CT Medical Assistance Program (CMAP) - Independent Practice & Licensed Behavioral Health Clinicians Training

Updated February 2023

Today's Goals

At the end of this training, participants will have a better understanding of:

- Who is eligible to seek reimbursement through HUSKY Health or CT Medical Assistance Program (CMAP), CT's Medicaid program
- What are the reimbursement and covered services rules
- Why billing errors happen, and how to prevent billing 'hot spots'
- How to have a successful connection with CMAP

Training Scope

This presentation is applicable to the following entities participating in CMAP:

Independent Behavioral Health Clinicians and Group Practices:
Clinical Social Worker (LCSW)
Alcohol and Drug Counselor (LADC)
Marriage and Family Therapist (LMFT)
Professional Counselor (LPC)
Psychologist (Ph.D and Psy.D)

Who Is Eligible For CMAP Reimbursement?

Only licensed behavioral health clinicians (licensed to practice independently) and are the following:

- Licensed Alcohol and Drug Counselor
- Licensed Marital & Family Therapist
- Licensed Clinical Social Worker
- Licensed Professional Counselor
- Licensed Psychologist

Important Note: A "Licensed Behavioral Health Clinician" does **NOT** include a Licensed Masters Social Worker (LMSW).

Services Rendered By An Associate Licensed Behavioral Health Clinician Working In Private Practice Under The Supervision Of An Applicable Qualified Independent Licensed Clinician

- Effective for dates of service October 1, 2022, associate licensed behavioral health clinician's working within such associate clinician's scope of practice may perform BH services under the supervision of a Licensed Behavioral Health Clinician.
- Please reference **Provider Bulletin 2022-67** which can be downloaded from the www.ctdssmap.com Web site. From the home page click on Information then publications. Select 22 from the Year dropdown list and enter 67 in the number field and click on search

Associate Licensed Behavioral Health Clinician

- Licensed Master Social Workers (LMSWs) – LMSWs may be supervised by physicians, advanced practice registered nurses (APRNs), licensed psychologists, licensed marital and family therapists (LMFTs), licensed clinical social workers (LCSWs), and licensed professional counselors (LPCs) – Conn Gen. Stat. § 20-195m.
- Licensed Marital and Family Therapy Associates (LMFT-As) – LMFT-As must be supervised by an LMFT – Conn. Gen. Stat. 20-195a.
- Licensed Professional Counselor Associates (LPC-As) – LPCAs may be supervised by an LPC, psychiatrist (only board-certified psychiatrists, not other physicians), psychiatric APRN (only an ARPN certified as a psychiatric and mental health clinical nurse specialist or nurse practitioner by the American Nurses Credentialing Center), licensed psychologist, LMFT, or LCSW – Conn. Gen. Stat. 20-195aa.

Reimbursement Rules

In order to seek reimbursement for behavioral assessments and treatment services, all behavioral health clinicians must be enrolled and adhere to all applicable state and federal requirements, including those set forth in the fee schedule, and provider bulletins and policy transmittals.

Federal Requirements are set forth in:

1) The CMAP Provider Agreement
2) The Requirements for Payment of Services Provided by Licensed Behavioral Health Clinicians in Independent Practice or The Requirements for Payment of Psychologists' Services
3) All Policy Transmittals and Provider Bulletins

Provider Rules And Regulations

Where do I find the Medicaid rules and regulations applicable to my provider type and specialty?

- https://www.ctdssmap.com
  - This site contains all resources pertaining to billing, reimbursement, enrollment, and provider bulletins for all provider types.
- http://www.ctbhp.com
  - This site contains resources on services and supports specific to behavioral health providers of the Connecticut Behavioral Health Partnership (CT BHP).

Provider Assistance Information

Gainwell Technologies Provider Assistance Center:

1-800-842-8440

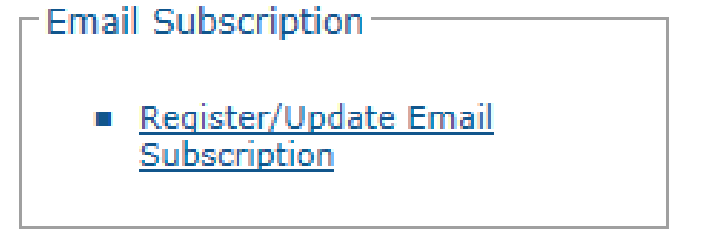
For questions on:

- client & provider eligibility
- claim submission procedures
- claims processing issues
- provider enrollment

The Provider Assistance Center is the provider's source for information not provided on the Web portal or from the Automated Voice Response System (AVRS).

Provider Information Cont.

Listserv-email updates on the ctdssmap.com, homepage:

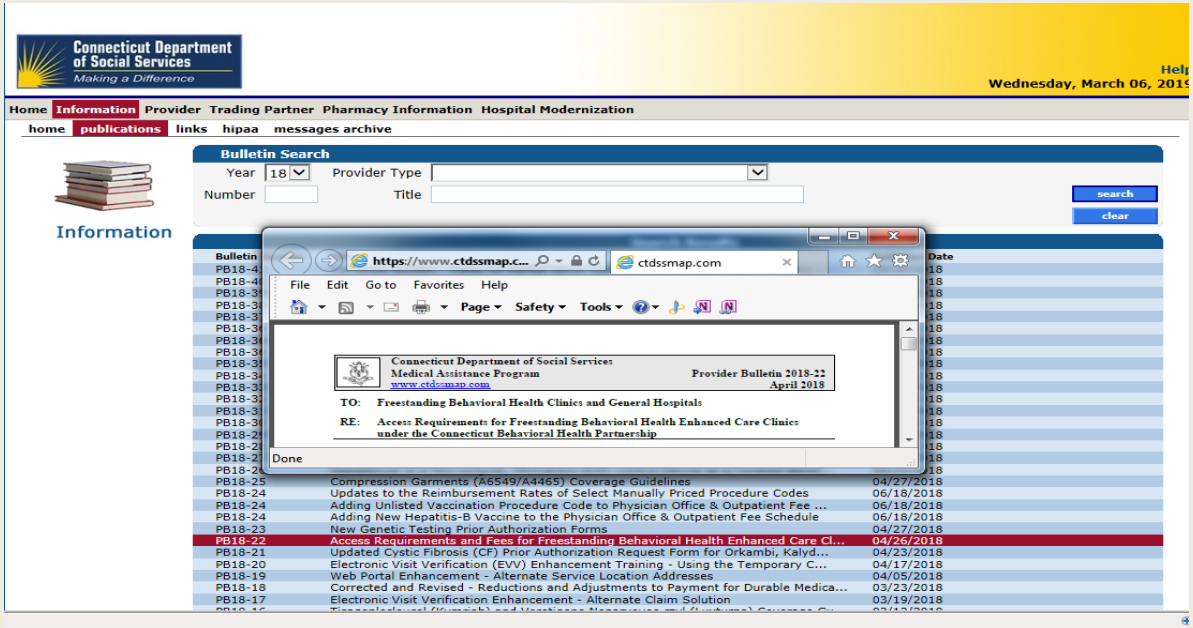


Gainwell Technologies Provider Trainings:

https://www.ctdssmap.com/CTPortal/portals/0/StaticContent/Publications/Provider_Training.pdf

Provider Information Cont.

Provider Publication or Provider Bulletins:



[Publications (ctdssmap.com)]

Registration/Authorization

- Carelon Behavioral Health (formerly known as Beacon Health Options) is the Department's ASO responsible for processing registration and authorizations for Behavioral Health services
- Services that require registration or authorization are noted at www.ctbhp.com, Providers, and selecting Covered Services
- The Department's fee schedule on ctdssmap will indicate services requiring authorization
- Authorization/registration does not guarantee payment.

For Prior Authorization/Registration information, providers can speak to a customer service representative directly by calling **1-877-552-8247.**

Services Covered

DSS will only pay for a behavioral health clinician's or psychologist's services that are:

1. Provided by an CMAP enrolled individual who has met all applicable licensing requirements, and
2. Within the licensed provider's scope of practice as defined in chapters 376b, 383, 383a, 383b, or 383c of the Connecticut General Statutes, and necessary to treat the member's condition, and
3. Accurately and completely documented in a medical record

Service Limitations & Non-covered Services

The Department may disallow and recover any payments that exceed service limitations or are for non-covered services, such as:

- Only 1 diagnostic interview (90791) per calendar year, per licensed behavioral health clinician, per client
- Only 1 unit of of the same service per member per day per provider
  - **For example, the same clinician cannot bill for two individual psychotherapy sessions for the same member on the same day**

Service Limitations & Non-covered Services

- Only 1 unit of family psychotherapy (90846,90847) per client, per day
- Only 1 unit group psychotherapy (90853) per client, per day
- Family and multiple-family group shall be reimbursable for one identified family member client per session, without regard to the number of family members in attendance
- Cancelled office visits or appointments not kept are non-covered services

Service Limitations & Non-covered Services Cont.

- Evaluations, diagnostic interviews, and therapy services performed in hospital inpatient or outpatient setting are non-covered services
- Services that are not properly documented in a medical record

For a complete list of service limitations and non-covered services, see the **Regulations of CT State Agencies, sections 17b-262-912-17b262-925**, the fee schedule, provider bulletins and policy transmittals

Documentation

If the service isn't documented then it is treated as if it didn't happen.

- DSS may disallow and recover any amounts to the provider for which the required is not maintained and provided to the department upon request.

Documentation Requirements- treatment Plans

Treatment Plans:

The Department will reimburse for covered services only in accordance with the treatment plan

- The provider must establish a treatment plan for each member based on the initial diagnostic evaluation before commencing treatment
- The treatment plan must be specific to each member in care
- The treatment plan shall be regularly updated in accordance with the member's progress as necessary and at least every 6 months

Documentation Requirements Treatment Plans

Treatment plans are a written individualized plan that contain, at minimum:

- Specific treatment modalities, amount, frequency, and duration of services to be provided
- Measurable goals and objectives developed in collaboration with the client after evaluation, in order to improve the client's condition
- Signed by the licensed behavioral health clinician

Documentation Requirements Progress Notes

Progress notes:

- Should follow one of the recognized note formats (e.g. SOAP)
- Must contain the type(s) of service or modalities
- Must align with the billing code used on the claim
- Must always include the date, location, the start and stop times of the service
- Must be signed and dated by the enrolled provider delivering the service claimed
- Should be readily understood by a third party entity

Documentation Requirements Progress Notes

Why Medical Records?

CT State Regulations 19a-14-40 (Public Health Code)

https://portal.ct.gov/DPH/Public-Health-Hearing-Office/Regulations/Public-Health-Code-Medical-Records-Regulations

A medical record provides:

- Documentation of actions taken in patient management;
- Documentation of patient progress; and
- Meaningful medical information to other practitioners should the patient transfer to a new provider or should the provider be unavailable for some reason

Documentation Requirements Progress Notes

CT State Regulation 19a-14-40 (continued)

A medical record shall include, but not be limited to:

- Information sufficient to justify any diagnosis and treatment rendered, dates of treatment, actions taken by non-licensed persons when ordered or authorized by the provider;
- Doctors' orders, nurses notes and charts, birth certificate work-sheets, and any other diagnostic data or documents specified in the rules and regulations; and
- All entries must be signed by the person responsible for them

Documentation Requirements Progress Notes

Who must maintain medical records?

CT State Regulation 19a-14-41

"Each person licensed or certified pursuant to the following chapters and Acts shall maintain appropriate medical records of the assessment, diagnosis, and course of treatment provided each patient, and such medical records shall be kept for the period prescribed: chapters 334b, 370 thru 373, 375, 376, 378 thru 381, 383 thru 384, 388, 398, 399, and Public Acts 83-352 and 83-441."

Documentation Requirements Progress Notes

CMAP Provider Bulletin 2018-11

Effective March 1, 2018, DSS implemented a thirty (30) day maximum time limit for the timely completion and authentication of medical records.

- However, if any other policy, statute, regulation, or requirement is more stringent than the guidance provided in the bulletin, that rule remains in effect and supersedes the bulletin.
- Authentication of the medical record includes a handwritten or electronic signature and date by the performing clinician operating within that individual's applicable scope of practice.

Documentation Requirements Progress Notes

CMAP Provider Bulletin 2018-11 (continued)

- A claim should not be submitted for reimbursement until the documentation in the medical record is completed.
- Failure to complete the medical record within thirty (30) days of the date of service may result in financial adjustments based upon post payment review of claims.

BILLING HOT SPOTS

Enrollment – Rendering Provider Not Licensed/Enrolled

Claim was paid for a service provided by a rendering provider who was **NOT**:

- Enrolled in the CMAP, or
- A licensed behavioral health clinician that can practice independently or psychologist on the date the service was performed.

Example: A group practice claims services provided by a "licensed eligible" individual, intern, by utilizing the NPI of an enrolled licensed behavioral health clinician.

Enrollment – Rendering Provider Not Licensed/Enrolled (Continued)

Individual and Group Enrolled Provider

Individually enrolled providers and group billing providers may only claim services that are provided directly by him/herself or provided by an associate licensed practitioner as stated in Provider Bulletin 2022-67 Guidance for Services Rendered by an Associate Licensed Behavioral Health Clinician Working in Private Practice Under the Supervision of an Applicable Qualified Independent Licensed Clinician

Lack Of Documentation

The documentation in the medical record does not support the procedure code billed.

The provider shall document the treatment intervention and progress with respect to the member's goals as identified in the treatment plan. This documentation must support the procedure code billed.

Example: provider bills 90834 (psychotherapy for 30 min) and the progress notes says "saw client today and he is doing much better".

Lack of Documentation

Claim was paid for a time-based procedure code; however, the provider did not document the length of the encounter.

- The progress note must include the start and stop times corresponding with the procedure code billed.
- The times documented are the actual times of the service provided and not the scheduled appointment times.

Example: Procedure code 90837-Psychotherapy, 60 minutes with patient. The clients record must include a start & stop time that documents the therapy provided was at least 53 minutes in duration.

Time Based Procedure Codes

Time Based Procedure Codes*

- Time is face to face time with the patient (unless the procedure code description states otherwise).
- A unit of time is attained when the mid-point is passed.
- When codes are ranked in sequential typical times and the actual time is between two typical times , the code with the typical time closest to the actual time is used.

*Per CPT 2018 Professional Edition

Time Based Procedure Codes

Psychotherapy

In reporting individual psychotherapy, choose the code closest to the actual time:

Procedure Code	Time Required
90832-30 minutes w/patient	16-37 minutes
90834-45 minutes w/patient	38-52 minutes
90837-60 minutes w/patient	53 or more minutes

Do not report psychotherapy of less than 16 minutes in duration.

Time Based Procedure Codes

Other Psychotherapy

DSS Regulations require a minimum session time of 45 minutes for the following procedure codes:

- 90846-Family therapy, w/o patient present, 50 min
- 90847-Family therapy, w/patient, 50 min
- 90849-Multiple-family group psychotherapy
- 90853-Group psychotherapy

Billing Multiple Procedure Codes For The Same Service

Billing two distinct procedure codes for the same service.

- If a session includes a combination of individual and family psychotherapy, the provider shall bill for the modality that comprises the greater part of the session.
- The provider shall not bill for both individual and family therapy for the same date of service unless each modality individually meets the minimum time requirements.

Billing For Multiple Family Members Same Service

Billing multiple family members for a family psychotherapy session on the same date of service.

Example: On July 9th, mother, father and daughter attend a family psychotherapy session.

The provider may bill for only one identified family member client per session, without regard to the number of family members in attendance or the presence of behavioral health conditions among other family members in attendance.

Billing For Multiple Units Of 90791- Psych Diagnostic Eval.

Billing multiple units of procedure code 90791- psychiatric diagnostic evaluation (aka diagnostic interview examination) for an examination that the provider takes two or more days to complete.

The reimbursement for procedure code 90791 represents one (1) unit of service. The provider shall bill for only one unit of service for 90791 regardless of the number of days it takes to complete.

Billing For Services Provided In A Nursing Facility

Billing for behavioral health clinician services provided in a skilled nursing facility and not utilizing the appropriate place of service code.

Eff. 10/1/2014, claims for behavioral health services provided in a skilled nursing facility (POS 31) or nursing facility (POS 32) must be designated on the claim form, as these service are reimbursed at a different rate.

Billing For Services In A Hospital Setting

Billing for behavioral health clinician services performed in a hospital inpatient.

Example: Provider sees their patient at Hartford Hospital and bills DSS for a therapy session. This is a non-covered service. This also includes service provided over the phone.

Billing For Non-covered Services

The provider billed for and received payment for non-covered services, such as:

- a cancelled or “no show” visit,
- information or services provided to the client electronically or over the phone.

Please note: Providers may not bill DSS clients for these non-covered services.

Please see Page 5 of the Provider Agreement for more information. [Get-Download-File (ctdssmap.com)]

Electronic Medical Records

The Provider was paid for a service where the supporting medical record did not comply with the requirements of the DSS Electronic Signature Policy.

Providers who maintain an electronic health records and/or utilize electronic signatures must sign and comply with DSS' Electronic Signature Policy.

Electronic Medical Records

- The Electronic Signature Policy Compliance document can be completed on-line during the enrollment and re-enrollment process.
- In between enrollments, the provider may fax the completed document to Gainwell Technologies at 1-877-899-5401. This must be accompanied by an explanation of the submission on company letterhead.
- The Electronic Signature Policy Compliance document may be found here: Get-Download-File (ctdssmap.com), or by visiting www.ctdssmap.com, Information, Publications, scroll to Provider Enrollment/Maintenance Forms, and selecting the Provider Enrollment Application. Section K contains the Electronic Signature Policy Compliance document.

Patient Record-cloning Documentation

Documentation for services rendered are identical or similar to other service entries/progress notes due to copying/pasting.

These type of entries in the patient's medical record lay question to the authenticity of the record and does not reflect updated clinical information.

<u>The Appropriate Procedure:</u> Documentation in the medical record is specific to the patient and his/her situation at the time of service.

DSS Audits

DSS Audits
Objective of an Audit

DSS conducts audits of all provider types for the purpose of determining whether:

- Services were rendered to an eligible recipient
- Claims properly reflect the services rendered
- Original documentation was maintained to accurately document evidence the services was provided
- Claims were submitted in accordance with Department policies, regulations, provider manuals and bulletins

Payment Errors-Summary

- Payment for duplicate items
- Payment for non-covered services
- Payment that should have been paid by a third party
- Data entry errors
- Lack of documentation
- Insufficient documentation
- Number of unit errors
- Policy violations
- Administrative errors

ClaimAdjustments

Providers should incorporate a compliance plan as part of their business practices, which includes:

- Adjusting paid claims that are either overpaid or underpaid
- Adjusting claims when information on a paid claim is incorrect ie; client ID, NPI, date of service

Adjustments should not be made to claims that are part of an open audit

Steps to Success

Provider Check List

DSS suggests providers carefully review the following prior to providing services:

- ❑ Your DPH license requirements and limitations
- ❑ Your license's Scope of Practice
- ❑ Applicable DSS/Medicaid regulations
- ❑ Applicable DSS/Medicaid fee schedule
- ❑ DSS/Medicaid Provider Enrollment Agreement
- ❑ Applicable DSS issued Policy Transmittals and Provider Bulletins

Enforcement

The Interagency Team

Administrative (DSS)

- Audits
- Payment Suspension (42 C.F.R. § 455.23)
- CMAP Suspension or Termination

Criminal

- **Federal**
  - Health Care Fraud (18 U.S. Code § 1347)
  - Up to 10 years imprisonment
  - Fines
- **State**
  - Health Insurance Fraud (Conn. Gen. Stat. § 53-441, *et seq.*)
  - Larceny (Conn. Gen. Stat. §§ 53a-122 to 53a-125b)
  - Up to 5 years imprisonment

Civil

- Federal False Claims Act (31 U.S. Code § 3729, *et seq.*)
- Connecticut False Claims Act (Conn. Gen. Stat. § 4-274, *et seq.*)
- Liability under both the Federal and State False Claims Acts:
  - Treble damages (e.g. 3 times the amount of damages)
  - Civil penalties ($5,500 - $11,000 per violation)
  - Costs of investigation and prosecution

Resources

Important DSS Resources

- **CMAP Website – Audit Protocols**
  https://portal.ct.gov/DSS/Quality-Assurance/Audit-Protocols

- **DSS Map www.ctdssmap.com**
  - Provider Manuals (Enrollment & Re-enrollment, policy, claim submission instructions)
  - Bulletins (searchable by provider type)

Important Regulation Resources

- **State of CT Statute**
  www.cga.ct.gov/lco/statutes.asp
- **State of CT Regulations**
  https://eregulations.ct.gov/eRegsPortal/
- **DSS Office of Quality Assurance**
  https://portal.ct.gov/DSS/Quality-Assurance/The-Office-of-Quality-Assurance

Important Contacts

Gainwell Technologies – Provider Assistance Center
1-800-842-8440

- Support for:
  - Provider enrollment and reenrollment
  - Member eligibility
  - Claims processing
  - Electronic claims submission

Carelon Behavioral Health
1-877-552-8247 or CTBHP@carelon.com

- Support for:
  - Clinical operations
  - Quality management
  - Covered services
  - Registration of services
  - Provider trainings