Behavioral Health Professional Refresher Workshop

Presented by
The Department of Social Services & HP
Training Topics

- Provider Bulletins
- Provider Fee Schedule
- Policy Changes
- Web Claim Inquiry
- Web Claim Submission
- Third Party Liability (TPL)
- Dual Eligible / Medicare Prime
- Frequent Claim Denials
- ICD-10
- Time for Questions
Provider Bulletins

Provider Bulletins

- Access the Publications page via our Web site www.ctdssmap.com and select “Publications” from either the Information box on the left hand side of the home page or from the “Information” drop-down menu.

- The Bulletin Search menu allows you to search for specific bulletins (by year, number, or title) as well as for all bulletins relevant to your provider type.
  - When searching by title, you can search by any word as long as that word is in the title of the bulletin.

- Searches by year and number are based on the Provider Bulletin number, not the policy transmittal number.
Provider Bulletins

Provider bulletin search by Year “14” and Number “29” to pull up a specific bulletin.

- Provider bulletins numbers are located on the actual document.

Connecticut Department of Social Services
Medical Assistance Program
www.ctdssmap.com

TO: All Providers
RE: Newly Eligible Clients under the Affordable Care Act (Part III)
Provider Bulletins

Provider bulletin search by Year “14” and Provider Type “Behavioral Health Clinician” to pull up all the bulletins for 2014 pertaining to Behavioral Health Clinicians and Psychologists.
Provider Bulletins

Provider Bulletin 2014-02 “Psychologist Fee Schedule Update”

• Effective for dates of service January 1, 2014 and forward, the Department of Social Services added Current Procedural Terminology (CPT) code 96116 to the psychologist fee schedule.

• Prior authorization is not required.

• To view the fee schedule, from the Web site www.ctdssmap.com go to “Provider”, then to “Provider Fee Schedule Download”, click on “I Accept” scroll to Psychologist and click on the PDF link.
Fee Schedule

• Prior authorization requirements and list of covered services and fee can be accessed under the fee schedule on the Web site at www.ctdssmap.com.

• Prior Authorization (PA) from the Connecticut Behavioral Health Partnership is required for these services.

• You can also refer to the Web site www.ctbhp.com for PA guidelines under “For Providers” and select covered services.

  ➢ Under Authorization Schedule select your provider type based on Independent – Group Practitioners.
    • Independent-Group Practitioners – PhD, PsyD
    • Independent-Group Practitioners – LCSW, LMFT, LPC, LADC
## Fee Schedule

- Psychologists fee schedule at [www.ctdssmap.com](http://www.ctdssmap.com)
Fee Schedule

- From www.ctbhp.com Web site, select “For Providers”, then “Covered Services” then click on the link for CT BHP Proposed Fees/Rates.
Fee Schedule

• Behavioral Health Clinicians fee schedules

• Accessing Behavioral Health Clinicians fee schedule:
  - From the Web site www.ctdssmap.com go to “Provider”, then to “Provider Fee Schedule Download”, click on “I Accept” scroll to Behavioral Health Clinicians and click on the PDF link.

• Behavioral health clinicians can only bill for those services that are on their fee schedule and which they personally provide.
### Fee Schedule

- Behavioral Health Clinicians fee schedules

<table>
<thead>
<tr>
<th>Procedure Description</th>
<th>Mod1</th>
<th>Rate Type</th>
<th>Max Fee</th>
<th>Effective Start Date</th>
<th>End Date</th>
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<td>90785 PSYTX COMPLEX INTERACTIVE</td>
<td>DEF</td>
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<td>Max Fee</td>
<td>5.29</td>
<td>1/1/2012</td>
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<tr>
<td>99407 BEHAV CHNG SMOKING &gt; 10 M</td>
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<td>Max Fee</td>
<td>14.46</td>
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<td>10.5</td>
<td>1/1/2012</td>
<td>12/31/2299</td>
<td>Y</td>
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</tbody>
</table>

Please contact Value Options at 1-877-552-8247 for all prior authorizations.
Policy Change


- Effective July 1, 2014, behavioral health assessment and treatment services provided by the following independent practitioners will be reimbursable for all HUSKY Health clients, regardless of the age of the client:
  - Licensed Psychologists
  - Licensed Clinical Social Workers (LCSWs)
  - Licensed Marital and Family Therapists (LMFTs)
  - Licensed Professional Counselors (LPCs)
  - Licensed Alcohol and Drug Counselors (LADCs)
Policy Change


• The policy change expands coverage for the HUSKY C and HUSKY D populations, who were previously able to obtain services from these independently practicing professionals only up to age 21.

• Targeted case management for children with a behavioral health disorder who are transitioning from an institutional setting, billed using CPT code T1016, remains available only for individuals under age 19.
Policy Change

Developmental and Behavioral Health Screens (CPT 96110)

- Please note while the Department encourages behavioral health clinicians, behavioral health clinics, psychiatrists and psychiatric APRNs to utilize the U3 and U4 modifiers, as applicable, use of the modifiers is not a requirement for claims submission and CPT code 96110 will not deny if U3 or U4 is not submitted.

- Modifier U3 should be used with CPT code 96110 when a developmental or BH screen results in a positive screen. Positive screens are defined based on the scoring criteria for the specific screening tool used.
Policy Change

Developmental and Behavioral Health Screens (CPT 96110)

• Modifier U4 should be used with CPT code 96110 when a developmental or BH screen results in a negative screen. Negative screens are defined based on the scoring criteria for the specific screening tool used.

• The Department is implementing the use of modifiers U3 and U4 with CPT code 96110 in an effort to not only track the number of HUSKY Health members under the age of 18 who receive a developmental or BH screen in primary care settings, but to also track the number of positive versus negative screens and, when appropriate, subsequent referral for additional assessment or follow-up care.
Web Claim Inquiry

• At the claims menu select claims inquiry to view claims processed regardless of the submission method.

• Search by:
  - Internal Control Number (ICN)
  - Client ID and date of service (no greater range than 93 days)
  - Date of payment (no greater range than 93 days)
  - Pending claims
# Web Claim Submission

Claim submission – Professional (Cont.)

## Diag-Sequence Table

<table>
<thead>
<tr>
<th>Code Set</th>
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</tr>
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<tbody>
<tr>
<td>Principal</td>
<td>[ Search ]</td>
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<tr>
<td>Other 1</td>
<td>[ Search ]</td>
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<tr>
<td>Other 2</td>
<td>[ Search ]</td>
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<tr>
<td>Other 3</td>
<td>[ Search ]</td>
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<td>Other 4</td>
<td>[ Search ]</td>
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<td>[ Search ]</td>
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<tr>
<td>Other 7</td>
<td>[ Search ]</td>
</tr>
<tr>
<td>Other 8</td>
<td>[ Search ]</td>
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</table>

## Detail Table

<table>
<thead>
<tr>
<th>Item</th>
<th>From DOS</th>
<th>To DOS</th>
<th>Procedure</th>
<th>Units</th>
<th>Charges</th>
<th>Status</th>
<th>Allowed Amount</th>
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<td>1</td>
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<td>1.00</td>
<td>$0.00</td>
<td></td>
<td>$0.00</td>
</tr>
</tbody>
</table>

- **Status**
  - Emergency Indicator: No
  - Pregnancy: Not pregnancy Related
  - EPSDT Referral: None
  - Family Planning: No

- **Allowed Amount**
  - $0.00

- **Medicare**
  - Medicare Paid Amount: $0.00
  - Medicare Deductible Amount: $0.00
  - Medicare Coinsurance Amount: $0.00
Web Claim Submission

- Provider must bill using modifiers identified in Provider Bulletin 2005-79 on all claims for all client coverage groups.

<table>
<thead>
<tr>
<th>Provider Type / Specialty</th>
<th>Modifier</th>
</tr>
</thead>
<tbody>
<tr>
<td>License Clinical Social Worker (LCSW)</td>
<td>AJ</td>
</tr>
<tr>
<td>Licensed Marital and Family Therapists (LFMT)</td>
<td>HO</td>
</tr>
<tr>
<td>Licensed Professional Counselors (LPC)</td>
<td>HO</td>
</tr>
<tr>
<td>Licensed Alcohol and Drug Counselors (LADC)</td>
<td>HO</td>
</tr>
<tr>
<td>Psychologists</td>
<td>N/A</td>
</tr>
</tbody>
</table>
Web Claim Submission - TPL

- Medicaid is the Payer of last resort. The three digit Carrier Code of the Other Insurance (OI) is required to be submitted on the claim when OI is primary.
  - The three digit code can be found on the client eligibility verification screen under TPL.
  - It can also be found on the claim submission screen under the TPL panel in the “Client Carriers” field.

- Other Insurance billing guides are located Web site www.ctdssmap.com; under publications, scroll to provider manual chapter 11 and select “Professional Other Insurance/Medicare Billing Guide”.
Web Claim Submission - TPL

- TPL payment of $100.00 from carrier code 060 with a paid date of 07/01/2014.
Dual Eligible / Medicare Prime

• Dual Eligible is when a client is eligible for Medicare and Medicaid. Medicaid is always the payer of last resort and claims must be submitted to Medicare first for Medicare eligible services.

• Medicare refers to traditional Medicare and Medicare HMOs.

• As of July 1, 2014 behavioral health clinicians claims will now be considered for reimbursement even if the behavioral health clinician cannot enroll in Medicare.

• If Medicare is prime and makes a payment we will pay co-insurance and/or deductible up to your Medicaid rate. If Medicare’s payment is greater than or equal to your Medicaid rate, Medicaid will pay zero.
Web Claim Submission – Medicare Payment

• To indicate a Medicare payment, the Medicare Crossover field on the Professional Claim panel must indicate Yes.

• Each claim detail must contain the following:
  ➢ Medicare Paid Date
  ➢ Medicare Calculated Allowed Amount
  ➢ Medicare Paid Amount
    • If Medicare allows services, but pays zero enter $0.00
  ➢ Medicare Deductible Amount
  ➢ Medicare Coinsurance Amount
Web Claim Submission – Medicare Payment

The image shows a section of a website page with a form for professional claim submission. The form includes fields for patient information, charges, and payment details. The Medicare Crossover checkbox is marked as Yes.

The screenshot is from CT interChange MMIS.
Web Claim Submission – Medicare Payment
Dual Eligible / Medicare Prime

• If Medicare does not cover services due to the fact that behavioral health clinicians cannot enroll in Medicare, Medicaid will still consider your claim for processing.

• If the provider cannot get a denial Explanation of Medicare Benefits (EOMB), the provider should receive a letter from Medicare/CMS stating they are not eligible to enroll in Medicare and letter must be dated within one year from the date of service on the claim.

• To request this letter, providers must submit a request in writing to National Government Services (NGS) at PO Box 7052, Indianapolis, Indiana 46207-7052.
Dual Eligible / Medicare Prime

• In lieu of the Medicare ‘Not Eligible To Enroll’ denial letters for behavioral health clinicians providers requested through NGS, providers may submit a copy of the list of suppliers not eligible to participate in Medicare as valid Medicare denial documentation.

• The list is documented in the Medicare Provider Integrity Manual, Publication # 100-8, under Chapter 15, Section 15.4.8 which is located on the CMS Web site, http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/pim83c15.pdf.

  ➢ A copy of this page must be stored in the client’s file for audit purposes and does not need to be submitted with the claim to HP.
Web claim submission – Medicare Denial

• To indicate a Medicare denial, the Medicare Crossover field on the Professional Claim panel must indicate No.

• The TPL panel must contain the following:
  ➢ Enter MPB for Medicare Part B in the Carrier Code field.
  ➢ Zero should remain in the Paid Amount field.
  ➢ In the Paid Date field enter one of the following:
    • Enter the Medicare denial date.
    • Date of the Medicare letter.
    • The print date of the Medicare CMS Web page documenting the list of provider not eligible.
# Web claim submission – Medicare Denial

## Professional Claim

<table>
<thead>
<tr>
<th>Field</th>
<th>Value</th>
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<tbody>
<tr>
<td>ICN</td>
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<tr>
<td>Provider ID</td>
<td>008000008 MCD</td>
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<tr>
<td>AVRS ID</td>
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<td>Client ID*</td>
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<tr>
<td>Last Name</td>
<td></td>
</tr>
<tr>
<td>First Name, MI</td>
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</tr>
<tr>
<td>Date of Birth</td>
<td></td>
</tr>
<tr>
<td>Patient Account #</td>
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<tr>
<td>Medical Record Number</td>
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<td>Referring Physician</td>
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<td>Accident Related</td>
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<td>To Date</td>
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<td>Medicare Crossover</td>
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Medicare Crossover is indicated as "No".
## Web claim submission – Medicare Denial

<table>
<thead>
<tr>
<th>Carrier Code</th>
<th>Plan Name</th>
<th>Policy Number</th>
<th>Paid Amount</th>
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Adjustment Reason Code

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[Image of the web claim submission interface]
Most Frequent Claim Denials

- **EOB 4801** “Procedure not covered. Check: Prior Authorization, FTC, Referring Provider, Quantity Restrictions.”

  - **Cause**
    - The procedure billed is not permitted to be paid to the billing provider on the date of service.

  - **Resolution**
    - If the procedure billed is not a covered procedure on the provider's fee schedule for the date of service, the service is not payable.
    - If the procedure billed is present on the provider's fee schedule, contact the Provider Assistance Center to request an update to the procedure code in question.
Most Frequent Claim Denials

- **EOB 4140** “The Services Submitted are not Covered Under the Client’s Benefit Plan” and **EOB 4250** “No Reimbursement Rule for the Associated Provider Type/Provider Specialty.”

- The provider should verify client eligibility to determine if services are covered for their provider type and specialty.

- If the services are covered under client’s benefit plan, client eligibility could have been updated at some point.
  - Providers should re-submit the claim for processing.
  - If the claim still denies, the provider will need to contact the Provider Assistance Center (PAC) to review the claim.
ICD-10

ICD-10 Changes Delayed

• On April 1, 2014, the Protecting Access to Medicare Act of 2014 (PAMA) (Pub. L. No. 113-93) was enacted, which said that the Secretary may not adopt ICD-10 prior to October 1, 2015. Accordingly, the U.S. Department of Health and Human Services expects to release an interim final rule in the near future that will include a new compliance date that would require the use of ICD-10 beginning October 1, 2015. The rule will also require HIPAA covered entities to continue to use ICD-9 through September 30, 2015.

• DSM diagnosis codes will not be accepted for dates of services on or after October 1, 2015. All providers must use ICD-10 codes on their claims.
ICD-10

ICD-10 Consists of Two Parts:

- ICD-10-CM: The clinical modification diagnosis classification system was developed by the World Health Organization (WHO) and the National Center for Healthcare Statistics (NCHS) for use in all U.S. health care treatment settings. (The CM codes increase from 13,000 to 68,000-plus in the ICD-10-CM code set.)

- ICD-10 codes must be used on all HIPAA transactions professional claims with dates of service (DOS) on or after the ICD-10 implementation date.

- On October 1, 2015 the ICD-9 code set used to report medical diagnosis will be replaced by ICD-10 code sets.
ICD-10

ICD-10 Changes Delayed

- The transition to ICD-10 is required for all providers, payers and vendors.

- Do make it a point to refer to the ICD-10 Implementation Information Important Message from the home page of our Web site www.ctdssmap.com frequently to keep abreast with the most recent ICD-10 developments.
Training Session Wrap Up

• Where to go for more information:
  ➢ www.ctdssmap.com
  ➢ www.ctbhp.com

• For questions on authorizations and the authorization processing contact:
  ➢ Value Options 1-877-552-8247

• For questions on claim and enrollment questions you can contact:
  ➢ HP Provider Assistance Center (PAC) 1-800-842-8440
  Monday through Friday, 8 a.m. to 5 p.m. (EST), excluding holidays.
Time for Questions

Questions & Answers