Vivitrol or long acting antipsychotics.

3. Can an individual who is receiving Medical Day services from a different provider than their PRP Day Program receive onsite PRP services?

4. Can an individual have an onsite service at a PRP Day Program, then leave the facility and have an offsite PRP service from the same provider, then return to the Day Program and have both the onsite and offsite visit count as two separate encounters in the same day? (The offsite service would not be provided by the PRP Day Program staff.)

5. **School-Based Services Identifier Edit Problems.** Since January, child providers have been waiting on an update to the 03-modifier for school-based claims on assessments. Can you provide an update on the timeline to ensure complete functionality of the 03-modifer?

6. **Supported Employment Modifier.** Beacon has been working on changes to correct problems with the supported employment modifier. This issue is sporadic; sometimes H2026-21 and S9445-52 have the modifiers stripped. There is never a remark code indicating it is has been stripped, the modifier just disappears. In the case of H2026-21 the services are paid at the lower H2026 rate. For S9445-52 the service gets denied without the modifier since we are not authorized for S9445. Providers are usually able to reprocess claims in ProviderConnect, but a technology fix is needed. Please provide an update of the work and timeline to anticipated completion.

7. **Telehealth/RCS Modifier.** Provider has submitted claims with both the -GT modifier for telehealth AND the -HE modifier for RCS professional services. The -HE modifiers were removed by Beacon's system during claims processing. Some of the claims were paid and one was denied for no authorization. Normally RCS professional services do not require a separate OMS authorization, but without the -HE modifier the Beacon system denies for no auth. To be clear for these claims the RCS location is the originating site and our OMHC is the distant site. It could be it was not correct to bill these with the -HE, but if so it would be great to see some explicit guidance on this. Also, providers would prefer to see a denial for something like this rather than BHO altering the claim and paying for a different procedure code/modifier. Issue has been previously raised with Beacon, but problem is not yet fixed. Please provide an anticipated timeline for correcting this problem.

8. **RCS Professional Services.** While we are on the subject of RCS professional services, providers report that theirs are paid at old rates. Any clinic procedure code with the -HE and the -22 modifiers should pay at the same rate as the non-HE version, but this has not been happening. If rate is supposed to be different, it

should be separately listed on the reimbursement schedule so providers can know what the correct rate is. Please clarify the correct rate for RCS professional services and provide an anticipated timeline for correcting this problem.

9. **Z03.89 Code for No Diagnosis**. In January, Beacon implemented R-69 for diagnosis deferred and indicated that it had added Z03.89 (no diagnosis to auth side) and was adding it to the billing side. Can you provider a timeline on when providers will be able to use the Z03.89 code?

10. **Fee Schedule Errors.** Provider is awaiting resolution of pending fee schedule errors for bed days and assessments, crisis. Please provide an anticipated timeline for correcting this problem.

11. **NPI Issue Westminster Location.** Provider continues to have all claims denied and would like update and timeline to resolution.

12. **Retractions More Than Six Months Old.** Beacon indicated that providers should not be seeing retractions more than 6 months old, but several providers have reported recently having retractions from past fiscal years. In March 2017, Cornerstone experienced retractions of $3141.96 for services in Fall 2014 and early 2015. Will Beacon waive timely filing and reprocess impacted claims? If so, when?

13. **Case Rates in New Authorization Structure.** Case rates are designed to be one unit per month. The new authorization structure for the DLA-20 deviates from this, and it is resulting in billing denials in the consumer's second month of service. In addition, Beacon is now authorizing 7 units and 7 months, instead of the six-month authorization period. If Beacon allowed overlapping authorizations, or if it would overwrite the authorization, these problems could be solved. Please indicate what solutions have been identified to correct these problems and an anticipated timeline to correct them.
    - Example: client starts today, 5/16.
    - Authorization given is 5/16 – 6/14 for 1 unit
    - Encounters are not supposed to split months (i.e. – you can't have May and June encounters grouped together in one case rate)
    - Provider bills May encounters toward this first authorization
    - Provider submits DLA before 6/14

- June encounters between June 1 and June 14 do not count toward June case rate
- A simple solution to this would be for Beacon to overlap the second authorization with the first authorization
- DLA submitted on or before 6/14
- Beacon writes second authorization as 6/1 – 10/31, which allows us to include the encounters that occurred in the beginning of the month.
- Beacon is not currently doing this and the result is a billing denial

14. **Workplan and Reducing Disruptions.** Providers are concerned with growing difficulties in claims processing with Beacon, with new technology changes implemented before pending issues have been fully resolved. Several issues raised today have been pending for six months or more, and CBH members collectively have nearly a million outstanding in claims due to the various problems identified above. Can Beacon, BHA and DHMH provide a workplan at monthly meetings that summarizes the status and pending work log for changes so that providers understand the status, workload and progress toward resolution for the many outstanding corrections that need to take place?

15. For ASAM Level 3.3 and 3.5 - What are the minimum duties of the physician/CRNP? Of the psychiatrist or CRNP psych? Of the recovery coach? What are the minimum hour requirements per week for the recovery coach?

16. For ASAM Level 3.3 and 3.5 - Originally we heard authorizations would take 14 days to get for new clients, now we are hearing 3 days. Which is accurate?

17. ASAM level III.5 is a more intensive level of care than III.3, yet the staffing requirements are less. Why is this?

Questions received concerning the new Residential Program will be addressed via FAQs from the Department.