

# Division of Behavioral Health



Covered Services

Service Authorization

Medical Assistance Billing & Payment

Post-Payment Activities (Appeals, Audits)

# Covered Behavioral Health Services

Refer to Alaska Medical Assistance Program Policies and Claim Billing Procedures Manuals

- Section I, Part B – Service Detail Sheets –
  - Service Definition/Description – from regulations
  - Service Code/Code Set Description – from national code sets
    - Current Procedural Terminology – CPT
    - Health Care Procedure Coding System – HCPCS
- Section I, Appendix I-D – Claims Billing & Payment Information
  - List of Procedure Codes & Modifiers, Adult/Child Coverage, Brief Descriptions, Unit Values, Payment Rates, Service Limits, Program Approval Categories

# Service Categories

## Screening, Clinic, Rehabilitation Services

### SCREENING

- Behavioral Health Screening (Alaska Screening Tool)
- Screening, Brief Intervention, and Referral to Treatment (SBIRT)

### CLINIC

- Professional Behavioral Health Assessments
  - Integrated Assessment
  - Mental Health Assessment
  - Psychiatric Assessment
- Psychological Testing & Evaluation
- Pharmacologic Management
- Psychotherapy Services (individual, group, family, multi-family group)
- Short-term Crisis Intervention
- Facilitation of Telemedicine

### REHABILITATION

- Client Status Review (CSR)
- Substance Use Assessment
- Short-term Crisis Stabilization
- Case Management
- Medication Administration
- Therapeutic Behavioral Health Services for Children
- Comprehensive Community Support Services for Adults
- Peer Support Services
- Recipient Support Services
- Residential Substance Use Disorder Treatment Services
- Detoxification Services
- Day Treatment Services (School-based)
- Facilitation of Telemedicine

# Coverage EXCLUSIONS & LIMITATIONS

- EXCLUSIONS

- Persons in the custody of Federal, State, or Local Law Enforcement (including juveniles in detention) Authority: 42 CFR 435.1009, 42 CFR 436.1005, 7 AAC 105.110
- Persons between age 22 and 65 who are residents of an Institution for Mental Diseases (IMD) Authority: 42 CFR 436.1005
  - IMD is a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care to patients with mental diseases
- Persons of any age who are residents of a Skilled Nursing or Intermediate Care Facility (SNF/ICF) Authority: 7 AAC 140.505, 7 AAC 140.580

- LIMITATIONS

- Persons who are inpatients of an acute care hospital or a residential psychiatric treatment center are limited to coverage of assessment and case management services for treatment planning or preparation for transition to lower level of care within 30 days of discharge from the acute care hospital

# Service Authorization

- Annual Service Limits changed from CALENDAR year to STATE FISCAL year (July 1 through June 30)
  - NEW Service Authorization request forms are available in provider manuals and via DBH and fiscal agent websites
- Requests are to be made in correlation with Client Status Review requirements
  - Requests limited to a maximum of 90 to 135 days of planned services (to be submitted approximately 3 to 4 times annually)
- Requires signature of directing clinician
- **ALL** Requests to be submitted to the fiscal agent for capture/control and entry into Medicaid Management Information System (MMIS).

# Claims Billing - General

- ALL CLAIMS MUST BE FILED WITHIN 12 MONTHS OF THE DATE SERVICES WERE PROVIDED TO THE PATIENT!
  - The 12-month timely filing limit applies to all claims, including those that must first be filed with a third party carrier.
- Ensure services are:
  - Performed as active treatment, documented in treatment plan, stated as a need in assessments, etc.
  - Performed by staff qualified
- Submit on paper form or electronically; complete required fields
  - Use Paper CMS-1500 Claim Form for Professional Services - Set B for billing behavioral health services
  - Use Electronic Claim Transaction (837-Professional)
  - Include Service Authorization number as required if services billed exceed annual service limits

# Claims Adjudication, Editing & Response

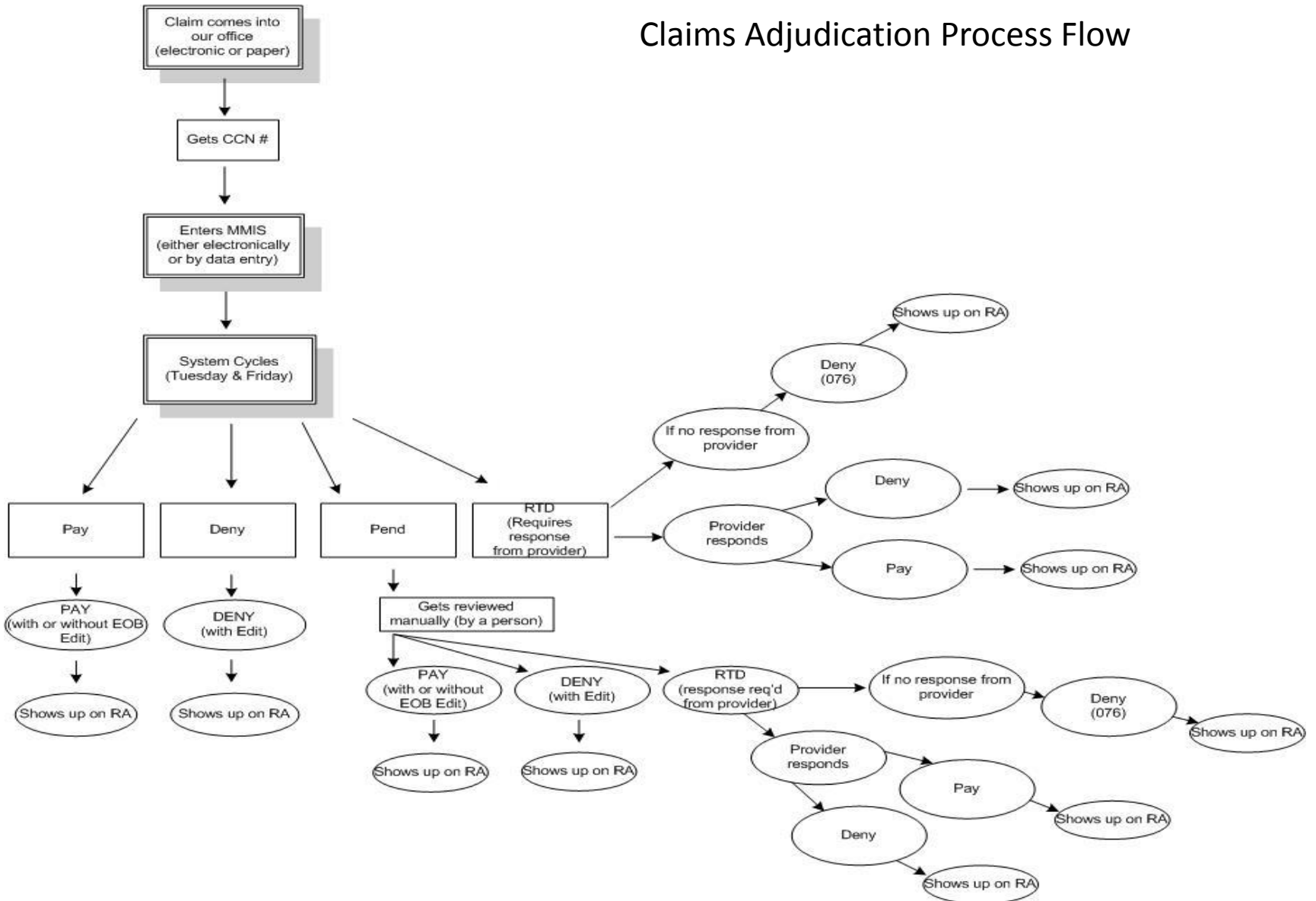
All claims submitted are processed according to program rules which will result in one of the following outcomes

- Adjudicated Claims (Paid or Denied)
  - reduction in payment
  - denial of service
- In-process claims (further internal review or information needed)
  - pending status requiring internal staff review
  - additional information requested from the provider (via RTD)

The Remittance Advice (RA) statement includes the claims processing details that include three-digit claims edit codes each with a unique explanation of how the claim was processed. These edit codes are listed on the Explanation of Benefit (EOB) description page of the RA and lists all EOB codes and a brief description of each code used within that specific Remittance Advice statement

- Contact the fiscal agent's Provider Inquiry for clarification as needed

# Claims Adjudication Process Flow





# Medical Assistance Appeals for Providers (7 AAC 105.270)

## REASONS for Providers to Request an Appeal

- Denied or reduced claims (180 days)
- Denied or reduced service authorization (180 days)
- Disputed recovery of overpayment (60 days)

## Three Levels of Appeals

- First level appeals
- Second level appeals
- Commissioner level appeals

# First Level Appeals- Fiscal Agent

Must be submitted in writing within 180 days of remittance advice for claim or other notification (service authorization decision, request for recovery of funds)

Appeal form is available in provider manual, include:

- A copy of the Claim or Disputed Authorization Decision
- A copy of the Remittance Advice Statement
- Supporting Documentation
- Completed Adjustment Request, if applicable
- Mail to

Xerox

Provider Services Unit

P. O. Box 240808

Anchorage, AK 99524-0808

# Second Level Appeals - DBH

- Must be submitted in writing to Division of Behavioral Health within 60 days of First Level Appeal Decision
- Include
  - Reason for Appeal including a description of the issue or decision being appealed
  - Copy of decision from First Level Appeal
  - Copy of denial or payment notice (Remittance Advice)
  - Copy of Original Claim
  - All information and materials for consideration

# Commissioner Level Appeals

- ONLY used to challenge/appeal adverse timely filing denials/reductions
- Must be submitted in writing to the DHSS Commissioner within 60 days of Second Level Appeal decision
- Include clear description of the reason for appeal (the issue or decision being appealed)

## Recommended Keys to Achieve Success in Billing/Payment

- Read and maintain your billing manual
- Verify recipient eligibility
- Verify eligibility code
- Verify dates of eligibility
- Verify Third Party Liability
- Verify the services you are eligible to provide
- Verify procedure codes
- Obtain Service Authorization, if applicable
- File your license renewals and/or certification/permits timely (keep your enrollment current)
- Ensure completion of claim forms (reference provider manual)
- Document Third Party Liability payment on claim, if applicable
- Include attachments as required
- FILE TIMELY
- RECONCILE PAYMENTS (Remittance Advice (RA) Statements)
- Read and distribute RA messages
- Address problems/issues promptly
- Call Provider Inquiry with questions

# Alaska Medical Assistance Regulations

## Request for Records

At the request of a DHSS representative or authorized federal, or other representative, including an employee of the Department of Law, **a provider shall provide records**, including financial, clinical, and other records, that relate to the provision of goods or services on behalf of a recipient:

- To the person making the request at the address specified in the request
- No later than the deadline specified in the request
- Without charge and in the format stated in the request

### **7 AAC 105.240 – Request for records**

# Audits

- Federal Audits
  - Department of Health and Human Services (DHHS)
    - Office of Inspector General
      - Maintain provider exclusion lists
      - Offer Provider Compliance Training videos/podcasts at <http://go.usa.gov>
    - Department of Justice
    - U. S. Government Accountability Office (GAO)
- State Audits
  - Department of Health and Social Services (DHSS)
  - Department of Law
  - Legislative Audits
- Fiscal Audits

# Previous Audit Findings

- No client signature on treatment plan
- No treatment plan reviews to cover dates of service
- No documentation to match billed services
- Progress notes do not match service billed
- Duplicates of notes for the same service on a different day
- Units billed and documented do not match notes
- Duration of service is not supported by content of note
- No treatment plan
- Insufficient documentation to support units of service billed
- Wrong service code submitted
- Agency forms that contained check boxes contained boxes that were unchecked and the missing information was not supported by a narrative explanation elsewhere in the note