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

Beacon Health Options
1099 Winterson Road, Suite 200
Linthicum, MD 21090
Friday, July 14, 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. In the June 30, 2017 FAQ, question #4, you replied that audits will require demonstration of competence in delivering the EBP attested to. Documenting staff ECUs is clear, but can you provide examples of what you mean by fidelity measurements of EBP implementation?

2. Regarding the March provider alert where the approval time frame increased to up to 14 days before an initial or concurrent PRP auth is approved by a Beacon clinical care manager. The concern is that waiting to start providing services until Beacon officially approves a client is a long lapse in time. There is a conflict

because we either wait to start services up to 14+ days later which poses a huge concern for our clients who are coming from the hospital or are in crisis and are in need of services sooner rather than later…or…we start services prior to official approval yet run the risk of the auth being denied, then must make referrals and transition the client which is good clinical practice…yet we will not be reimbursed for services already provided. How is it good clinical practice to provisionally provide services without knowing if the auth will be approved/denied? If the 30 day auths remain in pending status for up to 14 days (half of the time of the entire auth span), how can we be expected to confidently complete our documentation/orientation with the client, that includes the face to face assessment and IRP? Beacon isn't truly allowing for 30 days to complete these services as the COMAR regs state we are allowed to have. Related to #2 above, the auth date approval for the 30 day auths are not certain dates (such as the concurrent auths), some care managers are approving with less than a 30 day span and because the date range is adjusted, we cannot be sure what the span will be…which again related to our documentation requirements?

3. Will Beacon Health Options pay for Recovery Coaches that screen patients for substance abuse disorder when in the Hospital Emergency Room (rate regulated space)?

4. **Provider Communications.** It took Beacon several days to communicate with providers about EDI system errors that occurred on June 28 and 29, with providers not getting responses to their inquiries until up to 10 days later. As a result of this lack of communication, multiple providers left voicemail messages or emails with Beacon that went unreturned, often while providers are experimenting with test files to see if it's a problem on their end that needs to be corrected. Prompt communications with providers about system issues can spare both Beacon and providers a great deal of wasted time and resources. What steps can be taken to ensure that Beacon meets its contractual obligation to "have sufficient provider relations staff to respond to provider inquiries within one business day"?

5. **Correcting Errors in the Beacon/State's NPI Technology and Workflow.** Providers continue to experience problems with random dropping of NPI numbers. In some cases, it appears that the Medicaid file has overwritten Beacon's file. At other times, the Medicaid file is correct yet Beacon's system retains the outdated address. When NPIs are erroneously overwritten, multiple providers reported that it takes four months to get it corrected. Providers are not confident that the technology and human workflow for the assignment of NPIs is

working correctly between Medicaid and Beacon. What efforts have been taken at a systemic level by Beacon/Medicaid to examine the NPI issue and determine whether any technology or workflow corrections are needed?

6. **Clarifying School-Based Policy and Aligning Codes.** In October, a change to the Provider Manual indicated that school-based services were limited to assessment and individual & group therapy. BHA and Beacon subsequently clarified that all CPT codes paid in OMHC office settings were supposed to be paid in school settings. However, this correction has not been fully enacted: The provider manual section for school-based services has not been corrected, and it still states erroneously that school-based services are only assessment and individual & group therapy. When will this be corrected to reflect the stated BHA/Beacon policy of covering all OMHC services? The school-based 03-modifier does not work for treatment plans. When will this be corrected? The school-based 03-modifier does not work for crisis services (90839 and 90840). When will this be corrected? The school-based 03-modifier does not work for the discharge OMS code (90889). When will this be corrected?

7. **Sporadic Stripping of 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. What steps has Beacon taken to work with providers to identify this problem? When will it be fixed?

8. **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. What steps has Beacon taken to work with providers to identify this problem? When will it be fixed?

9. **-HE and -22 Modifiers and Fee Schedule Problems.** A provider reports fee schedule problems with RCS professional services. Any clinic procedure code with the -HE and the -22 modifiers should pay at the same rate as the non-HE version, but the provider reports that their services are paid at the 2013 rate. Can you clarify what the correct fee for these codes should be?

10. **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. We understand that BHA is considering an initial authorization for 2 months or the remainder of the current month plus the entire next month in order to line up with the case rate structure. Can you confirm this and describe the proposed modification? Can you make the change retroactive?

11. **Telehealth/Prescriber Evaluation.** The GT modifier is not loaded on the code 90792 (prescriber evaluation). Can you clarify if the GT-modifier will be included for prescriber evaluations? If so, by what date?

12. **PRP Authorizations**. In the last month, a provider who has a valid authorization for PRP services has had denial because there was no auth for onsite services. Has there been a policy change in the authorization process for PRP services?

13. **DLA-20 Tab Problems**. A provider reports that the DLA-20 tab doesn't show up in for a U2 auth request. Is this an oversight? A hospital-based PRP program reports that about 15 individuals (not youths or former youth) do not have DLA-20 tabs. Services are voided for lack of DLA-20. How can this be corrected and what work-around can be found until a technology correction is in place?

14. **Guest Dosing.** In mid-May, Beacon implemented a transient guest dosing code (W9520). Our only member using this code reports that all claims have denied, with unclear error messages. Has Beacon paid any transient guest dosing codes since implementation? With whom should the provider speak for help in identifying and resolving the issue?

15. **Modifiers for SUD 99211-99215.** A Type 50 SUD provider is trying to provide MAT services by employing a Data Waiver 2000 certified doctor. The provider alert containing the updated fee schedule has HG modifiers required to bill for ongoing services but there are no modifiers for induction (initial intake). How can we see and bill for new clients?

16. We have some differing opinions/ interpretations on whether ASAM Levels 3.3 and/or 3.5 allow for work therapy/work release while in treatment. I am wondering what Beacon/Medicaid's policy is. Are clients in ASAM Level 3.3 or 3.5 permitted to work while in treatment and still have Medicaid pay for their treatment?

17. I think the best way to ask my question is to give a theoretical example for a client: Client John Doe enters treatment at our program, ASAM Level 3.3 on June 18 under grant funds. Grant funds expired June 30 and he was approved for Medicaid to fund Level 3.3 treatment for 30 days starting July 1. Since Level 3.3,

under grant funding, did not require him to have a medical evaluation at the time of his intake on June 18, it was not done. Medicaid requires an initial medical evaluation on Medicaid-funded clients, but at the point Medicaid began paying for his treatment, he had been in ASAM Level 3.3 for 12 days. Does John Doe need a medical evaluation now to comply with Medicaid requirements?

18. Under provider type 54 there are two separate billing codes. If a patient is hospitalized and not physically sleeping at our program for multiple days, can we still bill for the room and board since the bed is being reserved for this patient?