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

Beacon Health Options
1099 Winterson Road, Suite 200
Linthicum, MD 21090
Friday, May 13, 2016
10:00 am to 11:30 am

In attendance: Daryl Plevy, Stephanie Clark, Karl Steinkraus, Donna Shipp, Page Morris, Helen Lann, Guy Reese, Kayla Moulden, Sueqethea Jones, Patricia Langston, Ty Queen, Bryce Hudak, Craig Lippens, Deana Krizam, Edgar Wiggins, Andre Delegrini, Jenny Howes, Annie Coble, Shannon Hall, Shanzet Jones, Mary Viggiani, Christina Trenton, Oleg Tarkovsky, Steve Johnson, Rebecca Frechard, Kathleen Rebbert-Franklin, Barbara Trovinger

Telephonically: Abby Appelbaum, Dawn Beckett, Cathy Baker, Robert Bartlett, Imelda Berry- Candelario, Kimberly Bittinger, Mary Brassard, Abigail Brooks, Greg Burkhardt, Carroll Canipe, Karen Carloni, Jan Caughlan, Jamie Cole, Kim Erskine, Cheryl Forster, Cindy Henderson, Lillie Hinkelman, J.R. Hughes, Connie Hutson, William K. Jamison, Wendy Kanely, Victoria Karakcheyeva, Donna Layman, Jody Levison-Johnson, Nicole McCleaf, Robin McCrea, Doris McDonald, Sean McDonald, Anna McGee, Carrie Medlin, Catherine Meyers, Rhonda Moreland, Eugene Morris, Stephanie Oliver, Jarrell Pipkin, Tina Raynor, Susan Richardson, Tim Santoni, Rich Schiffauer, Chalarra Sessoms, Lindsey Smith, Christie Sterling, Fran Stouffer, Teresa Tawes, Lavina Thompson Bowling, Tabetha Berg, Tonya Pleasant, Wendi Rolf, Wendy Shirk, Kevin Watkins, Susan Wilkoff

Topics & Discussion

Minutes – Review for Approval

- For individuals that have any suggestions or edits for the minutes, you can send all questions or concerns to MarylandProviderRelations@beaconhealthoptions.com

BHA Update

CCBHC Update:

- Daryl Plevy provided a brief overview of the CCHBC grant for any providers that are unfamiliar with this planning grant. She further explained that the state has run into design challenges due to Maryland being a fee-for-service state, and they are still working through the billing complexities. The state will continue to complete all requirements, such as stakeholder reporting and providing updates, as they work through these challenges and make final decisions to determine if they will continue to pursue this grant.
- Daryl informed providers that two provider alerts have gone out recently in reference to the transfer of grant funds to the ASO. These alerts were found to have errors. These alerts are being redrafted and should be coming out shortly. They will contain an accurate list of the early adopter counties, as well as information regarding state support for all counties as they transfer to fee-for-service both in July of this year and January of 2017.
- She further informed providers that another alert should be coming out that will provide guidance on eligible services for Medicare and private insurance consumers. Individuals that fall below the 250% poverty level are eligible to go through the uninsured workflow. Individuals that are above the 250% mark should go through the local jurisdictions and ask for an exception. The local jurisdictions will work to make these exceptions and collect the necessary data to better assist the state in analyzing which exception are appropriate and make adjustments as time goes on.
- As these services move under the ASO, it is important to note that there is no desire to move anyone out of treatment and that this is only a change in how you obtain treatment approval.
- Kathy Rebbert-Franklin provided an update on the accreditation process, announcing that the regs should be published today. On May 23rd, the accreditation regulations will be effective and providers can visit the BHA website to download a PDF version. (Note, the effective date was subsequently changed to July 1, 2016). Providers are encouraged to read through the regulations, the FAQ's and the crosswalks that are available to help navigate through this process. BHA is also creating a user-friendly timeline to better assist providers.

Medicaid Update

- Rebecca Frechard announced that there will be a Provider Alert coming out for PRP, Mobile Treatment and ACT providers on the upcoming trainings on the DLA-20. The training will focus on the assessment tool and providers are encouraged to save the date. Trainings will begin in June and, while other trainings will be offered, providers are encouraged to sign-up and attend the June trainings.
- Medicaid has extended the re-bundling comments period to Monday, May 16th and providers are reminded that it is still an informal process. Even though it is informal, Medicaid would like the comments in writing so that they can evaluate and analyze the questions and determine the appropriate next step.

- Medicaid requested that if providers would like specific updates, please submit inquiries prior to provider council and every effort will be made to tailor these monthly updates to provider inquiries.

Beacon Health Options Update

- Karl Steinkraus informed providers that there will be a series of lunch and learn webinars, hosted by Beacon, coming soon. More details on topics and dates will be announced shortly.

Questions

Provider Questions:

1.) Regarding the R-69 code that we can use when we screen someone and they do not meet criteria to be admitted to SUD services, what are the criteria to bill for this code and what does the code pay?

Karl Steinkraus stated that the R-69 code is the ICD-10 equivalent to the 799.9 ICD-9 code. Providers may use the R69 as the primary diagnosis for their assessment of mental health or SUD services when the provider has not yet been able to identify the consumer's current condition. After the initial review of the consumer, providers are expected to have an appropriate diagnosis code to process claims. Beacon has had issues with setting up the R-69 code in our system. We are finalizing the code and will be reprocessing claims internally so that providers do not need to resubmit to obtain payment.

2.) It is related to authorizations in provider connect and possibility of having two auths at different providers offices. We had a new client who was active with Beacon MA. We obtained an initial auth prior to the client's assessment. However, the claim was denied as a duplicate, which we later found out was because the client also had an assessment at another facility on the same day and Beacon paid the other facility because they billed first. I know this would not be very common for a client to be seen for the same service at two facilities in the same day, and I am not even sure why the client did that, but question is more related to why we were both able to obtain the authorization. It is my understanding that even if a provider has an open auth, a client can terminate that auth in order for another provider to obtain an auth, but I am pretty sure in this case the client was not involved in the auth process at all. When we called, the claims person told us that there were currently two auths that were active and that the provider connect system allowed for that. Is this supposed to be allowed or is this a problem with the provider connect system? Please provide clarity on the protocol for having two of the same types of auths open at once at different providers. Thank you.

Donna Shipp informed providers that the ProviderConnect system allows for an OMS, a non-OMS and a med management authorization to be entered electronically. If a consumer has another request that is at the same level of service, the system will block the authorization. The second provider would need to call Customer Service. Customer Service will create and route a request to the Clinical Department for a manual review. If the request is deemed clinically appropriate, it can be approved without closing the existing authorizations. If the consumer wants to terminate their relationship with the other provider(s) that too is done through Customer Service. Providers should note that they are able to submit authorizations electronically and via phone.

3.) **You sent out an alert about retroactive authorizations stating that they would not be backdated. When we were first trained back in January 2015, we were told that for Outpatient OMS they would backdate 30 days. I believe on the call someone may have mentioned that it was still ok to backdate for OMS, but it was not clear. Is that still the case for OMS only? The provider alert makes it sound like it applies to all levels of care. Please clarify if it applies to OMS and if that was changed, what the reasoning was for that change.**

Page Morris clarified for providers that the 29-day window is for OMS and is designed to allow providers to complete the questionnaire that assesses their consumers and enter that data into the ProviderConnect system. For concurrent reviews, providers have 100 days from the end date to enter their information. Providers should make note that claims do not pay unless there is an authorization on file.

4.) **The R69 code was mentioned in the meeting and I understand the system had technical difficulties, but I just wanted to clarify that if we complete an assessment and do not yet have a diagnosis for the client, we can select the R69 code for the auth in Beacon and it will pay the claim? Or is this a code that needs to go on the claim as the diagnosis? Please clarify the practicality of using this code.**

Please see question 1 for full answer.

5.) **In addition to the Evaluation and Management (E/M) codes for established patients (99211-99215), the DHMH fee schedule for mental health services includes E/M codes for new patients (99201-99205). For those patients who meet the definition of "new" as set forth in the AMA's CPT manual, can a physician bill both the psychiatric evaluation code (90792) and whichever is the most appropriate E/M code for such patients?**

Page Morris stated that no, a physician cannot bill both. A psychiatrist must use an add-on code for any psychotherapy services. Providers have a choice for an initial evaluation of doing a full psychiatric diagnostic evaluation or a new patient evaluation. Attempts to

bill both codes or billing a higher level of E/M code than necessary, can be viewed as up coding and are reviewed during audit.

6.) **Does Beacon reimburse for interns and residents who treat patients in outpatient substance abuse programs and/or outpatient mental health centers? I am specifically interested in social work, psychology and addiction counselor interns. Also, the residents are 4th year and have licenses. If so, what are the supervision requirements? For example, does the provider have to be in the room the entire time that the trainee is seeing the patient?**

Page Morris informed providers that there are regulations that govern who is allowed to bill and under what circumstances and licensures. Beacon recommends that providers consult with COMAR and the appropriate licensing board to get the specific answers on licensure level and supervision requirements.

7.) **For the clinician to clinician authorization calls, how does Beacon define a clinician? What clinical licenses are required?**

Helen Lann stated that for inpatient level of care, the standard for a peer-to-peer review is with the attending physician. For other levels of care, the importance is that Beacon speaks with the individual that knows the consumer the best and will be able to supply the necessary clinical information. There is no rigidity on this being a physician but if there are issues related to medical care where a doctor is needed, Beacon would make this request known to the provider.

Webinar Questions:

1) **Why aren't Inpatient facilities allowed some type of "grace period" in obtaining Beacon authorizations for care? Mentally ill patients cannot provide accurate insurance info in EDs.**

COMAR regulations state that you have 24 hours to submit your authorization for inpatient admissions.

2) **If a client sees 2 different mental health providers (ex. psychiatrist and psychologist) on the same day and Beacon denies one of the services, can we bill the client for the denied service?**

No, you may not bill a Maryland Medicaid consumer for denied services. If providers have questions about the number and types of services that can be administered on the same day, they can view the combination of services document on the Beacon website at http://maryland.beaconhealthoptions.com/ or email provider relations at Marylandproviderrelations@beaconhealthoptions.com.

3) **Is the authorization for R-69 covered under the initial 12? What is the reimbursement rate for R-69?**

R69 is covered under the initial 12, but this diagnosis code should not be used more than two visits as providers should be assessing and diagnosing appropriately.

4) **Do non-Mobile treatment teams need to follow the CARF ACT standards?**

BHA requested that providers send questions on accreditation in writing through the website at http://bha.dhmh.maryland.gov/Pages/Regulations.aspx. This will allow BHA to appropriately research each question and provide an accurate and helpful answer.

5) **How did Donna get to the section of the website about multiple services?**

A direct link this site can be found at: http://maryland.beaconhealthoptions.com/provider/prv_info.html. Providers should look under Clinical/Utilization Management, Combination of Service Rules (Effective 01-01-15)

6) **After the initial OMS do we still have 100 days to back date a concurrent auth?**

Please note that the OMS window is not back-dating. This is a window designed to allow providers to properly assess and complete the additional data entry portion of the OMS authorization. For concurrent review, OMS providers do have a 100 day window to enter this data.