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

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

In attendance:

Telephonically:

Topics & Discussion

Minutes

BHA Update

Medicaid Update

- **AHS**

Beacon Health Options Update

Provider Questions

1. For Child and Adolescent PRP Providers there has been discussion around the lag time that is taking place with the approval of authorizations. I know some providers are even reporting more frequent denials. My concern is that with the delayed approval kids are sometimes experiencing a delay in services for 2 weeks or more. These kids have intense needs and we are trying to avoid things like hospitalizations so for them to go 2 weeks without their PRP worker coming out is a problem. As a provider we are uneasy about seeing kids without an approval especially given the increased denials that other providers are reporting. What can be done to address these concerns?

2. If an OTP patient attends 2 groups in a single day, we are submitting the claim using the H0005 and 2 units. We are having these 2 units H0005 claims denied with the BS denial code indicating that the billed amount exceeds fee schedule rate. Are we only able to be reimbursed for 1 group per day per client?

3. My question has to do with State Care Coordination. When moving Residential services to Beacon was in the planning stages; there was some talk about how State Care Coordinators were going to get notified when an individual from their jurisdiction was admitted to Levels 3.7/ 3.7WM. We are now a month into the transition to Beacon and our County has not gotten any notification that we have anyone in those levels of care. Our Care Coordinators have been calling the local facilities weekly to check for admissions, but my fear is we are missing folks. Has there been any determination how the Care Coordinators are being notified and when will it start? Can the Care Coordinators get a list of all the approved Providers who are offering Levels 3.7/ 3.7WM, 3.3 through Beacon Health Options?

4. **Aligning Fee Schedule with CPT Codes**. In January 2017, the AMA made changes to the CPT psychiatry code section. Codes 90846 and 90847 (Family Therapy with and without client) had changes to time components. The codes now have a time of 50 minutes. According to time guidelines, the AMA and CMS have instituted mid-point timeframes for billing. The minimum time for 90846 and 90847 is 26 minutes (in other words, the mid-point threshold is passed). For these 50 minute codes, no services can be billed under 26 minutes. A modifier is not appropriate. Per the new Beacon rate sheet, 90847-52 modifier shows an "abbreviated" session for a C&A client, 90847 is listed for 45-60 minutes (adult and C&A). Beacon has not recognized this change. Will it do so? If so, when?

5. **Clarifying Provider Alert**. A recent provider alert (dated Aug 4) modifies the authorization span in response to provider concerns, effective for new clients. For existing clients, will a review and modification of authorizations take place? For example, the provider may only bill for services in six of the seven months covered by the authorization span. Can the span be adjusted to end on 11/30/2017, or can a third line be adding approving an additional unit for December 2017?

6. **Clarifying Provider Alert.** A recent provider alert indicated that, effective June 15, 2017, all pre-authorizations are approved for physician's services for 90 days, rather 60 days. Does this include the physician anti-psychotic drug pre-authorization requirement for all youth under 18?

7. **Clarifying Provider Alert.** From a Provider Alert 7-2010, Family Psychotherapy without client present (90846) for NON-OMS consumers (Children under 5, usually being served in Head Start programs), are limited to 4 per year, and additional may be requested. What is the definition of a year in this context – calendar year, treatment authorization year, or treatment authorization period? Providers have received conflicting guidance and would appreciate clarification.

8. **270/271 Eligibility Verification File Exchange Capacity**. Several CBH members have recently developed the capacity to do 270/271 file exchange, which allows for eligibility verification for multiple consumers. Providers have received conflicting guidance on whether Beacon's system currently has capacity to do 270/271 file exchanges. Does it? If not, is such capacity under development and, if so, by what date do you anticipate having it?

9. **Multiple Modifier Capacity**. In recent months, we have raised two issues with claims not paying correctly with multiple modifiers (i.e., using -GT and -HE modifiers on RCS services, and using -HE and -22 modifiers on RCS services). It is our understanding that these problems occur because Beacon's system does not support using multiple modifiers on one code. Is that correct? If so, that raises a host of questions about how policies – such as the proposed expansion of Medicaid telehealth services – can be correctly operationalized. If multiple modifiers cannot be used, what steps are planned to correct this, and with what anticipated timeframe?

10. **Processing Authorizations for Outpatient Services.** In March 2017, Beacon issued a Provider Alert indicating that the deadline for responding to non-urgent authorization requests would be expanded to 15 days. At the time, Beacon indicated that it didn't intend to take longer to process routine authorization requests but, where insufficient information was submitted, Beacon would have time to request more information, rather than deny an authorization request.

11. **Inconsistent Slowdown.** Since about mid-July, 11 providers reported a slowdown in processing some authorization requests. Providers report that some authorizations are approved in 2-3 days, while others pend for up to 15 days prior to being approved. Can you clarify what providers should expect for processing a routine, outpatient authorization request that contains sufficient information?

12. **Backdating Authorizations for Disappearing DLA-20 Tabs.** Last month, we reported a single-provider issue about not being able to access DLA-20 tabs; that issue has been resolved. However, this month, another provider reports a similar problem; Upper Bay indicates that the DLA-20 tab disappears when they're doing authorizations. They had previously gotten this problem resolved, and now it's broken again. This has been brought to Beacon, which is working on fixing it again. For providers impacted by DLA-20 functionality problems, can authorizations be back-dated?

13. **Modifiers for SUD 99211-99215.** (This was asked at July meeting and may be moot if resolved in July minutes.) Three CBH members seek clarification about billing for Type 50 providers. The July question related to a Type 50 SUD 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?

14. When requesting authorization (Concurrent) for Methadone Maintenance using Methadone OMS it states we should receive 2 weeks to complete the OMS and 30 units, this to cover the first 4 weeks. After the initial Concurrent we are to receive 6 months Methadone Maintenance visits and 160 units. However that is not how Provider Connect is now authorization units, which results in a mass amount of claim denials. Why is the service split, (one line for methadone maintenance and a separate line for substance use disorder services? Why does the date span not match? Per your claims department because of the way it is listed via Provider Connect to split up the dates and list specific services they are now reading as if we have no authorization for these services. I have over 40 claims now that have denied. Is there any update on this issue?