

Medicaid Behavioral Health Clinic/Rehabilitation Services Manual

WV DHHR Bureau for Medical Services
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Charleston, WV



Clinic/Rehab Collaboration



Over the past year, BMS, BHHF, behavioral health providers from across the state, and contractors for DHHR held collaborative workgroups in an effort to revise and update the Behavioral Health Clinic and Behavioral Health Rehabilitation Services, Chapters 502 and 503.

This collaboration was vital in the development of the manuals. Meetings were held weekly to biweekly on average and are credited for the successful revisions. A statewide training and multiple webinars will be conducted over the next few weeks along with agency-specific trainings over the next year as needed to assist providers to learn and implement the new policy. This presentation will be placed on both the BMS and APS Healthcare websites.

Clinic/Rehab Manuals



Any provider of Medicaid and/or BHHF services will be expected to have working knowledge of Chapters 502 and 503 as well as other chapters relevant to the services provided (please see Chapters 100 through 900).

www.dhhr.wv.gov/bms/pages/providermanuals.aspx

For further clarifications, you may access the BMS and APS Healthcare websites where FAQs will be posted following these trainings. APS Healthcare trainer-consultants are also available for assistance.

www.dhhr.wv.gov/bms/hcbs/pages/default.aspx

www.apshealthcare.com/publicprograms/west_virginia/West_Virginia1.htm

Introduction To The Manual



- ▶ The West Virginia Medicaid Program offers a comprehensive scope of medically necessary behavioral health services to diagnose and treat eligible members.
- ▶ Covered and authorized services must:
 - Be rendered by enrolled providers within the scope of their license, and
 - Be in accordance with all State and Federal regulations.
 - Any service, procedure, item, or situation not discussed within the manual must be presumed non-covered unless informed otherwise, in writing, by BMS.

Priority To Children In Foster Care

- ▶ Foster children must be made a priority in providing assessments and services.
- ▶ Providers should make a good faith effort to complete assessments in a timely manner as well as work with the Bureau for Children and Families (BCF) to ensure that information is shared in a timely manner with BCF, court systems, as well as other entities involved in the care and treatment process of the foster child while conforming to state and federal confidentiality requirements.

Mandated Reporting of Abuse and Neglect

- ▶ WV Code 49-6A-2 requires that professionals who suspect, witness, or learn of abuse or neglect from a credible source, report it immediately and no later than 48 hours to Child or Adult Protective Services and to Law Enforcement when appropriate.

▶ **1-800-352-6513**

Freedom Of Choice

- ▶ All Medicaid members have the right to freedom of choice when choosing a provider for treatment.
- ▶ A Medicaid member may receive one type of service from one provider and another type of service from a different provider.
 - The provider agreement requires that members be allowed the freedom to choose providers.
 - Coordination of care should occur when a Medicaid member has different Medicaid services at different sites with other providers to ensure quality of care and safety.
 - Appropriate Releases of Information should be signed in order that HIPAA Compliant Coordination of Care takes place.

Part 1

Administrative, Billing, and General Medicaid Requirements

Chapters 503.1 - 503.11, 503.26 - 503.33, 503.14

Member Eligibility

- ▶ Behavioral Health Rehabilitation and Clinic Services are available to all Medicaid members with a known or suspected behavioral health disorder.
- ▶ Each member's level of services will be determined when prior authorization for Behavioral Health Rehabilitation/Clinic Services is requested of the agency authorized by BMS to perform administrative review.
- ▶ The Prior Authorization process is explained in Section 503.29 of the Rehab manual and 502.26.2 of the Clinic Manual.

Medical Necessity

- ▶ All Behavioral Health Rehabilitation Services covered in the Clinic and Rehabilitation Manuals are subject to a determination of medical necessity.
- ▶ Medical Necessity must be demonstrated throughout the provision of services.

- ▶ Services and supplies that are:
 - (1) **appropriate** and **necessary** for the symptoms, diagnosis or treatment of an illness;
 - (2) provided for the diagnosis or **direct care** of an illness;
 - (3) within the standards of **good practice**;
 - (4) **not** primarily **for the convenience** of the plan member or provider; and
 - (5) the most **appropriate level of care** that can be safely provided.

Medical Necessity

- ▶ The following five factors will be included as part of the determination for Medical Necessity:
 - Diagnosis (as determined by a physician or licensed psychologist)
 - Level of functioning
 - Evidence of clinical stability
 - Available support system
 - Service is the appropriate level of care

Medical Necessity

- ▶ Consideration of the five factors contributing to the determination of medical necessity in the service planning process must be documented and reevaluated at regular service plan updates.
- ▶ As stated in section 503.15.1, the provider may perform one assessment per calendar year in order to confirm medical necessity.
- ▶ Diagnostic and standardized instruments may be administered at the initial evaluation and as clinically indicated.
 - The results of these measures must be available as part of the clinical record, as documentation of the need for the service, and as justification for the level and type of service provided.

Registration

- ▶ The Bureau for Medical Services requires that providers register and/or prior authorize with the agency designated by the Bureau to perform administrative review for services that are rendered.
- ▶ Prior Authorization does not guarantee payment for services rendered.
- ▶ Sections 503.4, 503.4.1, and 503.4.2 outline Provider Enrollment requirements.

Criminal Background Checks

- ▶ All Clinic/Rehabilitation provider staff, having direct contact with members must, at a minimum, have results from a state level Fingerprint Based Background check.
 - This check must be conducted initially and again every 3 years.
 - Providers may do an on-line preliminary name based check and use these results for a period of 3 months while waiting for state and/or federal fingerprint results to be received.

- ▶ If the current or prospective employee, within the past 5 years, has lived or worked out of state or currently lives or works out of state, the agency must request an additional federal background check through the West Virginia State Police also before providing Medicaid services and every 3 years thereafter.

Non-Eligible Staff

- ▶ Abduction, violent felony, child/adult abuse or neglect, exploitation of a child or incapacitated adult, felony battery, felony arson, felony or misdemeanor crime against a child or incapacitated adult which causes harm, felony drug related offenses within the last 10 years, felony DUI within the last 10 years, hate crimes, kidnapping, murder/homicide, neglect or abuse by a caregiver, pornography, purchase or sale of a child, sexual offenses, healthcare fraud, or felony forgery.
- Please Refer to section 503.5 for a full listing of disallowed convictions.

Criminal Background Checks

- ▶ Fingerprint based background check results, other than those listed above, which may place a member at risk of personal health and safety or have evidence of a history of Medicaid fraud or abuse must be considered.
- ▶ The Clinic/Rehabilitation provider will notify the Program Manager for Behavioral Health Services as he/she becomes aware of recent convictions or changes in conviction status of an agency staff member.

Criminal Background Checks

- ▶ The Federal Office of the Inspector General List of Excluded Individuals and Entities must be checked by the provider for every agency staff who provides Medicaid services *prior to providing Medicaid services and monthly* thereafter.
- ▶ Persons on the OIG Exclusion List cannot provide Medicaid services.
- ▶ The list can be checked at <http://exclusions.oig.hhs.gov/>
- ▶ A form may be printed from this website to verify that the check occurred. Any document that has multiple staff names may be kept in a separate file and made available to staff as needed and during agency audits.

- ▶ The purpose of clinical supervision is to improve the quality of services for every member while ensuring adherence to WV Medicaid policy, therefore the provider must have a policy for Clinical Supervision including guidelines for the following:
 - The responsibilities of the supervisor
 - Credentialing requirements of the supervisor, and
 - The minimum frequency for which supervision should occur.

Clinical Supervision

- ▶ Each agency shall have a chart demonstrating clinical chain of command and responsibility.
- ▶ Each agency shall have a documented process for ensuring all staff are aware of their clinical and administrative supervision.

Clinical Supervision

- ▶ The clinical supervisor should have an equal or higher degree, credential, or clinical experience than those they supervise.
- ▶ If a clinical supervisor is responsible for a Medicaid funded program, the supervisor should be able to demonstrate familiarity with Medicaid requirements and relevant manuals.

*This applies to all Clinic/Rehabilitation services rendered.

Authorization For Services Form - Clinic



- ▶ A physician, physician extender, must certify the need for Behavioral Health Clinic Coordinated Services, by signing the “Behavior Health Clinic/Rehabilitation Services, Authorization for Services” form within 72 hours of the member’s admission to the program for services and prior to the start of treatment.

Authorization for Services Form - Rehab



- ▶ A physician, physician extender, licensed psychologist, or supervised psychologist must certify the need for Behavioral Health Rehabilitation Coordinated Services, by signing the “Behavior Health Clinic/Rehabilitation Services, Authorization for Services” form within 72 hours of the member’s admission to the program for services and prior to the start of treatment.

Authorization For Services Form



- ▶ If an Initial Service Plan is created on day of intake then a 72 Hour Authorization For Services Form is not required.
- ▶ This form, which is filled out by the provider initiating/admitting staff, authorizes the provision of all Behavioral Health Clinic/Rehabilitation Services until the development and initiation of the Initial Service Plan.
- ▶ A 72 hour Authorization is **not** required for individuals receiving only Focused Treatment Services.
- ▶ A provider **cannot** bill for Service Planning for a member in Focused Care.

Authorization For Services Form

- ▶ For members receiving Coordinated Care (Formerly High End – or services that require a formal service plan), the following is required:
 - Signed 72 Hour Authorization For Services Form, *unless* the Service Plan is created on date of intake
 - Development of the Initial Service Plan within seven days of the initial admission and intake
 - Development of the Master Service Plan within 30 days of the initial admission and intake
 - Review and re-evaluation of the service plan at a minimum every 90 days, or sooner if dictated by the member's needs.

Authorization For Services Form

- ▶ If any Behavioral Health Clinic/Rehabilitation Services occur outside the time frames of these forms which authorize services, the services provided are not billable.

Methods Of Verifying BMS Requirements

- Enrollment requirements, as well as provision of services, are subject to review by BMS and/or its contracted agents. BMS' contracted agents may promulgate and update utilization management guidelines that have been reviewed and approved by BMS. These approved guidelines function as policy.
- Additional information governing the surveillance and utilization control program may be found in *Chapter 800 (A), General Administration*, of the Provider Manual and are subject to review by state and federal auditors.

Provider Reviews

- The primary means of monitoring the quality of Clinic/Rehabilitation services is through provider reviews conducted by the Contracted Agent and OHFLAC as determined by BMS on a defined cycle.
- At a date to be determined by BMS, the Contracted agent will perform on-site and desk documentation provider reviews and face-to-face member/legal representative and staff interviews to validate documentation and address CMS quality assurance standards.

Provider Reviews

- ▶ Prior to the retrospective review all records requested must be presented to the reviewers completing the retrospective review.
- ▶ If requested, the providers must provide copies of Medicaid members' records within one business day of the request.
- ▶ Providers must facilitate the records access that is requested as well as equipment that may need to be utilized to complete the Comprehensive Retrospective Review Process.
- ▶ A point of contact must be provided by the provider throughout the Review Process.

Provider Reviews

- Face to Face Exit after the review
- Draft exit report to be completed/commented on by the provider
 - If disallowances are identified by BMS, the provider has 30 business days to send comments to the contracted agent and submit a plan of correction. Failure to meet timelines could result in a hold on claims.
- BMS reviews the draft report, plan of correction, and provider comments and issues a final report which includes:
 - Provider's overall performance
 - Details of the review
 - Any disallowances for inappropriate or undocumented billing
- If no potential disallowances are identified during the Contracted Agent review, then the Clinic/Rehabilitation Provider will receive a final letter and a final report from BMS.

First Round Targeted Disallowances

- ▶ Initial reviews will concentrate on several targeted areas:
 - Credentialing
 - CIB (fingerprint check at initial and every three years – can do name based check for 90 days while waiting on print returns)
 - OIG monthly checks
 - Degree (diploma and transcript)
 - License verification
 - Internal credentialing for services including a policy for services provided while seeking internal credentialing
 - Clinical Supervision
 - Chart demonstrating the clinical “chain of command”
 - Supervisor must have an equal degree, clinical experience, credential, or higher than the supervisee

Disallowances Continued

- ▶ 72 hour Authorization forms for Coordinated Care
- ▶ Signed Service Plans (physician, physician extender, licensed psychologist, supervised psychologist)
- ▶ Legible Records
- ▶ Documentation requirements of date, start/stop times, place of service, signature, and credentials
- ▶ Duplicate billing
- ▶ Up-Coding
- ▶ Services not permitted by Tele-health
- ▶ ACT team composition and credentials

- ▶ A cover letter to the Clinic/Rehabilitation provider's Executive Director will outline the following options to effectuate repayment:
 - 1) Payment to BMS within 60 days after BMS notifies the provider of the overpayment; or
 - 2) Placement of a lien by BMS against further payments for Medicaid reimbursements so that recovery is effectuated within 60 days after notification of the overpayment; or
 - 3) A recovery schedule of up to a 12-month period through monthly payments or the placement of a lien against future payments.

Provider Reviews

- ▶ If the provider disagrees with the final report, the provider may request a document/desk review within 30 calendar days of receipt of the final report pursuant to the procedures in *Common Chapter 800 (A), General Administration* of the West Virginia Medicaid Provider Manual.
- ▶ The provider must still complete the written repayment arrangement within 30 calendar days of receipt of the Final Report, but scheduled repayments will not begin until after the document/desk review decision. The request for a document/desk review must be in writing, signed and set forth in detail the items in contention.

- ▶ The letter must be addressed to the following:

Commissioner Bureau for Medical Services
350 Capitol Street, Room 251
Charleston, WV 25301-3706

- ▶ The Plan Of Correction must include the following:
 - 1.) How the deficient practice for the services cited in the deficiency will be corrected and what system will be put into place to prevent recurrence of the deficient practice;
 - 2.) How the provider will monitor to assure future compliance and who will be responsible for the monitoring;
 - 3.) The date the Plan of Correction will be completed; and
 - 4.) Any provider-specific training requests related to the deficiencies.

Training & Technical Assistance

- ▶ The Contracted Agent develops and conducts training for providers and other interested parties as approved by BMS as necessary to improve systemic and provider-specific quality of care and regulatory compliance.
- ▶ Training is available through both face-to-face and web-based venues.

Other Administrative Requirements

- ▶ The provider must assure implementation of BMS' policies and procedures pertaining to service planning, documentation, and case record review.
- ▶ Uniform guidelines for case record organization should be used by staff, so similar information will be found in the same place from case record to case record and can be quickly and easily accessed.
- ▶ Copies of completed release of information forms and consent forms must be filed in the case record.

Other Administrative Requirements

- ▶ Records must contain completed member identifying information.
- ▶ The member's individual plan of service must contain service goals and objectives which are derived from a comprehensive member assessment, and must stipulate the planned service activities and how they will assist in goal attainment.
- ▶ Discharge reports must be filed upon case closure.
- ▶ Records must be legible.

Other Administrative Requirements

- ▶ In addition to the documentation requirements described in chapters 502 and 503 , Behavioral Health Clinic/Rehabilitation Service providers must comply with the documentation and maintenance of records requirements described in Chapter 100, *General Information*, Chapter 300, *Provider Participation*, and Chapter 800 (A) *General Administration* of the Provider Manual.
- ▶ Documentation of the services provided must demonstrate only one staff person's time is billed for any specific activity provided to the member.

Service Limitations and Exclusions

Service limitations are governed by Chapter 100.

In addition, the following services are excluded for payment:

- ▶ Services not meeting the definition of Medical Necessity
- ▶ Telephone consultations
- ▶ Missed appointments
- ▶ Time spent in preparation of reports
- ▶ A copy of medical report when the agency paid for the original service
- ▶ Experimental services or drugs
- ▶ Methadone administration or management
- ▶ Any activity provided for the purpose of leisure or recreation
- ▶ Services rendered outside the scope of a provider's license

Rounding Units of Service

- ▶ Services covered by Medicaid are, by definition, either based on the time spent providing the service or episodic. Units of service based on an episode or event cannot be rounded.
- ▶ Many services are described as being “planned”, “structured”, or “scheduled”. If a service is planned, structured, or scheduled, this would assure that the service is billed in whole units; therefore, rounding is not appropriate.

Rounding Units of Service

The following services are eligible for rounding:

- ▶ Mental Health Service Plan Development (H0032)
- ▶ Mental Health Service Plan Development by Psychologist (H0032AH)
- ▶ Physician Coordinated Care Oversight Services (G9008)
- ▶ Case Consultation (90887)
- ▶ Comprehensive Medication Services; Mental Health (H2010)
- ▶ Crisis Intervention (H2011)
- ▶ Therapeutic Behavioral Services – Development (H2019HO)
- ▶ Therapeutic Behavioral Services – Implementation (H2019)

Rounding Units of Service

- ▶ In filing claims for Medicaid reimbursement for a service eligible for rounding, the amount of time documented in minutes must be totaled and divided by the number of minutes in a unit. The result of the division must be rounded to the nearest whole number in order to arrive at the number of billable units. After arriving at the number of billable units, the last date of service provision must be billed as the date of service. **The billing period cannot overlap calendar months. Only whole units of service may be billed.**

Prior Authorization Procedures and Requirements



- ▶ Prior authorizations are governed in Chapter 300.
- ▶ All services must be prior authorized, with the exception of Transportation Services, procedure codes A0120HE and A0160HE.
- ▶ Prior authorizations requirements will be determined by the ASO and approved by BMS.
- ▶ The ASO requirements may be found in APS's UM manuals:
- ▶ http://apshealthcare.com/publicprograms/west_virginia/documents/clinic_rehab_tcm_um_guidelines.

Billing Procedures

- ▶ Claims from providers must be submitted on the BMS designated form or electronically transmitted to the BMS fiscal agent and must include all information required by BMS to process the claim for payment.
- ▶ The amount billed to BMS must represent the provider's usual and customary charge for the services delivered.
- ▶ Claims must be accurately completed with required information.
- ▶ By signing the BMS Provider Enrollment Agreement, providers certify that all information listed on claims for reimbursement from Medicaid is true, accurate, and complete. Therefore, claims may be endorsed with computer-generated, manual, or stamped signatures.
- ▶ Claim must be filed on a timely basis, i.e., filed within 12 months from date of service, and a separate claim must be completed for each individual member. Claims which have issues that do not allow successful processing will be allowed 12 months after the initial filing of the claim to resolve those issues.

Program of Service Requirements

- ▶ Program approval from BMS is required for the following Behavioral Health Rehabilitation Services Programs and the applications can be found in the appendices:
- ▶ Day Treatment
- ▶ Assertive Community Treatment
- ▶ Comprehensive Community Supportive Services

Documentation

- ▶ The WV Bureau for Medical Services recognizes that some providers use an electronic system to create and store documentation while other providers choose to use a hard copy based system.
- ▶ When services require documentation the Bureau will accept both types of documentation.
- ▶ Each service code in this manual describes the required documentation.
- ▶ All requirements must be met no matter the modality of system choice.

Follow Up Training

As follow up to the webinars being offered on the Medicaid manual, APS trainer consultants will be available for onsite trainings, simulated reviews, and phone and email consultation regarding site specific questions.

APS Trainer Consultant Staff Available for Trainings/Simulated Reviews



Christy Gallaher	(304) 533-8862	cgallaher@apshealthcare.com
Nancy Graham	(304) 410-7829	Nancy.Graham@apshealthcare.com
Thea Johnson	(304) 859-7390	tjohnson@apshealthcare.com
Lisa Richards	(304) 575-7945	lrichards@apshealthcare.com
Susan Starkey	(304) 904-1653	sstarkey@apshealthcare.com
Gene Surber	(304) 904-0800	resurber@apshealthcare.com
Cindy Wanamaker	(304) 533-5389	Cindy.wanamaker@apshealthcare.com
Samantha Mann	(304) 964-5767	smann@apshealthcare.com
(Trainer Consultant Team Leader)		