

## 2019 IMC Mid-Adopter Rapid Response Call Questions Tracker

#	Topic	Region/ Provider	Question	HCA/MCO/BH-ASO Response
1	SERI Guide	Spokane	Are all Managed Care Organizations (MCOs) MCOs set up to accept codes that comply with the 7/31/2018 SERI guide?	Yes, all MCOs are set up to accept codes from the latest SERI guide.
2	SERI Guide/Fee Schedules	Greater Columbia  (Yakima Valley Farm Workers Clinic (YVFWC))	<ol style="list-style-type: none"> <li>1. What is the difference between Specialized Mental Health and Mental Health Fee Schedules? YVFWC BHS has always been considered a Specialty Mental Health (MH) Service.</li> <li>2. CPT codes in the current SERI that we use now are not on the 2019 Specialized MH Fee Schedule. Are we supposed to use the Fee Schedule or the SERI? We opted to continue with the SERI until 7/1/19. Some of the codes we use that are not on the Specialty Mental Health Fee Schedule are 90785, H2021 and H0032 (the last two are used by WISE).</li> <li>3. YVFWC is an FQHC so we have to take into consideration the FQHC, MH and substance use disorder (SUD) billing claims submission. Since we have been instructed to follow Health Care Authority (HCA) billing guides when submitting claims to the MCOs, do</li> </ol>	<p>1. The Mental Health Fee Schedule is for those services rendered as part of the physical benefits. These services are covered by all the MCOs and HCA's fee-for-service program. An eligible provider must be licensed by DOH. It is a limited set of services that does not include: inpatient, residential SUD, wrap around services or all the other services covered by the BHO. In the past we would have said these services are for people who do not meet the BHO access to care standards. The Specialized Mental Health fee schedule is applicable to those individuals <b>who are not assigned to a BHO, BHSO or BHASO for their BH services</b>. However, these clients do receive the more comprehensive BH services (comparable to the services a BHO used to provide when the access to care standards were met)) through a new HCA fee-for-service program with very specific rules as to who it services and who can provide services under it. Eligible providers bill ProviderOne directly for payment. A provider must be eligible meet the criteria as described on page 99 of the MH PG at this link: <a href="https://www.hca.wa.gov/assets/billers-and-providers/mental-health-svc-bi-20190101.pdf">https://www.hca.wa.gov/assets/billers-and-providers/mental-health-svc-bi-20190101.pdf</a> An FQHC does not meet the criteria on this page and therefore, cannot provide or be paid for services as described in this specific section of the guide. Neither of these fee schedules is going to be a reliable place for an IMC BHA provider, who renders higher acuity services,</p>

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			<p>we submit claims using the TG modifier and specified taxonomies?</p>	<p>to look for assistance in what is covered or how or how much will be paid. The BH code set used for IMC is in the SERI, each MCO should work with their providers to assist them in knowing how to bill for the SERI services AND not reference the MH guides or fee schedules.</p> <p>2. Use the SERI to bill services you are delivering as a licensed BHA. There is no application of the Specialized MH Fee schedule to any service rendered under the BHA umbrella, including WISE services, rendered in the IMC regions. Please use the SERI and follow the instructions about which codes are considered a WISE service with the U8 modifier. Bill this to the MCO in the IMC regions.</p> <p>3. An FQHC may be providing both level of BH services: lower acuity as a physical benefit and higher acuity as a comprehensive BH benefit. As stated previously, use the SERI guide for coding assistance when you are licensed as a BHA and rendering what is generally considered a higher level acuity service. If you are rendering a lower level of service, the basic MH fee schedule may be helpful to you. For both level of service, use the FQHC provider taxonomy of 261QF0400X for the billing provider level taxonomy. The FQHC program manager is determining if any further specific data is required and when that decision is made we will share it with the providers and the plans.</p>
3	<b>SERI Guide/Fee Schedules</b>	Spokane	The H0038 CPT code is not on the HCA MH Fee Schedule but it is on the	The Specialized MH fee schedule and Provider guide and the SERI support two different BH programs

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		(Spokane Addiction Recovery Centers (SPARC))	<p>Specialized MH Fee Schedule. The SERI shows a number of possible modifiers but the Specialized Fee Schedule shows only a TG modifier.</p> <ol style="list-style-type: none"> <li>1. Can this code be billed WITHOUT the TG modifier?</li> <li>2. Would the rate from the Specialized Fee Schedule still apply, or is there a different rate?</li> </ol>	<p>administered by different entities for two different types of clients. If you are a qualified provider and enrolled with ProviderOne to provide services to a person that is covered under the FFS Specialized BH program follow the instructions in that guide and Fee schedule; if you are providing services to a person covered by the BHO or the MCO BHSO or a BHASO use the SERI. How to determine who is covered by what program is in the HCA MH guide.</p> <p>Note that on our daily calls, we are trying to focus on questions from the integrated managed care perspective; the Specialized Fee Schedule was developed for specific providers who treat a group of clients who receive BH services through a benefit administered by HCA FFS program. Questions about which codes to use for the FFS population can be directed as below:</p> <p>For questions about billing guides, contact the Medical Assistance Customer Service Center (MACSC) online or at 1-800-562-3022. For questions about rates or fee schedules, email <a href="mailto:ProfessionalRates@hca.wa.gov">ProfessionalRates@hca.wa.gov</a>.</p> <p>HCA also followed up directly with the provider and the AI/AN program leads.</p>
4	NPI	Pierce	Do providers have to wait until their National Provider Identifier (NPI) registration is completed in order to begin submitting claims?	No. HCA has instructed the MCOs that they should accept claims from providers without waiting for the providers to be enrolled by HCA.

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5	NPI	King	How long does it take for an NPI application to go through at the federal level?	In general, the NPI process takes minutes.
6	NPI	King (Crisis Connections)	We have been able to get NPI numbers for our staff at Crisis Connections...One of the requirements to get the organization NPI is to get the EIN which we are not able to provide (became an issue during federal govt shutdown). Also some of our new staff don't have provider one access and we need the NPI organization number in order to get them Provider one access.	The last we heard from CMS, the NPI applications are continuing to be processed and enumerated as normal.  If providers are having problems with this process, please forward the tracking numbers for NPI applications that are delayed to George Wagner at <a href="mailto:george.wagner@hca.wa.gov">george.wagner@hca.wa.gov</a> , cc'ing Provider Enrollment at <a href="mailto:ProviderEnrollment@hca.wa.gov">ProviderEnrollment@hca.wa.gov</a> , and we will forward on to CMS so they can look into it more closely.
7	Credentialing	Spokane (NEW Alliance)	When new providers come in, whether they're new to our system, we have them fill out a Department of Health (DOH) application for agency affiliated or other applicable.  1. Can these providers provide direct services 60 days from the date of hire, or is it 60 days from pending status with DOH?  2. To even get the ProviderOne application started, we have to have a DOH credential. Can individuals provide services while this process is pending, either under a supervisory oversight with someone who is already fully	See MCO responses below:  AMG: It appears the question being asked is whether a provider can bill for services when their DOH credential or license is pending. AMG will not credential anyone who is not licensed with the WA DOH. If the provider is billing under a supervising licensed behavioral health provider and that individual is contracted and PAR in our system, then claims should pay to the rendering licensed behavioral health provider. If there are additional question on this please contact Kathleen Boyle.  Specific to the second question, Molina allows our IMC behavioral health providers to be loaded into our system and render services prior to confirmation that their NPI has been registered with HCA. Please see additional detail below:

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			<p>credentialed with all of the systems, or do we need to wait? Or, can we provide services with the assumption that there will be credentialing approval and then upload those with the MCOs once the individual is credentialed?</p>	<ul style="list-style-type: none"> <li>• Provider must have an NPI to be loaded into our system.</li> <li>• Provider can be loaded into our system and render services prior to obtaining a ProviderOne number (which would signify that the provider has registered their NPI with HCA).</li> <li>• BH Agencies have been credentialed via HDO, so for Molina, credentialing does not come into play in this scenario.</li> </ul> <p>Coordinated Care: For Question 1, we believe this may be a question for DOH rather than MCOs. Please see below a DOH FAQ on this topic. If we're misunderstanding something, please let us know.</p> <p><a href="https://www.doh.wa.gov/LicensesPermitsandCertificates/ProfessionsNewReneworUpdate/AgencyAffiliatedCounselor/FrequentlyAskedQuestions">https://www.doh.wa.gov/LicensesPermitsandCertificates/ProfessionsNewReneworUpdate/AgencyAffiliatedCounselor/FrequentlyAskedQuestions</a></p> <p>In regards to question 2, we believe the question of whether an individual can provide services before credentialing is complete is a question for DOH based on our understanding that MCOs credential on the agency level and that agencies credential agency affiliated counselors. Regarding payment, CCW requires a roster of individual agency counselors, which includes individual NPI for rendering providers. NPI is required for claims systems configuration to ensure timely claims payment.</p>

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				<p>CHPW: Question 1: CHPW will not credential without DOH license; Question 2: CHPW will credential providers with current DOH license if they have a Core Provider Agreement or application in process.</p> <p>UHC: For behavioral providers, new providers joining a contracted and credentialed agency must be an enrolled Medicaid provider with the state prior to us adding to the agency roster for claims payment, but can otherwise be added. We are able to credential at an agency level on the BH site because individual credentialing is not available for providers who are not independently licensed. We know that non independently licensed staff provide direct services to our Medicaid beneficiaries. The agency credentialing allows us to use a provider roster that is then loaded into our claim databases to allow claims payment and encounters.</p> <p>For medical providers, we require each individual provider complete credentialing with UHC before they can see members and bill for services. This is because all medical providers do have required licensure, and we must verify that they are in good standing with all regulatory entities for all lines of business. The only exceptions are for true hospitalist providers, including anesthesia and emergency medicine working out of a hospital.</p> <p>HCA recommends reaching out directly to MCOs if needed on this question.</p>

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8	<b>Credentialing</b>	Spokane (New Alliance)	Can a provider bill an MCO before they get a ProviderOne number/Medicaid ID?	Yes
9	<b>ProviderOne Enrollment Applications</b>	Spokane (Pioneer Human Services)	<p>On December 21, 2018, Pioneer Human Services completed and submitted several Servicing Only Provider applications on ProviderOne following the instructions given in the October NPI/SERI webinar. All continue to show as being reviewed.</p> <ol style="list-style-type: none"> <li>1. Is there something else we need to do, or is this a matter of everyone submitting applications at the same time and the HCA is flooded and needing more time to process applications?</li> <li>2. If the latter is the case, will this affect any of our MCO billings? I generally try to submit claims when an individual discharges, which means that it is conceivable I will be submitting prior to the applications being finalized. I would rather hold off on submitting if the claims will not be considered "clean" due to this process.</li> </ol>	<p>HCA is currently working through a backlog of ProviderOne applications due to the large volume of applications we received during the month of December. It will probably be several weeks to catch up the pending enrollment. Any BH provider applications received before Dec. 31, 2018 will be backdated to January 1, 2019. Newer BH provider applications will be back-dated to the date of application until March 30, 2019.</p> <p>The MCOs are aware of the issue and should be able to handle these claims. Let HCA know if you run into problems, or reach out directly to the MCOs.</p>
10	<b>ProviderOne Enrollment Applications</b>	Molina	Will the backdating of provider enrollment applications to 1/1/19 be done for all applications received in	See above. The MCOs should check with their WISE providers and make sure they got their applications in by Dec. 31. If not please alert HCA.

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			December, or just those applications that are processed after 1/1/19?	
11	<b>Provider Taxonomy</b>	Spokane (Pioneer Center East)	How do we correct an erroneous ProviderOne provider taxonomy?	Pioneer can reach out to Provider Enrollment directly for assistance with correcting an erroneous provider taxonomy; call Provider Enrollment at 1-800-562-3022 Ext 16137.
12 <b>NEW</b>	<b>Provider Taxonomy</b>	Greater Columbia (Somerset Counseling Center)	<p>1. One of the first tasks I completed was registering our NPI's. I registered using the separate taxonomy codes for my CDP's and CDPT's. Then in the Provider Readiness group we were told that these NPI numbers wouldn't work and both CDP's and CDPT's need to be registered under the same federal tax ID. I attempted to update the NPI registration for my CDPT's and we got this response back from HCA: "We are unable to add this taxonomy to the NPI's listed below since they only have a trainee certification."</p> <p>2. I also attempted to register a contracted employee's NPI with HCA today and got an error message stating we could not do so as her NPI is already in the production area. She is a full-time employee of another agency for her mental health taxonomy code. However, she is contracted to provide SUD services with our agency. It is my</p>	<p>1. The confusion seems to be with the Taxonomy 101YA0400X that is being requested for some of the CDPT providers not their NPI's. That taxonomy is reserved for fully licensed CDP providers.</p> <p>We have provided a list of acceptable taxonomies for these professionals that are not fully licensed:</p> <p><b>Mental Health &amp; CDPT in Training 101Y99995L.</b></p> <p>There are 2 other NCCU taxonomies that are acceptable, they are:</p> <p><b>Mental Health Counselor 101Y00000X or Student/Trainee 390200000X.</b></p> <p>2. Please update your list of Servicing Only providers by adding her NPI and Start Date and because she is already enrolled her name will auto fill.</p>



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			<p>understanding that any encounters and claims we submit must be linked to a provider, their NPI, and their taxonomy. How do I get her registered under our agency for her SUD taxonomy code? Will our claims/encounters go through if I do not enroll her under the CDPT code, since she's already enrolled with Catholic Charities under her mental health taxonomy?</p>	
13	<b>Provider Taxonomy</b>	Spokane (Children's Home Society (CHS))	Is the billing provider taxonomy required in box 33B on the CMS 1500 HCFA form?	Yes
14	<b>Provider Taxonomy</b>	Pierce	<p>Are the MCOs validating taxonomies against services? There isn't a CDPT federal taxonomy code so we would have to bill with the counselor taxonomy. Would that make it past billing edits? Also, our EHR only allows us to enroll practitioners with one taxonomy.</p>	<p>1. Provider Enrollment states that are no edits validating that a taxonomy used on an encounter is on the provider's file. As long as the taxonomy is recognized by P1, the encounter won't be rejected. So from HCA, the validation shouldn't be an issue.</p> <p>Note: assume provider is referring to a CD counselor code</p> <p>2. If they bill a clearing house they will need to enroll with HCA with two taxonomies: the one they registered their NPI with and the one assigned in SERI. When they</p>

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				<p>bill they will bill with the one that they used to get their NPI.</p> <p>If they bill directly, when they enroll use the SERI taxonomy only.</p>
15	<b>Provider Taxonomy</b>	King County	<p>As you know, when new guidance indicated encounters should not be submitted with local (HCA) taxonomy codes, but rather with NPPES taxonomy, providers have been struggling to determine which federal taxonomy to use for unlicensed staff. Guidance was to use their best judgement. King County initially set validation rules in place against the crosswalk provided by HCA, which doesn't include a cross walk for the local taxonomy codes. So potentially, providers could potentially submit taxonomies that are not on the crosswalk. We don't have an official SERI guide, and the draft SERI only has the local taxonomy codes for under masters level staff.</p> <p>Will HCA accept a taxonomy in an encounter that is not listed in the draft SERI? I'm not certain what level of validation will be done for taxonomy. Can you confirm for me?</p>	See the response above.

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<b>16</b> <b>NEW</b>	<b>Provider Taxonomy</b>	King County	<ol style="list-style-type: none"> <li>1. Encounters will not be validated to specific taxonomy codes cross walked to provider types in the IMC SERI (only seen in draft form so far), correct?</li> <li>2. Does P1 recognize the full set of taxonomy codes published by NUCC? Or this there a specific set of recognized codes for behavioral health, and if so, is there a list of recognized codes?</li> </ol>	<ol style="list-style-type: none"> <li>1. ProviderOne does not currently have edits in place for Managed Care encounters which validate specific taxonomy codes cross walked to provider types in the IMC SERI.  However, providers should follow the guidance already provided for submitting encounters and applicable taxonomy codes.</li> <li>2. ProviderOne does not use all of the taxonomy codes published by NUCC; however all of the codes listed on the crosswalk table in the attached Fact Sheet are recognized by P1.  When submitting applications using the online ProviderOne portal, the available taxonomies in P1 are listed given the taxonomy provider type and provider specialty chosen.  Outside of the ProviderOne functionality described above, there is not a list of HCA-recognized taxonomy codes which has been published by HCA.</li> </ol>
<b>17</b>	<b>Provider Taxonomy</b>	Spokane  (Partners with Families)	I am using/referencing the BHT/HCA Taxonomy codes published November 2018 and Kolleen has identified other taxonomy codes as she has registered our clinicians for their NPI's (identified the codes on their website).	Typically, HCA has been recommending enrolling at the highest applicable level, but I recommend you contact Provider Enrollment (info below) to get specific answers on these. Please let us know if you're still having issues after contacting Provider Enrollment.  <b>Provider Enrollment</b>

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			<p>Examples:</p> <ul style="list-style-type: none"> <li>• Masters level students, I used 'Below Master's Degree' 101Y99995L and she has used 'Student in an Organized Health Care Education/Training Program 390200000X;</li> <li>• LICSW I used 104100000X and she used 'Social Worker; Clinical' 1041C0700X;</li> <li>• and for Masters level whom are not licensed I used 'MA/PHD (non-licensed)' 101Y99996L and she used 'Social Worker' 104100000X.</li> </ul> <p>Would the taxonomy code for interns fall under 390200000X? When we're linked to the taxonomy code list from the NPI website it shows the title being, "Student in an Organized Health Care Education Training Program". The definition of "Organized Health Care Education Training Program" is listed as 'pending'. Would we be able to apply for NPIs for the interns through this? Are interns required to have a license or certification in order to apply for an NPI?</p>	<p>Phone: 1-800-562-3022 ext. 16137                      Email: <a href="mailto:providerenrollment@hca.wa.gov">providerenrollment@hca.wa.gov</a></p>

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18	AI/AN	Spokane (Spokane School District)	<p>Two questions regarding AI/AN:</p> <p>3. Do you have contact at HCA that is specifically in charge of AI/AN?</p> <p>4. All of my clinicians have a Master's degree and licensed. Some are under supervision to obtain independent licensure. Can those individuals provide AI/AN services under supervision?</p>	<p>1. HCA does have a Tribal Affairs team that serves as the liaisons for Tribal Health care issues. The best point of contact for HCA and Tribal affairs is going to be our inbox at <a href="mailto:tribalaffairs@hca.wa.gov">tribalaffairs@hca.wa.gov</a> (or Michael Longnecker at <a href="mailto:michael.longnecker@hca.wa.gov">michael.longnecker@hca.wa.gov</a>)</p> <p>2. Michael Longnecker is working directly with the provider to assist them with this process. His response included this information:</p> <p>Spokane Schools can bill P1 <b>today</b> (or <i>yesterday</i>) for mental health services for clients who are not enrolled in one of the managed care plans.</p> <ul style="list-style-type: none"> <li>• Regular HCA mental health services are billable for clients who are not enrolled in a managed care plan, using the <a href="#">Mental Health Billing guide</a> (stay in Part 1)</li> <li>• Claims will be billed with your servicing provider information. The folks that are waiting for independent licensure (e.g. Licensed Associates and the other Master's level folks) will just work under the supervision of one of the fully licensed providers and their services will be billed to P1.</li> <li>• HCA requires that MHPs who see kids have at least 2 years' experience working with kids. It is a simple attestation.</li> </ul> <p>General information about using the FFS billing guides from the Tribal Affairs staff:</p>

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				<p>You can also follow the below step-by-step process for determining when/how to use the MH billing guide:</p> <ol style="list-style-type: none"> <li>1. What is the category? Mental health (MH) or SUD? (assuming MH, if it is SUD, stop reading)</li> <li>2. What is the client's insurance? (assuming FFS, if client has managed care that covers the BH service, stop reading)</li> <li>3. For "low acuity mental health (or whatever the current words are) – follow the <u>MH billing guide</u>, page 0-97. Do not read anything past page 97</li> <li>4. For "specialized mental health" – follow the <u>MH billing guide</u>, page 0-35 &amp; 97-120             <ol style="list-style-type: none"> <li>a. H0038 is defined (in the MH guide) as Self-help/peer services, per 15 minutes modifier TG is required for pricing reasons in P1. Follow regular CPT/HCPCS coding guidelines for other modifiers not listed in the billing guide.                 <ol style="list-style-type: none"> <li>i. The MH billing guide technically does not "own" the policy behind H0038, we go to the <u>SERI guide</u>, page 62 for the modality definition and then page 63 for the coding (for SERI, not for P1)                     <ol style="list-style-type: none"> <li>1. GT = interactive telecommunication. This modifier is not in the MH guide.</li> <li>2. UC = state-defined modifier. This modifier is in the MH guide but is in page 49 for psych testing ("low acuity"). No other definition for modifier UC for P1</li> <li>3. UD = state-defined modifier. This modifier is not defined in the MH guide</li> </ol> </li> </ol> </li> </ol> </li> </ol>

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				4. U8 = state-defined modifier. This modifier is not defined in the MH guide.
19	AI/AN	Spokane (Providence Sacred Heart)	How do we get paid for inpatient mental health detention for AI/AN individuals? HCA is telling us that we need authorizations for these services.	Providence needs to establish a contract with DBHR and be identified as an AI/AN provider within that network in order to bill for these services. Providence was not sure if they have this contract/are identified as an AI/AN provider, they are looking into this internally.
20	AI/AN	Spokane (Spokane Schools)	<p>Since we are set up to bill FFS for AI/AN, I'm not sure how this will work for eligibility checks in ProviderOne.</p> <p>I have a kiddo I'm checking on and she doesn't have one of the MCO's that we contract with but she is AI/AN according to Amy. P1 doesn't actually <b>tell</b> us if they are AI/AN or not. Will the Therapists have to verify that?</p> <p>If they don't have one of the MCO's that we bill, do we then submit the claims using the ProviderOne AI/AN payer that is set up in CareLogic?</p>	See question 65 below for how to determine if a client is in the American Indian/Alaska Native FFS program. If the client is AI/AN, the provider needs to submit the claim to ProviderOne. (HCA also followed up directly.)
21	AI/AN & Fee Schedules	Spokane (Passages)	AI/AN codes on HCA website – there are two fee schedules. One for Specialized MH codes which includes H codes for peer support and case management, versus the one labeled Mental Health & Psychology Services does not include any H codes. The	Specialized MH Fee Schedule and the SERI guide support 2 different BH programs. If you are supporting a person that is to be covered under the FFS Specialized BH program, follow the instructions in that guide. If you are providing services to someone covered by the MCOs, use the SERI. Who is covered by what program is in the Mental Health Guide.

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			<p>Specialized MH you have to use the teaching modifier for complex or high level care, and our clients aren't falling under those categories necessarily. Wondering if we can get those H codes added to the regular MH &amp; Psych fee schedule?</p> <p>The regular fee schedule doesn't list all the BH service codes that we would usually use that are in the SERI. It only has very basic therapy. It doesn't have the H Codes, and that's one of the main services we provide – care support and case management.</p> <p>I do want to clarify that the fee schedule that we should be using is the only labeled Mental Health &amp; Psychology Services, not the one labeled "Specialized Mental Health, correct? The latter requires the TG modifier for "complex/high level of care".</p> <p>Here are the H codes we tend to use most often: H0004, H0023, H0025, H0032, H0038, H0046, H2011, H2015, H2027</p>	<p>See also our response to Question 2 above.</p> <p>Examples: case management is not a Medicaid service that is payable under FFS. The peer support code is a billable service in the state plan, and is available to AI/AN FFS client.</p> <p>If you notice other specific codes that are not included in that guide, please send to <a href="mailto:HCAintegratedMCquestions@hca.wa.gov">HCAintegratedMCquestions@hca.wa.gov</a>.</p>





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22	SUD ROIs	King County	King County is still getting Releases of Information (ROIs) for SUD, do they need to continue sending these to HCA?	HCA does not need these ROIs any longer. At this point, providers should be able to figure out which MCO the client is assigned to and reach out directly to them for a new authorization. King County BH-ASO will continue to gather the information needed from their providers.
23	Continuity of Care Spreadsheet	Spokane	There is a missing NPI number on Spokane's continuity of care spreadsheet.	The missing NPI number is for Inland.
24	Medicare Clients/Dual-Eligibles	Greater Columbia (Comprehensive)	Comprehensive's dual-eligible clients are not assigned to an MCO in ProviderOne, but they should be enrolled as Behavioral Health Services Only (BHSO).	Comprehensive and YVFWC sent a list of examples of these dual-eligibles. HCA staff checked the examples and responded directly to providers. No glitches were uncovered; all the unassigned clients made sense in terms of lost eligibility or other changes.
25	Medicare Clients/Dual-Eligibles	Greater Columbia BH-ASO	We have been told that Medicare does not cover stays in an E&T and that the BH-ASO is required to pay for all voluntary and involuntary clients with Medicare. Is this true?	A person who is MEDICARE-only is covered by the BH-ASO, true. A person who is on BOTH Medicaid and Medicare is covered by the MCO as a BHSO enrollee, unless they are on spend-down (which they would be likely to meet quickly at an E & T facility).
26	List of Residential and Inpatient Facilities	Greater Columbia (Comprehensive)	BH providers need a list of the residential and inpatient facilities that the MCOs are contracted with across the state that the providers can use to determine which facilities they can refer their patients to. Providers tried finding this information on the MCO websites but there were issues with the information loading and/or the list being incomplete.	<p>The MCOs suggested using their websites for locating facilities under contract, but have also offered to create these lists for distribution to providers.</p> <p><u>AMG</u>: Yes, we referred people to our website as it has the most current information, however we also sent a list out to Greater Columbia ACH with a list that was up to date at that time.</p> <p><u>Molina</u>: We have provided a list of residential and inpatient facilities directly to each Greater Columbia provider to utilize as a resource.</p>

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#	Topic	Region/ Provider	Question	HCA/MCO/BH-ASO Response
27	<b>Discharge Notification</b>	Pierce (Park Place)	How would each MCO like to be notified of patient discharges?	The MCOs will be engaging in ongoing conversations and information exchange with providers about their clients' treatment and progress, so they should know about planned discharges coming up. For discharges that are unplanned (i.e. the patient suddenly decides to leave the facility), then you can call or fax the MCO to give them that information.
28	<b>Authorizations</b>	Spokane (YFA Connections)	<p>We have been trying to get a patient into SUD inpatient (IP) treatment all day. The inpatient provider believes they are waiting for CHPW to authorize the treatment before they will admit her. We submitted the form from the CHPW portal as requested and were told it's 1. the wrong form; 2. the wrong fax #; 3. the wrong member ID # (we were told to use the ProviderOne number) - we have been unable to get this person any help.</p> <p>It is my understanding from many previous meetings with MCOs that the SUD outpatient (OP) provider completes a SUD IP referral form and sends it to an MCO. It is also my understanding that the SUD IP provider then admits the patient and then gets the authorization from the MCO.</p> <p>It would be very helpful if EACH MCO could please send providers the</p>	<p>Individual problems should be routed to the BH UM Manager of each MCO for assistance. A contact list for those staff was distributed to the rapid response call list 2/1/19.</p> <p>In addition, MCOs have distributed authorization guidance relating to different services.</p> <p><u>Coordinated Care:</u> Please find attached CCW's Prior Authorization Summary and UM Leadership contacts for reference.</p> <div style="display: flex; justify-content: space-around; align-items: center;"> <div style="text-align: center;">               2019 CCW PA Summary.docx         </div> <div style="text-align: center;">               CCW Leadership Contacts Utilization M         </div> </div> <p><u>CHPW:</u> Go to CHPW webpage for proper forms and processes. Providers can also call customer service.</p> <p>Either outpatient or inpatient provider can submit clinical information for authorization.</p> <p><u>AMG:</u> Kathleen Boyle is now the point of contact for Amerigroup for these issues.</p>

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#	Topic	Region/ Provider	Question	HCA/MCO/BH-ASO Response
			<p>correct information/form/process for each of their services.</p>	<p><u>Molina</u>: Best practice is that whichever entity holds the most current and comprehensive clinical to support the request can submit the authorization form for higher level services. It can be the referent (OP provider) or the rendering provider of those services. Our BH authorization form is tailored to accommodate either scenario and both the requesting provider and the accepting provider will be notified of the outcome of that authorization request. Our current BH Authorization form is available on our Provider portal and/or may be requested by contacting any member of our BH UM team at Molina. See attachments titled: 2019 MHW BH Authorization Request Form Final and MHW BH UM TEAM Contact List updated 1.19.</p> <div style="text-align: center;">                   2019 MHW BH Authorization Request Form Final.pdf             </div> <div style="text-align: center;">                   MHW BH UM TEAM Contact List update             </div>
29	Authorizations	Spokane (YFA Connections)	<p>What are the wait times for pre-authorization for Amerigroup and Molina? (CHPW will authorize urgent SUD IP referrals in 72 hours.)</p>	<p>MCOs distributed authorization guidance to providers.</p> <p><u>Molina</u>: Urgent requests are processed (reviewed and decided) within 24 hours if initial clinical information is sufficient to make a medical necessity decision. If needing additional notes, providers will be given up to 72 hours. Standard TAT is 5 days which can be extended and up to 14 days if additional information is needed. If there are extenuating circumstances wherein providers are unable to provide within the initial 14 days, an</p>

## 2019 IMC Mid-Adopter Rapid Response Call Questions Tracker

#	Topic	Region/ Provider	Question	HCA/MCO/BH-ASO Response
				additional 14 days can be requested. A total of 28 days. All MCOs adhere to these TATs.
30	Authorizations	Pierce	An issue was brought up at the Pierce Integration and Oversight Board meeting on 1/3/19 that the MCOs were taking a while to approve authorizations.	<p>MCOs acknowledge this and noted that they were just then receiving the information they needed. To get referrals processed more timely the provider should say “urgent” on the authorization form. However, the MCOs requested that providers do this only for urgent/special cases.</p> <p><u>Molina:</u> It is to be expected that there would be delays at the onset of the 1.1 implementation given the volume of requests, complexity of transition authorizations and number of providers who are new to the process of working with MCOs. Providers should see an improvement in TAT over time.</p>
31	Authorizations	Spokane (Providence)	There are patients residing in Greater Columbia that are receiving involuntary treatment at Providence Sacred Heart who were admitted prior to 1/1/19. Providence has tried contacting Greater Columbia to receive the authorization but they have not heard back.	Greater Columbia offered to follow up. The MCOs also have a new contact number for Greater Columbia authorizations that they will share with the group.
32	Authorizations	Spokane (SPARC)	RTC counselors are letting us know that one of the health plans is only authorizing RTC for 7 days. Will this be the norm for them? The grid provided says that 14 days would be approved initially.	<p>The health plan responded that 14 days is the normal authorization time for RTC. They were doing only 7-day authorizations under certain circumstances, but going forward 14 days will be the norm. Other MCOs agreed.</p> <p><u>Molina:</u> MCOs vary in authorization segment length for various bedded services. Please see the 2019 MCO Combined PA Grid.</p>

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#	Topic	Region/ Provider	Question	HCA/MCO/BH-ASO Response
33	Authorizations	Pierce County (Comprehensive)	Comprehensive is trying to get a patient in to residential SUD treatment. The MCO says they are following the correct process, but the receiving provider is telling Comprehensive that their paperwork is not correct. How do they resolve issues like this that arise between agencies?	The MCO's BH UM Manager can facilitate communication between the agencies and work to resolve these types of issues. In this specific case, the MCO will reach out to address the issue.
34	Authorizations	Pierce County	For detained patients at CHI Franciscan, some insurances are saying they need clinical for authorization. There is confusion among providers around how MCOs handle detained patients- providers need guidance from the MCOs about the process for authorizing treatment for detained patients on single bed certifications. MCOs need to align their processes and eliminate barriers where they can.	The process for patients detained on single bed certifications should be notification within 24 hours or business day (regardless if ITA or voluntary), followed by concurrent review. This is the same across all MCOs. The MCOs are required to pay if the stay is the result of an ITA, but MCOs want to do concurrent review to monitor progress.  The MCOs can send out more information about this process.
35	Authorizations	Pierce County	Over the weekend a patient was detained at St. Anthony's on a single bed certification. An MCO denied this stay due to the notice not being timely and not having a psychiatrist see the patient daily.	The MCO responded that these issues should not have been a barrier for approval and they will follow up directly with the provider.
36	Authorizations	Pierce County	Can the MCOs extend the authorization period for mental health RFT beyond 14 days?	At this point the MCOs will not be making any changes to the authorization timeframe, but they will collaborate


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#	Topic	Region/ Provider	Question	HCA/MCO/BH-ASO Response
				on this and loop back in later (probably sometime next quarter).
37	<b>Authorizations</b>	Pierce County	Do providers have to get prior authorization for IOP level of care?	See the 2019 MCO Combined PA Grid.
38	<b>Coordination of Authorizations With Other Regions</b>	Greater Columbia (Comprehensive)	Comprehensive has a FFS arrangement for out-of-network services and attempted to submit an authorization for treatment for a client who resides in Clark County but was receiving services in Yakima. The MCO denied the auth. because the patient is registered as living in Yakima County. How does Comprehensive resolve this, do they submit a change of address form for the client?	Since the patient is from an IMC region, they should contact the individual plan the member is assigned to and work with the plan to figure it out. (The MCO in this case confirmed that they're following up with Comprehensive on this.)
39	<b>Authorizations/ Notification and Concurrent Review</b>	Spokane (New Horizon)	Can the MCOs use a longer window of time for notification/prior authorization? 14 days is negligible for Pregnant and Parenting Women (PPW).	The MCOs see why 14 days is burdensome, but they need this timeframe for effective care coordination. It also keeps them aware of barriers/discharge issues. They can schedule a meeting with the provider to discuss this further.
40	<b>Authorizations/ Notification and Concurrent Review</b>	Greater Columbia (Comprehensive)	1. On the MCO Prior Authorization Grid, the MCOs have slightly different windows for the number of days they will initially authorize for crisis stabilization services. Could the MCOs all agree to standardize this timeframe to 5 days?	The MCOs will consider standardizing their different timeframes, and they have been working on standardizing their prior authorization information and forms.  The MCOs are continuing to look at this request as a group. IMC implementation and stabilization is our priority right now so this may be a 2nd Quarter consideration.

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#	Topic	Region/ Provider	Question	HCA/MCO/BH-ASO Response
			<p>2. Could the MCOs also try to standardize their forms and information requested for prior authorizations/notifications with concurrent review?</p>	
41	<p><b>Jail Transitions/ Authorizing Services for Incarcerated Individuals</b></p>	<p>Spokane (NE Counseling Services) &amp; Pierce</p>	<p>How should regions coordinate jail pre-authorizations for inmates needing direct placement to inpatient/residential SUD treatment upon release from jail?</p> <p>(An authorization needs to be put in place prior to release in order to get the individual in to treatment, but an MCO was telling Spokane that because the client was not showing that they had coverage with that MCO in ProviderOne, Spokane would have to go through HCA to coordinate this.)</p>	<p>In coordinating jail transitions, follow the steps below:</p> <ol style="list-style-type: none"> <li>1. Identify which MCO had the inmate enrolled prior to incarceration. They will be “reinstated” with that MCO upon release if still available in your region. If not, please reach out to HCA at <a href="mailto:integratedmcquestions@hca.wa.gov">integratedmcquestions@hca.wa.gov</a></li> <li>2. Contact that MCO to inform that you need the prior authorization for inpatient treatment upon release from jail. The MCOs should be prepared for these calls. The MCOs/AMG will need clinical documentation to process the authorization- same as any request for this service.</li> <li>3. If the county is having trouble, let HCA or the provider know and we can help coordinate.</li> <li>4. If the individual has an MCO that is no longer in the region, the provider can coordinate with HCA to determine which MCO will be responsible for the inmate upon release. Then they will work with that MCO to get the prior authorization.</li> </ol> <p>The client will not show coverage with a health plan in ProviderOne because are suspended while incarcerated. They will be reinstated with the health plan (or a new health plan if that plan is no longer in the region) upon release from jail. This is not a new process. It will take 24</p>

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#	Topic	Region/ Provider	Question	HCA/MCO/BH-ASO Response
				<p>hours to process this enrollment on HCA's end, so the provider won't see it in the system until the following day.</p> <p>The MCO has worked with their UM team to educate them about these cases and developed a process for providing an interim verbal authorization until the enrollment is complete. The MCO will accept prior authorization requests for those with suspended eligibility and pay for services provided to the person once their eligibility is reinstated, so long as the provider notes on the authorization form that the client is on suspended status.</p> <p>Molina: Please see our process attached regarding Jail Transition Authorization</p> <div style="text-align: center;">  <p><b>MHW SUSPENDED BENEFITS PROCESS.I</b></p> </div>
42	<b>Notification vs. Prior Authorization</b>	Pierce Greater Columbia King Spokane	<ol style="list-style-type: none"> <li>1. What is the authorization process for crisis triage?</li> <li>2. What about when stepping down to a lower level of care?</li> </ol>	<p>The process is notification with concurrent review, including when stepping down to a lower level of care.</p> <p>Molina: For admissions to crisis stabilization in a residential setting, Molina requires notification of that admission within 24 hours of admission followed by concurrent (clinical) review. Each level of care (for example, residential treatment) requires separate authorization so if the member is in crisis stabilization moving to short or long term residential treatment, the</p>



## 2019 IMC Mid-Adopter Rapid Response Call Questions Tracker

#	Topic	Region/ Provider	Question	HCA/MCO/BH-ASO Response
				<p>provider would need to obtain prior authorization for those services as they are planned.</p>
43	<p><b>Notification with Concurrent Review</b></p>	<p>Pierce (Greater Lakes &amp; Prosperity)</p>	<p>If an outpatient provider makes a referral for inpatient treatment, is it the outpatient provider's responsibility to provide the information to the MCO for notification and concurrent review? Or, is it the inpatient provider's responsibility?</p> <p>(Prior to 1/1/19 it was usually the outpatient provider's responsibility to get the authorization.)</p>	<p>The MCOs can accept the information from either provider, they do not have a preference between inpatient or outpatient providers. The MCOs just need the most current clinical information, so the providers can work among themselves to figure that out.</p> <p>Molina: Best practice is that whichever entity holds the most current and comprehensive clinical to support the request can submit the authorization form for higher level services. It can be the referent (OP provider) or the rendering provider of those services. Our BH authorization form is tailored to accommodate either scenario and both the requesting provider and the accepting provider will be notified of the outcome of that authorization request. Our current BH Authorization form is available on our Provider portal and/or may be requested by contacting any member of our BH UM team at Molina. See attachments titled: 2019 MHW BH Authorization Request Form Final and MHW BH UM TEAM Contact List updated 1.19. (Above.)</p>
44	<p><b>Authorization Notification Requirement</b></p>	<p>Greater Columbia</p>	<p>The Prior Authorization Grid notes that emergent, unplanned admissions to acute inpatient BH facilities require notification of the admission to the MCO within 24 hours of that admission. Does this include only business hours, or would this include non-business hours? (I.e. if the patient is admitted on a Saturday, does the</p>	<p>The notification requirement is referring to one business day. For example, if a patient is admitted on a Saturday the provider can send in the notification for authorization on the following Monday.</p>

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#	Topic	Region/ Provider	Question	HCA/MCO/BH-ASO Response
			provider need to send the notification by Sunday, or the following Monday?)	
45	<b>Billing for Withdrawal Management/Sub-Acute Detox</b>	Greater Columbia (Comprehensive & Lourdes)	An issue came up today at our meeting with providers in Greater Columbia that a claim was denied for withdrawal management based on the admission starting after midnight (12:15 a.m.) and the client being required to report to court at 8:00. No overnight stay, so the claim was denied. The BH-ASO said they had a similar policy, and other MCOs on the call weighed in to say “yes, we also deny such services if the person is not in the bed over one midnight.” Is there some other way the provider should be billing? This policy also effects crisis stabilization.	HCA is working with several providers and the MCOs to figure out a solution to this issue. We will keep you posted on this and let you know once we have decided on a final approach.
46	<b>Private Insurance &amp; Authorizations</b>	Greater Columbia BH-ASO	<ol style="list-style-type: none"> <li>1. If a client with private insurance is detained on an ITA, does the BH-ASO have to authorize this?</li> <li>2. Would the BH-ASO need to enter this into ProviderOne?</li> </ol>	<p>If the private insurance is covering the ITA stay, you do not need to enter it into ProviderOne or authorize it. It seems it would be a rare private insurance company, but maybe your experience is unique.</p> <p>HCA is putting together guidance on who covers what regarding hospitalizations.</p>
47	<b>Private Insurance</b>	Spokane (American Behavioral Health Systems (ABHS))	ABHS has had some patients come into their facility under an ITA with commercial insurance carriers ABHS is not credentialed with. In these circumstances, when ABHS cannot get payment or can get only partial	If the patients are not Medicaid eligible, and private insurance is denying payment, the BH-ASO is responsible for the ITA admission. For admissions that have occurred in the past, ABHS should try reaching out to the Spokane BH-ASO to see if they would be willing to consider these for retroactive authorization and reimbursement.

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#	Topic	Region/ Provider	Question	HCA/MCO/BH-ASO Response
			payment, how does ABHS get reimbursed for the remaining balance due?	Ideally, approval from the BH-ASO should be pursued once the Designated Crisis Responder has done the assessment and has decided to seek the court ordered admit. HCA encourages ABHS to reach out to the BH-ASO to develop a relationship and process for handling these types of cases moving forward.
48	<b>WISe- CANS Report</b>	Spokane (Excelsior) & Greater Columbia (Comprehensive)	Do the MCOs need a copy of the CANS report for WISe services when the provider sends in the notification form?	See individual MCO responses:  <u>Coordinated Care:</u> While CCW has access to the BHAS database, we are unable to review the CANS for our members until the provider updates MCO information. If the provider has correctly listed the assigned MCO we do not require the CANS to be submitted to us, but until the database is updated we will need a copy of the CANS.  <u>CHPW:</u> CHPW is now able to access the CANS through BHAS, so no need to submit CANS with notification for CHPW members.  <u>AMG:</u> Yes Amerigroup does need the CANS report.  <u>Molina:</u> We do not require the CANS assessment be sent with the notification form, as we can access the assessment through the BHAS system.
49	<b>WISe- Service Locations</b>	Greater Columbia (Comprehensive)	Can a WISe provider serve more than 1 location?  This is an issue because their WISe teams cover the whole county/multiple counties.	HCA will follow up on this. We are putting together a meeting with the Greater Columbia region to discuss these WISe issues. It is scheduled for February 20 <sup>th</sup> . HCA will be exploring arranging statewide meetings in the future. HCA will be working with the DBHR team to determine the best approach to these meetings going forward.

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#	Topic	Region/ Provider	Question	HCA/MCO/BH-ASO Response
50	<b>WISe Notifications</b>	Pierce County (CCS)	CCS was confirming their WISe enrollees with United and were informed that their WISe notification had expired. United seems to have a slightly different process for WISe notifications than the other MCOs.	United: We will be joining the common form created by the MCOs. The provider could also use the pre-authorization fax form & indicate that the person is a WISe patient.  CCS will forward the email to Bea Dixon so she can look in to the issue further.
51	<b>Claims Testing</b>	Spokane (YFA Connections)	How are agencies doing with their claims testing? We are having some issues with responsiveness and are only able to send claims to Coordinated Care after 6 weeks into the process.	Generally things are going well, there are a few providers that are having issues but others are not having any issues at all.
52	<b>Billing/Who Responsible for What?</b>	Greater Columbia (Lourdes)	For clients who are Medicaid eligible but not yet active or assigned to an MCO, the provider can initially work with the BH-ASO for crisis services. But once assigned, there are questions about whether a new auth. is needed from the MCO and who to bill.	Yes, once you know a client is enrolled with an MCO, you should reach out to them for authorization.
53	<b>Billing/Coding</b>	Greater Columbia (Comprehensive)	Comprehensive is having an issue with the R0001 code for room and board for residential treatment; an MCO's clearinghouse is saying this is not the correct code.	Referred to the specific MCO for follow up, the MCO has addressed this with the provider directly.
54	<b>Billing/Coding</b>	Greater Columbia (QBH)	The ITA investigation code modifier is not available. Do providers bill the BH-ASO or the MCO?	Providers should bill the BH-ASO for ITA investigations.

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#	Topic	Region/ Provider	Question	HCA/MCO/BH-ASO Response
55	Billing/Coding	Greater Columbia (Comprehensive)	Can the MCOs confirm that submitting a claim/encounter with the HH modifier will not create a rejection?	<p>MCOs will check back with their subject matter experts and get back to Comprehensive on this.</p> <p><u>Coordinated Care</u>: The HH modifier is accepted and will not create a rejection.</p> <p><u>AMG</u>: Amerigroup worked directly with the provider on this question.</p> <p><u>Molina</u>: Submitting the HH modifier will not impact claim processing. It would include as informational.</p>
56	Billing/Coding	Greater Columbia (Lourdes)	<p>How do we bill for crisis services provided by non-crisis service agencies?</p> <p>As a specific example, when a client is in crisis and goes to a BH agency for therapeutic treatment, what code(s) should the therapist use for therapeutic crisis treatment? (The provider said they tried to use H2011 but the MCO rejected that code.)</p>	<p>The provider has to be credentialed for the specific service to bill using the code for crisis. So, if the therapist is credentialed to provide this type of crisis service and they do in fact provide the crisis service, then they would bill the BH-ASO.</p> <p>If the provider does not actually provide crisis services, or if they do not have a crisis services certification added to their license, then they would bill the MCOs using whatever the typical individual service code would be for the therapy/treatment session.</p> <p>However, if the provider is a WISe team member providing the service they would bill the MCO using the H2011 code with a U8 modifier.</p>
57	Billing/Coding	North Central (Columbia Valley Community Health)	I am needing assistance determining whether we are going to run into any billing issues in hiring a Licensed Advanced Social Worker for our children's behavioral health program. Note that we are a Federally Qualified Health Center.	<p>MCOs following up directly with provider.</p> <p><u>Amerigroup</u>:</p> <p>MCO's in accordance with our state Medicaid contract, do not directly reimburse FQHC encounter payments via the T1015 code today. If in a future state MCO's are responsible for payment via the T1015 an LASW would be a valid specialty type for this payment.</p>

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#	Topic	Region/ Provider	Question	HCA/MCO/BH-ASO Response
			<p>Would you be able to confirm whether:</p> <ol style="list-style-type: none"> <li>1. LASW (Licensed Advanced Social Worker) encounters are reimbursed the same as LMHC's and LMFT's, and</li> <li>2. Whether they qualify for FQHC (T1015) encounter billing?</li> </ol>	<p><u>Coordinated Care:</u></p> <ol style="list-style-type: none"> <li>1. Yes, they are reimbursed the same. We currently do not pay FQHCs using encounter billing (T1015).</li> <li>2. No, as long as services are appropriate for their license.</li> </ol>
58	<b>MHP Attestation Form</b>	Pierce (Consejo Counseling)	One of our providers is applying for a Mental Health Professionals Attestation Form, how do we do this?	<p>The MHP Attestation Form was specifically designed for providers participating in FFS (which now only applies to AI/AN), so the agency would only need to fill this out if they are trying to sign up for AI/AN FFS.</p> <p>If it isn't completed, FFS payments for some services performed by the professional could be interrupted, but there would be no impact to any Managed Care Encounter.</p>
59	<b>Encounter Submission Attestations</b>	King County	Do providers need to do attestations with MCOs regarding encounter submissions moving forward? If so, is how do providers send this? Is there a universal form?	<p>CHPW: Yes, this is on the delegation grids for all MCOs.</p> <p>The MCOs addressed these questions at a local King County meeting the following day.</p>
60	<b>Crisis Triage Guidelines</b>	Greater Columbia	Will HCA/MCOs be developing guidelines regarding crisis triage?	If you would like HCA to create an information sheet for this please let us know what specific questions you have and we can put together a document with these guidelines.
61	<b>Primary Care Provider Assignment</b>	Greater Columbia (Yakima Neigh. Health)	YNHS has three clients enrolled with an MCO in a different region, but who are temporarily in Yakima for residential care that need a PCP.	YNHS should work with the MCO to get authorizations through a single case agreement or non-participating provider agreement. MCO will follow up.

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#	Topic	Region/ Provider	Question	HCA/MCO/BH-ASO Response
62	<b>Address Confidentiality Program (ACP)</b>	Pierce (Greater Lakes)	Greater Lakes is having a hard time helping clients navigate through the HCA to update their profile. These clients currently are listed with a Thurston County code and with Thurston BHO. When calling per the instructions they received from the HCA, the HCA staff are confused by their request or give the client the impression that by making a change, they would be removed from the Address Confidentiality Program. Ron Messmer, Greater Lakes' financial navigator, has done conference calls with the client and HCA, and Ron has been working with Tammy Schroeder at the HCA on the issue. However, they still haven't had much success in helping clients or providing clients with adequate protocols to make the changes necessary.	<p>Clients in the Address Confidentiality Program (ACP) cannot change the Thurston County designation that is seen in ProviderOne because that would jeopardize their confidentiality status. However, HCA has a process to update ACP clients that reside in an IMC region if they call the HCA Call Center and let HCA know their county. <b>Important Note:</b> They will always show the Thurston County PO Box even when HCA updates the program code.</p> <p>How to do this: Clients or those that are assisting them need to contact the HCA Call Center. The Call Center will forward the request to one of the call center leads (who have authority to make these changes in ProviderOne). The lead will prospectively make the change. If there is an urgent need or other problems, the leads will send the request to the MCO mailbox which is staffed every day.</p> <p><u>Note:</u> ACP clients do not change to IMC automatically. They must call in and ACP clients are eligible for managed care.</p>
63	<b>Serving Clients From Non-IMC Regions</b>	Pierce (RI International)	RI International had a call with Thurston-Mason BHO/Great Rivers and Salish last week because the Pierce Evaluation & Treatment facilities were worried about out of county clients in their facilities and not getting paid. The issue was that Optum was running interference with them and either just	<p>HCA talked with the Pierce folks and the 2020 BHOs to discuss this issue and clarify the process.</p> <p>The provider should contact the BHO to work out a single case agreement, which may not involve the whole credentialing process.</p>

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#	Topic	Region/ Provider	Question	HCA/MCO/BH-ASO Response																								
			<p>paying for the E &amp; T stay OR working with the other BHO.</p> <p>How should a provider handle serving patients who live in one of the 2020 regions?</p>																									
64	<b>Serving Clients from Other IMC Regions</b>	Spokane (New Alliance)	We provided crisis services to a Coordinated Care enrollee who resides in the North Central region. How do we report/bill for these services?	HCA met with the BHO and BH-ASOs to discuss the out of region issues. Guidance will be finalized towards the end of February. In the interim, work with your BH-ASO to assist you in the interim processes established.																								
65	<b>AI/AN Eligibility</b>	Spokane	How do you determine if a client is in the American Indian/Alaska Native FFS program?	<p>If you have specific question about a client’s eligibility, you can email: <a href="mailto:hcaintegratedmcquestions@hca.wa.gov">hcaintegratedmcquestions@hca.wa.gov</a>.</p> <p>To determine if a client is in the American Indian/Alaska Native you can use the below process. It is a 1-2-3 step process that is more like a process of elimination.</p> <p>See below: =====</p> <ol style="list-style-type: none"> <li>1. If the provider is providing SUD Services or mental health, <b>AND</b></li> <li>2. The client has one of these RAC codes for the date of service:</li> </ol> <table border="1" style="width: 100%; border-collapse: collapse;"> <tbody> <tr> <td>1014-1023</td> <td>1039</td> <td>1046-1049</td> </tr> <tr> <td>1052-1055</td> <td>1059</td> <td>1061</td> </tr> <tr> <td>1065-1074</td> <td>1083-1084</td> <td>1086</td> </tr> <tr> <td>1088-1089</td> <td>1091</td> <td>1101-1111</td> </tr> <tr> <td>1121-1122</td> <td>1124</td> <td>1126</td> </tr> <tr> <td>1134</td> <td>1146-1153</td> <td>1162-1169</td> </tr> <tr> <td>1174-1175</td> <td>1196-1207</td> <td>1209</td> </tr> <tr> <td>1217-1225</td> <td>1236-1269</td> <td></td> </tr> </tbody> </table>	1014-1023	1039	1046-1049	1052-1055	1059	1061	1065-1074	1083-1084	1086	1088-1089	1091	1101-1111	1121-1122	1124	1126	1134	1146-1153	1162-1169	1174-1175	1196-1207	1209	1217-1225	1236-1269	
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#	Topic	Region/ Provider	Question	HCA/MCO/BH-ASO Response
				<p style="text-align: center;"><b>AND</b></p> <p>3. The client is not enrolled in any of these Apple Health Managed Care plans:</p> <ul style="list-style-type: none"> <li>• North Sound Behavioral Health Org</li> <li>• Thurston-Mason Behavioral Health Organization</li> <li>• Great Rivers Behavioral Health Organization</li> <li>• King County Behavioral Health Organization</li> <li>• Optum Pierce BHO</li> <li>• North Central Washington Behavioral Health</li> <li>• Salish Behavior Health Organization</li> <li>• Spokane Behavioral Health Organization</li> <li>• Greater Columbia Behavioral Health</li> <li>• AMG Fully Integrated Managed Care</li> <li>• AMG Behavioral Health Services Only</li> <li>• CCW Fully Integrated Managed Care</li> <li>• CCW Behavioral Health Services Only</li> <li>• CHPW Fully Integrated Managed Care</li> <li>• CHPW Behavioral Health Services Only</li> <li>• MHC Fully Integrated Managed Care</li> <li>• MHC Behavioral Health Services Only</li> </ul> <p style="text-align: center;"><b>THEN</b></p> <p>4. The client is AI/AN Fee-For-Service</p>
66	<b>Eligibility</b>	Greater Columbia  (Serenity Point Counseling Services)	Serenity Point has been unsuccessful in finding a way to do batch eligibility checks on the platforms that we are aware of. At the MCO symposium, it was said that there is a way to do this.	<p>The instructions for doing batch eligibility checks may be in the ProviderOne enrollment guide, or providers can contact ProviderOne staff.</p> <p>The provider could also call the general Medical Assistance Customer Service Center (MACSC) number below:</p>

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#	Topic	Region/ Provider	Question	HCA/MCO/BH-ASO Response
				<p><b>Phone:</b> 1-800-562-3022 (choose "provider services")</p> <p><b>Online:</b> <a href="#">Secure web form</a></p>
67	<b>Eligibility/Enrollment</b>	Greater Columbia BH-ASO	How is HCA communicating with BHOs and other BH-ASOs to ensure they're checking ProviderOne to confirm the region the client resides in as well as the client's eligibility/enrollment status?	HCA takes note of this concern, and we have told the BHOs, MCOs, BH-ASOs, and providers that they should be regularly checking a client's eligibility.
68	<b>Eligibility/Enrollment</b>	Spokane (New Horizon)	New Horizon needs to change BHSO coverage for a client to a different MCO, but the HCA call center referred them to Medicare.	This was an error and the call center rep. should not have referred you to Medicare. We recommend mentioning that you are calling about "Behavioral Health Services Only (BHSO)" coverage when you call again. HCA will also follow up with ProviderOne staff to clarify how to handle these cases.
69	<b>Eligibility/Enrollment</b>	Greater Columbia (Sundown M Ranch)	Why is ProviderOne not showing BHO assignment for some clients in the 2020 regions?	This could be because the individuals are AI/AN, or the clients may not be receiving BH benefits. You can submit a ProviderOne Help Ticket and we can look in to this further.
70	<b>Enrollment</b>	Greater Columbia (Lourdes) & Spokane	If a person moves to a new regions and has to enroll with a new MCO, do they have to wait until the following month to be covered under this plan?	<p>Yes, in most situations coverage under the new plan would not start until the following month. However, the provider and MCO could work out a single case agreement.</p> <p>If the provider and MCO cannot do a single case agreement, then the patient could request a mid-month transfer or retroactive enrollment. In this case, clients are usually backdated to the 1<sup>st</sup> of the month, but we can do up to 3 months for retroactive enrollment.</p>

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#	Topic	Region/ Provider	Question	HCA/MCO/BH-ASO Response
				Note: Enrollment is the responsibility of the MCO, not the BH-ASO.
71	Benefits Booklet	Pierce County (CCS)	Do agencies have to provide clients with the Medicaid Benefit Booklet?	No, HCA provides the electronic copy of this booklet and the booklet no longer has to be provided in hard copy. This is also true for the MCO Benefits Booklets.
72	Member ID Cards	Spokane (YFA Connections)	Have the MCO's Member ID cards been sent out to enrollees yet (question was asked on 1/16)?	Yes, the MCOs have all already mailed out the member IDs. They were staggered in their delivery so some enrollees may still be waiting, but most should have them by now. If enrollees still do not have cards, they can call the MCO's Customer Service line and the MCO can send the card electronically.
73	Providence ITAQ Program	Spokane  (Providence Sacred Heart Medical Center & Children's Hospital)	Providence runs an ITAQ program for patients that are detained. Even though these patients are insured, the hospital still has overhead costs for the person being detained- court evaluators and attorneys, holding court at the hospital, office space, etc. In the past Providence was able to garner a small portion of the charges, but it is unclear whether this option is still available.	Spokane BH-ASO pays the court costs to the court, but not to providers. HCA does not have a mechanism for paying for this cost – overhead should be built into the rates agreed to in contract.
74	42 CFR Part 2	Spokane  (SPARC)	SUD service providers are held to a higher confidentiality requirement than HIPAA. 42 CFR Part 2 prohibits redisclosure of assessment/ documentation from other agencies.  Does SPARC need to have a consent to redisclose?	Yes, you need to have consent to re-disclose.

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#	Topic	Region/ Provider	Question	HCA/MCO/BH-ASO Response
75	<b>SUD Assessments</b>	Spokane (SPARC)	Do MCOs want providers to submit the full SUD assessment paperwork, or are summaries ok?	<p>MCOs need the full assessment paperwork, summaries are probably not sufficient.</p> <p><u>Molina</u>: We do not require the full SUD assessment although it likely contains all of the clinical information we would need in order to make a medical necessity determination for either withdrawal management or SUD RTC. Providers may summarize as long as the critical clinical elements are provided. At Molina, we have created a documentation template that outlines the data points necessary for review and are available on request.</p>
76	<b>SUD Assessments</b>	Spokane (SPARC)	How often can intake assessments be billed? Every 12 months, or every treatment episode or medical necessity?	<p>Intake assessments should be updated every 6 months.</p> <p>For purposes of authorization, the MCOs need an updated assessment, and then they need an updated assessment every week or so, (every 7-14 days for CHPW specifically).</p> <p><u>Coordinated Care</u>: This response is accurate. Per the SERI guide, there are no limits on alcohol or drug assessments H0001. CCW does require clinical information to complete an authorization for residential treatment and updated clinical information ongoing in order to establish that the member meets criteria to be at that level of care. It may be that the provider updates the intake assessment, but typically they are providing updated progress notes and some form of an ongoing assessment of the member. We do not require the provider to complete another intake assessment every 14 days because the majority of the information would be the same. Providers complete an intake assessment when members present for services. We review clinical</p>

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#	Topic	Region/ Provider	Question	HCA/MCO/BH-ASO Response
				<p>information every 7- 14 days depending on the service and the LOS.</p> <p><u>AMG</u>: Amerigroup would seek any new clinical information or changes to status- update to dx or presenting problems, etc.</p> <p><u>Molina</u>: This question is a little unclear and if being addressed from the perspective of how current the clinical needs to be if requesting a level of care that requires authorization of those services.</p> <p>If an assessment is “aged” we cannot accept it in isolation for a request to enter SUD RTC. Example, the assessment is 4 months old and the provider is requesting admission to SUD RTC. We can utilize some of the historical information but would need an update on current use pattern, support psychosocial factors, support system, etc. To simplify, we would need information obtained within the past 7 days in order to make a reasonable medical necessity determination for the level of care being requested. Going forward in that level of care, we typically perform continued stay (or concurrent reviews) every 14 days to primarily insure;</p> <ul style="list-style-type: none"> <li>• that the member is actively engaged in treatment</li> <li>• that we are addressing any barriers to transition from this level of care</li> </ul>
77	Crisis Plans	Spokane (Lutheran)	Are crisis plans still required post-IMC? What is being looked at in these reports?	The ASO does not plan on changing their process. Creating crisis plans for all individuals in outpatient services is a best practice, and DOH does request crisis

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			Lutheran is currently doing crisis plans on all outpatients even though they're not technically required to (the previous BHO policy dictates that providers should create plans as-needed, on a case-by-case basis based on safety risk factors).	plans for all patients. These plans are still helpful and important so providers should continue creating these. Spokane ASO is working on an approach for collecting crisis plans from providers the MCOs contract with to ensure they are available to the crisis system providers in the Spokane Regional Service Area. Once this approach is finalized, the Spokane ASO will communicate with the group. In the interim, the ASO has carried over the previous BHO (pre-IMC) crisis plans from mental health outpatient providers.
78	<b>Complaints Grievances</b>	Spokane (YFA Connections)	The BH-ASO employs an Ombuds that deals with client complaints and grievances. She is coming to meet with our staff in a couple of weeks. At the IMC Symposium we were told that complaints and grievances were to go directly to the MCO – so which is it? Do we refer to the Ombuds or the MCO for client complaints?	The client should follow the MCO process for filing a complaint/grievance; the Ombuds is available to help clients through this process. The MCO and providers should be informing their clients that assistance from the Ombuds is available, should the individual wish.
79	<b>Critical Incident Reporting</b>	Pierce (Catholic Community Services (CCS))	The MCOs have told CCS that every referral call to Child Protective Services (CPS) must be submitted to them by completing an Incident Report. Currently every CPS contact is documented in charts and submitted on an organizational incident report where all incidents are then aggregated and analyzed in different configurations. This process and resulting documents aggregating	HCA has clarified that this is not a requirement for MCOs, which allows MCOs to remove this requirement for providers. Providers should continue to report as a critical incident if it meets other criteria for a CI e.g. likely to have media attention.

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#	Topic	Region/ Provider	Question	HCA/MCO/BH-ASO Response
			incidents is scrutinized through a number of groups within the organization - Clinical Directors, Vice Presidents and other Corporate Officers and finally our Board.	
80	<b>Critical Incident Reporting</b>	Pierce (Greater Lakes Mental Healthcare)	Greater Lakes was not aware of the requirement to complete an incident report on all CPS reports and they are concerned about this requirement. Last year Greater Lakes made 992 CPS reports. Most of them (around 99%) are very low level. Each agency manages its own risk and has procedures in place to mitigate that risk.... Greater Lakes suggests modifying this requirement by only requiring agencies to send CPS reports that rise to a sentinel event, which HCA could define, for example, as a potential media event, death, serious injury, etc.	See HCA's response to the question above.
81	<b>Critical Incident Reporting</b>	King	Will HCA's guidance regarding critical incident reporting be applicable to just the regions that have expressed concern, or to all regions statewide?	HCA guidance on this issue will apply to all regions in the state.
82	<b>Independent Financial Audit</b>	Greater Columbia (Somerset Counseling)	When previously contracted with GCBH, we were contractually obligated to have an Independent Financial Audit performed yearly. This was "a Medicaid requirement." I have not	When GCBH operated as a BHO, it required that service providers get audited F/S yearly. It was not a requirement from the state---it was a requirement GCBH added to the contract.

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#	Topic	Region/ Provider	Question	HCA/MCO/BH-ASO Response
			seen any language in our MCO contracts regarding this being a continued requirement nor is there any language about it in our HCA Core Provider Agreement.	HCA does require the MCOs to oversee providers for Program Integrity. It is up to the MCOs and BH-ASOs to determine how they will do that, in compliance with state and federal rules.
83	<b>State Hospital Liaison</b>	Greater Columbia (Comprehensive)	Comprehensive's state hospital liaison was told that she could no longer work on state hospital transition planning and that this process is now being handled by the MCOs. Is this accurate?	The MCOs do have their own state hospital liaisons, but they recognize the importance of having other state hospital liaisons in the region. The MCOs expect their liaisons will work closely with other community liaisons. The MCOs will keep this in mind and work to figure out how best to coordinate moving forward.
84	<b>State Hospital &amp; Community Long-Term Bed Access</b>	Pierce County	<p>1. When a person is already in an E&amp;T and has a 90-180 day order, how does the patient get on the Western State Hospital (WSH) waitlist?</p> <p>2. What is the process/criteria for getting a patient into a community hospital bed?</p>	<p>1. When a person in the E&amp;T receives a 90 day court order, the facility should reach out to the MCO/ASO 'Waitlist approver'. HCA will be sending out a list of contacts. On the WSH tab, the MCO/ASO waitlist approver can be found in the far right column. The facility and the MCO/ASO should review the case and unless alternate placement is anticipated within 30 days, the decision should be made to place the person on the waitlist. WSH expects the facility to contact Sharon Regan (Admissions Person) to place a person on the waitlist.</p> <p>2. An algorithm is used to identify who can access a community long-term bed. The process is separate from the WSH waitlist process, although if a person is on the WSH waitlist and it is decided that they will admit to a community LT bed, WSH should be informed so they can remove the person from the waitlist. If a patient is already in that facility, the MCO/ASO and facility should discuss whether an individual can access one of the LT</p>



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#	Topic	Region/ Provider	Question	HCA/MCO/BH-ASO Response
				<p>beds. If the patient is not in a facility that has LT beds, the MCO/ASO can reach out to a facility with community LT beds and inquire about a bed. Admission is prioritized based on the following algorithm.</p> <p><b><u>Admits to facilities under contract with HCA to provide 90-180 day civil commitment beds are prioritized as follows:</u></b></p> <ul style="list-style-type: none"> <li>1) Individuals currently in facility             <ul style="list-style-type: none"> <li>a. Clinically appropriate                 <ul style="list-style-type: none"> <li>i. Co-morbidity (mental health/physical health)                     <ul style="list-style-type: none"> <li>1. Plan/facility agree</li> </ul> </li> </ul> </li> <li>b. From the region of facility</li> <li>c. Court order; date/time (first come, first served)</li> </ul> </li> <li>2) Outside Placement             <ul style="list-style-type: none"> <li>a. From that region &amp; clinically appropriate                 <ul style="list-style-type: none"> <li>i. Co-morbidity (mental health/physical health)</li> </ul> </li> <li>b. Current location is not clinically appropriate                 <ul style="list-style-type: none"> <li>i. i.e. Emergency Room</li> </ul> </li> <li>c. Court Order; date/time (first come, first served)</li> </ul> </li> </ul> <p>Example Question: If Molina has 6 people on a short term hold in a facility that has contracted beds, Coordinated Care has 2, CHPW has 1....do we get all 6 contracted beds first as they come available because our volume is greater?</p>

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#	Topic	Region/ Provider	Question	HCA/MCO/BH-ASO Response
				<p>Answer:</p> <p>Using the decision algorithm that was created for the scenario you are describing, clinical staff in the facility would determine if it was a good fit for both physical/mental health to be in that particular facility for up to 90 days. Then the individual would need to be from the region that the facility is located which is beneficial to the individual for a number of reasons including discharge planning; then we would go off of the court order date/time.</p>
85	Interpreter Services	Greater Columbia (TCCH)	Will the MCOs be covering interpreter services? The BHOs used to cover this service but under the IMC model providers are not sure who to bill.	<p>HCA has created FAQ documents that contain detailed information about our brokered interpreter services vendor. This information is posted on HCA's website at <a href="https://www.hca.wa.gov/billers-providers-partners/programs-and-services/interpreter-services">https://www.hca.wa.gov/billers-providers-partners/programs-and-services/interpreter-services</a>. The links to the individual FAQs are also included below:</p> <p><a href="#">IMC - FAQ</a>  <a href="#">IMC webinar - FAQ</a></p>
86	UA Guidance	Spokane	When will the updated guidance regarding urinalysis be available?	<p>On 1/24 the Medical Director's office at HCA released new guidance on urinalysis, and HCA forwarded that guidance to the rapid response call participants. Comments on the updated guidance were due on 2/8 directly to Charissa and Judy Hull. The finalized guidance will be sent out shortly thereafter.</p>
87 NEW	Transportation	Spokane (NE Counseling Services)	Residential treatment facilities (RTFs) are responsible for transporting patients back to the homes once they have completed their stay, how do	<p><b>Updated response:</b> The HCA Non-Emergency Medical Transportation (NEMT) program now allows non-emergency transportation for all clients going to and/or from SUD or MH facilities for any length of stay.</p>

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#	Topic	Region/ Provider	Question	HCA/MCO/BH-ASO Response
			they do this? Does the RTF have to pay for this?	
88	Transportation	Spokane (SPARC)	Is there a way to be reimbursed when we purchase a bus ticket for an individual leaving our residential facility to get back to their county of origin? Prior to 1/1/19, some of the BHO's were reimbursing for bus and cab fare.	See the response above.
89	Transportation	Greater Columbia (Sundown M Ranch)	I am trying to find transportation options for our Medicaid eligible patients who need to go home after they are discharged from their inpatient stay at Sundown M Ranch. Most of the BHO's reimbursed us for our shuttle tickets or Greyhound Bus tickets. Now that we have MCO's nobody is paying for them. What options are available for us? I will bill the patient as a last resort because most of them are unemployed and have no resources. This is a very expensive tab for Sundown to fund. Last year it ran around \$18,000 - \$20,000. We are not in a position to continue to cover their transportation. Any information you can provide would be very beneficial.	See the response above.

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#	Topic	Region/ Provider	Question	HCA/MCO/BH-ASO Response
90	Transportation	Spokane (Northeast Washington Alliance)	For inmates in county jails that are going from jail to inpatient SUD treatment, we are having the same issue with the Medicaid Transportation Brokers that we had with the MCOs: Since the Medicaid is suspended, the Transportation Broker won't let us schedule the "trip." Can HCA do something with the Medicaid Transportation Brokers like they did with the MCOs to help us get past this impasse?	<p>HCA's NEMT subject matter experts researched this issue and came to the conclusion that providers can use the brokered transportation system for incarcerated people to SUD residential treatment.</p> <p>In order to do this, the provider (the facility to which the person will be admitted) needs to fill out a form to notify the transportation broker that the client is being released from jail. Note: The provider only needs to send this form if the facility is an IMD.</p> <p>For additional questions or information, please contact HCA's NEMT department at <a href="mailto:HCANEMTTRANS@hca.wa.gov">HCANEMTTRANS@hca.wa.gov</a>.</p>
91	Early Warning System	Greater Columbia (Catholic Charities)	Are providers going to see data on submission rates and denials, like they did during the North Central Early Warning System (EWS) webinars last year?	Yes, that data will be shared in the EWS webinars.
92	CLIP	Greater Columbia	Which entity is responsible for sending the CLIP referral?	<p>Usually the CLIP Committee makes the recommendation, then coordinates with the BH-ASO regarding meeting times and sends them forward to the state. However, the BH-ASO does not have to fill them out.</p> <p><u>Molina</u>: In SWWA, Molina actually helps facilitate this and can help facilitate in other regions.</p>
93	MCO Contact List	Greater Columbia	When will the MCO Contact List be updated and sent out?	Done 2/1/19. Ask Jodie Polehonka if you are not on distribution.

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#	Topic	Region/ Provider	Question	HCA/MCO/BH-ASO Response
94 <b>NEW</b>	<b>Sub-acute Withdrawal stays</b>	Several	How do providers bill for withdrawal if less than 24 hour stay	Gail Kreiger is soliciting input and will finalize this policy.
96 <b>NEW</b>	<b>Crisis Stabization payment</b>	Greater Columbia	<p>Who pays for crisis stabilization for clients with commercial insurance?</p> <p>Should we be directing clients to services private insurance or Medicare does cover, or use state only funds?</p> <p>Very few E&amp;T facilities will take a voluntary admit if covered by Medicare. Could use a lower level like crisis stabilization, but not covered traditionally.</p>	Charissa Fotinos is following up.
97 <b>NEW</b>	<b>MCO Retro- enrollment and provider payment</b>	Spokane County Regional Behavioral Health (SCRBH- ASO)  Better Health Together  Greater Columbia	<ol style="list-style-type: none"> <li>1. What happens when MCO enrollment is back-dated and services were already provided and paid for by the ASO?</li> <li>2. If the MCO is going to cover the services, will they provide a retro-authorization or just honor the authorization given by the ASO?</li> <li>3. If a client is retro-enrolled:                             <ul style="list-style-type: none"> <li>• Do we deny or invalidate the authorization;</li> <li>• Do we change data in ProviderOne and,</li> </ul> </li> </ol>	<p>If a <b>crisis related service</b>, use the process of reconciling twice a year between MCO and ASO. The provider does not need to re-bill.</p> <p>If a <b>non-crisis</b> related service, the ASO would need to recoup payment, then the provider would need to bill the MCO. MCOs would honor the ASO's authorization for services, assuming that normal rules for medical necessity under Medicaid applied to that authorization. MCOs would then be responsible for confirming ongoing authorization at the point they receive the enrollee on their 834. The provider will resubmit the authorization request as a retro authorization request to the MCO. The provider will identify the request as a retro enrollment request as well as provide information on the previous ASO approval if available.</p>


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			<ul style="list-style-type: none"> <li>Does PSHMC have to get a retrospective review for authorization from the MCO?</li> </ul> <p>Example: There was an individual who was not enrolled in Medicaid at the time of the admission into the psychiatric unit.</p>	<p><u>Additional notes:</u> If the service requires prior authorization, claims personnel will look for the authorization in the system and the ASO previous authorization will not be known. Providers should resubmit the authorization request as a retro-authorization to the MCO.</p> <p>The MCOs do need the clinical information about the client and the Prior Authorization information from the ASO or the provider.</p>
<b>98</b> <b>NEW</b>	<b>Interim Codes</b>	Greater Columbia	What codes do we use during this interim period while waiting for the IMC SERI guide to be released? Should we use the updated codes from the draft IMC SERI and NPI/SERI guidance last October or stick with the 7/1/18 SERI until the new one is finalized?	The providers were instructed to inform the MCOs whether they preferred to use the old SERI guide or the draft IMC SERI, and each provider was configured to send encounters based on their preference.
<b>99</b> <b>NEW</b>	<b>Clients not on Medicaid Yet</b>	Greater Columbia/Dr. Lippman	Who takes responsibility for clients who will eventually be on Medicaid	<p>Either 1) ASO takes initial responsibility (if not immediately on Medicaid on discharge), and then the MCO takes over responsibility once coverage begins. ASO bills MCO if backdated to beginning of month that ASO provided services.</p> <p>– or –</p> <p>2) MCO hospital liaison takes responsibility to get services prior authorized. HCA can assist (and is assisting in this case) to make sure the liaison is assigned to help this process.</p>

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#	Topic	Region/ Provider	Question	HCA/MCO/BH-ASO Response
<b>100</b> <b>NEW</b>	<b>Credentialing/facilities/rendering provider</b>	Better Health Together & YFA Connections	Why we are credentialed and contracted as “facilities” but the HCA wants claims reported at the “rendering provider” level?	<p>Rendering/servicing provider is a required field under Federal requirements for what HCA as a Medicaid health care provider must require reported. PER CFF HCA must enroll rendering providers and know who is rendering services on any given claim to assure they are enrolled because an individual that receives federal funds cannot be a person that has been found guilty of fraud or had action taken against their license and been reported to the OIG’s national provider data base as a person who cannot practice in Medicare or Medicaid.</p> <p>IN the SERI framework this correlates to the two digit provider specialty # you used to use, but it now requires a NPI and taxonomy for this field.</p> <p>The managed care provider network enrollment requirement was included in the CMS managed care Final Rule changes in May of 2016.</p>
<b>101</b> <b>NEW</b>	<b>UA For Clients Newly Released Jail</b>	Pierce	This provider provides UAs to folks (Medicaid and non-Medicaid) who are newly released from jail and who have to take a UA twice a week as a court condition.	Beacon has the CJTA funds that cover this provider’s UA’s and has followed up with the provider. HCA is working on guidance for who should generally cover non-medically necessary UAs.
<b>102</b> <b>NEW</b>	<b>NEMT &amp; IMD Facilities</b>	HCA	<b>Updated NEMT Policy</b>	NEMT is now covering transportation to and/or from SUD or MH treatment at an IMD for any length of stay, for both managed care and fee-for-service clients. Brokers have received the message and are accepting trip requests.

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				<p>The requestor must certify that the client is safe for transport without an attendant to qualify for NEMT transportation.</p> <p>Let HCA know if you need any assistance in conveying</p> <div style="text-align: center;">  <p>NEMT and IMD Facilities--Clarificati</p> </div> <p>this message to providers.</p>
<p><b>103</b> <b>NEW</b></p>	<p><b>Secure Detox facility/out-of-state patient</b></p>	<p>Spokane Regional Behavior Health</p>	<p>If a Medicaid patient is from out of state and their home state denies authorization for a secure detox facility stay in Washington, is the BH-ASO responsible to cover the individual's placement?</p>	<p>Yes, the BH-ASO is responsible for covering the individual's placement.</p>
<p><b>104</b> <b>NEW</b></p>	<p><b>NEMT &amp; bus tickets</b></p>	<p>Beacon Health Options</p>	<p>Optum previously reimbursed providers for this as it was given to clients to ensure they were able to make individual/group therapy appointments.</p> <ol style="list-style-type: none"> <li>1. Is this something that is continuing, and if it is, whom should the provider reach out to for reimbursement.</li> <li>2. Can NEMT reimburse for bus tickets (pre-arranged)?</li> </ol>	<p><u>Question 1 Response:</u> If the provider has SABG funds in their contract, they can pay for this. I have not heard of a reimbursement process. The provider would make arrangements and pay for this not a client.</p> <p><u>Question 2 Response:</u> Providers should work directly with the broker that serves their county. Brokers would need to confirm that the client has Medicaid eligibility and that the service to (or from) which they are travelling is covered. The broker should be setting up the trip or purchasing bus tickets (after screening the client) rather than reimbursing another entity after the fact since all NEMT trips must be prior authorized by the transportation broker.</p>



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				For additional questions or information, please contact HCA's NEMT department at HCANEMTTRANS@hca.wa.gov.
<b>105</b> <b>NEW</b>	<b>Interqual Authorizations</b>	<b>Spokane</b> <b>Better Health Together</b>	We've been told that all MCO's use Interqual for authorizations, but none have provided us with cheat sheets to identify criteria for medical necessity.	The MCOs identified which authorization guidelines they use in their FAQ in the Authorization tab.
<b>106</b> <b>NEW</b>	<b>Eligibility checks and timing</b>	<b>Spokane</b> <b>Better Health Together</b>	<p>Processes are in place to check eligibility on admit, first of month, and again on 15<sup>th</sup>.</p> <p>We have clients who are admitted in January under AI/AN fee-for-service (FFS) and on 2/1 he was still had no assigned IMC Care Manager. However, he received a letter on 2/3/19 that indicated he was enrolled in Molina and the enrollment was back-dated to 2/1/2019.</p> <p>Why is enrollment to the MCOs back-dated to the 1<sup>st</sup> of the month? Do we have to check the eligibility of every client every day to ensure a change has not been made and back-dated to the 1<sup>st</sup> of the month?</p>	<p>99% of the time the enrollment should be correct on the 1st of the month. Back-dating enrollment does not normally occur, so it is not necessary for providers to check eligibility daily.</p> <p>Generally speaking, it is not normal to switch MCO coverage in the middle of the month, but it does happen in certain situations (i.e. AI/AN clients, stepping down from state hospital or for mid-month transfers (rare).</p> <p>HCA may have to do retro-enrollment to make sure there are no access to care issues.</p>
<b>107</b> <b>NEW</b>	<b>Different Reporting requirements for WISE</b>	Pierce & CCS	MCOs are inconsistent or have different expectations around WISE so that makes it hard to automate.	<p>HCA is looking to do a statewide WISE meeting in April, so that could be a good forum to discuss this issue.</p> <p>There is also a Pierce regional meeting on the 27th to discuss streamlining processes so that would be a good</p>

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			Can we have the MCOs and HCA agree on what is the requirement? This needs to be sustainable and it isn't right now.	forum to discuss this issue as well. CCS said they would be happy to host another future meeting if needed- will send Jodie dates for availability for after 2/27.
<b>108</b> <b>NEW</b>	<b>Anger Management billing</b>	Okanogan	<p>Okanogan has an anger management program, where some clients fill out an intake, while others who are only there for a short period of time, (i.e. only taking 8 hour class) don't need to complete the intake.</p> <p>However, the code they were told to use via the MCOs requires an intake.</p> <p>How do they bill for those Medicaid clients that are receive the short-term services and don't have an intake?</p> <p>Could they still use the code even if no intake was done?</p> <p>Are there other codes the program could bill?</p>	Molina does not require an intake when using that particular code, so not having an intake is not a problem.
<b>109</b> <b>NEW</b>	<b>Taxonomy codes</b>		Does HCA plan to add edits in ProviderOne for Managed care encounters which validate specific taxonomy codes	HCA does not currently have plans to add taxonomy edits to ProviderOne.
<b>110</b> <b>NEW</b>	<b>Non-Medicaid UAs</b>		What codes do the MCOs want submitted for non-Medicaid covered UAs.	<u>Amerigroup</u> : For the non-Medicaid covered UAs, Amerigroup will use code H0047 as per our non-Medicaid fee schedule. We will pull all claims that paid with code H0047 to ensure these services are paid with

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				<p>GFS funds. We are also willing to use code H0003 in order to align with other plans.</p> <p><u>CHPW</u>: We use H0003 for non-Medicaid UAs. There is no other relevant information necessary for providers to bill. CHPW will continue to use this code for non-Medicaid UAs, unless the SERI billing guide states otherwise.</p> <p><u>Coordinated Care</u>: Non-Medicaid UAs are predominately paid for utilizing CJTA funds, which is only available through the ASOs. Since GF-S are limited and we must ensure adequate funding for priority categories, such as Room and Board, UAs are reimbursed using non-Medicaid funds only if specified in provider contracts. In those cases, we would have providers use code H0003.</p> <p><u>Molina</u>: Molina is using H0003 for non-Medicaid UA's. As these are non-Medicaid funds, payment is subject to availability of funds.</p> <p><u>United Healthcare</u> is able to accept H0002 &amp; H0003 for Non Medicaid UAs.</p>