Sample Questions from 2019 IMC Mid-Adopter Rapid Response Calls

#	Topic	Question	HCA/MCO/BH-ASO Response
1.	**SERI Guide/Fee Schedules & FQHCs**	1. What is the difference between Specialized Mental Health and Mental Health Fee Schedules?	1. The Mental Health (MH) Fee Schedule is for those services rendered as part of the physical benefits. These services are covered by all of the managed care organizations (MCOs) and Health Care Authority's (HCA's) fee-for-service (FFS) program. An eligible provider must be licensed by the Department of Health (DOH). The MH Fee Schedule covers a limited set of services that does not include: inpatient, residential substance use disorder (SUD), wrap around services or all the other services covered by the Behavioral Health Organization (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 **who are not assigned to a BHO, Behavioral Health Services Only (BHSO) or Behavioral Health-Administrative Services Organization (BH-ASO) for their behavioral health (BH) services**. 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 meet) through a new HCA FFS 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: https://www.hca.wa.gov/assets/billers-and-providers/mental-health-svc-bi-20190101.pdf

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			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 Integrated Managed Care (IMC) behavioral health provider, who renders higher acuity services, 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.
		2. CPT codes in the SERI Guide are not on the 2019 Specialized MH Fee Schedule. Are we supposed to use the Fee Schedule or the SERI? Some of the codes that are not on the Specialty Mental Health Fee Schedule are 90785, H2021 and H0032 (the last two are used by WISe).	2. Use the SERI to bill services you are delivering as a licensed behavioral health agency (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.
		3. FQHCs have to take into consideration the FQHC, MH and SUD billing claims submission. Since providers have been instructed to follow HCA billing guides when submitting claims to the MCOs, do we submit claims using the TG modifier and specified taxonomies?	3. An FQHC may be providing both levels 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

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			determining if any further specific data is required and when that decision is made we will share it with the providers and the plans.
2.	**SERI Guide/Fee Schedules**	The H0038 CPT code is not on the HCA MH Fee Schedule but it is on the Specialized MH Fee Schedule. The SERI shows a number of possible modifiers but the Specialized Fee Schedule shows only a TG modifier. 1. Can this code be billed WITHOUT the TG modifier? 2. Would the rate from the Specialized Fee Schedule still apply, or is there a different rate?	The Specialized MH fee schedule and Provider guide and the SERI support two different BH programs 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 BH-ASO, use the SERI. How to determine who is covered by what program is in the HCA MH guide. Note that on our daily calls, we are trying to focus on questions from the IMC 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: 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 ProfessionalRates@hca.wa.gov.

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3.	**NPI**	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.
4.	**NPI**	How long does it take for an NPI application to go through at the federal level?	In general, the NPI process takes minutes.
5.	**Credentialing**	When new providers join a BHA, they fill out a 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 oversite with someone who is already fully 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?	See MCO responses below: <u>Amerigroup (AMG):</u> 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. <u>Molina:</u> 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: • Provider must have an NPI to be loaded into our system. • 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).

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			• BH Agencies have been credentialed via DOH, so for Molina, credentialing does not come into play in this scenario. Coordinated Care of Washington (CCW): 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. https://www.doh.wa.gov/LicensesPermitsandCertificates/ProfessionsNewReneworUpdate/AgencyAffiliatedCounselor/FrequentlyAskedQuestions 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. Community Health Plan of Washington (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.

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			United HealthCare (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. For medical providers, we require each individual provider to 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. HCA recommends reaching out directly to MCOs if needed on this question.
6.	**Credentialing**	Can a provider bill an MCO before they get a ProviderOne number/Medicaid ID?	Yes.

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#	Topic	Question	HCA/MCO/BH-ASO Response
7.	**Credentialing/ facilities/rendering provider**	Why are we credentialed and contracted as "facilities" but the HCA wants claims reported at the "rendering provider" level?	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. 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. The managed care provider network enrollment requirement was included in the CMS managed care Final Rule changes in May of 2016.
8.	**Provider Taxonomy**	How do providers correct an erroneous ProviderOne provider taxonomy?	Providers 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.
9.	**Provider Taxonomy**	1. A BHA registered their CDP's and CDPT's NPIs using the separate taxonomy codes. Then in the Provider Readiness group they 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. When attempting to update the NPI registration for the CDPT's, the BHA got this	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. We have provided a list of acceptable taxonomies for these professionals that are not fully licensed:

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		response back from HCA: "We are unable to add this taxonomy to the NPI's listed below since they only have a trainee certification." 2. This BHA also attempted to register a contracted employee's NPI with HCAand got an error message stating they 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, but she is also contracted to provide SUD services with this agency. How does the BHA get the contracted employee registered under the agency for her SUD taxonomy code? Will the claims/encounters go through if the BHA does not enroll her under the CDPT code, since she's already enrolled with the other agency under her mental health taxonomy?	**Mental Health & CDPT in Training 101Y99995L**. There are 2 other NCCU taxonomies that are acceptable, they are: **Mental Health Counselor 101Y00000X** or **Student/Trainee 390200000X.** 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. For more information on NPIs, enrolling providers, provider taxonomies, and the SERI Guide, please see the resources posted on HCA's website at https://www.hca.wa.gov/about-hca/healthier-washington/regional-resources (under the "General" tab).
10.	**Provider Taxonomy**	Is the billing provider taxonomy required in box 33B on the CMS 1500 HCFA form?	Yes.
11.	**Provider Taxonomy**	1. Are the MCOs validating taxonomies against services? There isn't a CDPT federal taxonomy code, so BHAs would have to bill with the counselor taxonomy. Would that make it past billing edits?	1. Provider Enrollment states that there 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.

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			Note: Assume provider is referring to a CD counselor code
		2. What if the BHA's EHR only allows them to enroll practitioners with one taxonomy?	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 bill they will bill with the one that they used to get their NPI. If they bill directly, when they enroll use the SERI taxonomy only.
12.	**Provider Taxonomy**	1. Encounters will not be validated to specific taxonomy codes cross-walked to provider types in the IMC SERI, correct? 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?	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. HCA does not currently have plans to add taxonomy edits to ProviderOne. However, providers should follow the guidance already provided for submitting encounters and applicable taxonomy codes. 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 Fact Sheet (see link) 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.

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			Outside of the ProviderOne functionality described above, there is not a list of HCA-recognized taxonomy codes which has been published by HCA.
13.	**Provider Taxonomy**	In reference to the taxonomy codes published in the NPI Fact Sheet linked in the question above, a BHA identified other taxonomy codes they registered their clinicians under for their NPI's. Examples: • Masters level students, 'Below Master's Degree' 101Y99995L vs. 'Student in an Organized Health Care Education/Training Program 390200000X; • LICSW, 104100000X vs. 'Social Worker; Clinical' 1041C0700X; • Masters level whom are not licensed, 'MA/PHD (non-licensed)' 101Y99996L vs. 'Social Worker' 104100000X. Would the taxonomy code for interns fall under 390200000X? 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?	Typically, HCA has been recommending enrolling at the highest applicable level, but you can contact Provider Enrollment (info below) to get specific answers on these. **Provider Enrollment** Phone: 1-800-562-3022 ext. 16137 Email: providerenrollment@hca.wa.gov
14.	**American Indian/Alaska Native (AI/AN)**	Do you have contact at HCA that is specifically in charge of AI/AN?	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 our inbox at tribalaffairs@hca.wa.gov (or Michael Longnecker at michael.longnecker@hca.wa.gov)

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15.	**AI/AN Provider**	If a clinician has a Master's degree and is licensed, and is under supervision to obtain independent licensure, can they provide AI/AN services under supervision?	They can bill P1 **today** (or *yesterday*) for MH services for clients who are not enrolled in one of the managed care plans. • Regular HCA mental health services are billable for clients who are not enrolled in a managed care plan, using the Mental Health Billing guide (stay in Part 1) • 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. • HCA requires that MHPs who see kids have at least 2 years' experience working with kids. It is a simple attestation.
16.	**AI/AN**	General Information about AI/AN program	General information about using the FFS billing guides from the Tribal Affairs staff: You can also follow the below step-by-step process for determining when/how to use the MH billing guide: 1. What is the category? MH or SUD? (assuming MH, if it is SUD, stop reading) 2. What is the client's insurance? (assuming FFS, if client has managed care that covers the BH service, stop reading) 3. For "low acuity mental health" (or whatever the current words are) – follow the MH billing guide, page 0-97. Do not read anything past page 97

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			4. For "specialized mental health" – follow the MH billing guide, page 0-35 & 97-120 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. i. The MH billing guide technically does not "own" the policy behind H0038, we go to the SERI guide, page 62 for the modality definition and then page 63 for the coding (for SERI, not for P1) 1. GT = interactive telecommunication. This modifier in not in the MH guide. 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 3. UD = state-defined modifier. This modifier is not defined in the MH guide 4. U8 = state-defined modifier. This modifier is not defined in the MH guide.
17.	**AI/AN**	How does a provider get paid for inpatient mental health detention for AI/AN	The provider needs to establish a contract with the Division of Behavioral Health and Recovery (DBHR) and

<table>
<tr><th>#</th><th>Topic</th><th>Question</th><th>HCA/MCO/BH-ASO Response</th></tr>
<tr><td></td><td></td><td>individuals? Do they need authorizations for these services?

How does billing FFS for AI/AN work?</td><td>be identified as an AI/AN provider within that network in order to bill for these services.

If the client is AI/AN, the provider needs to submit the claim to ProviderOne.</td></tr>
<tr><td>18.</td><td>AI/AN Eligibility</td><td>How do you determine if a client is in the American Indian/Alaska Native FFS program?</td><td>If you have specific question about a client’s eligibility, you can email: mmishelp@hca.wa.gov

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.

See below:
==========
1. If the provider is providing SUD Services or mental health,
AND
2. The client has one of these RAC codes for the date of service:
<table><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></table>
AND
3. The client is not enrolled in any of these Apple Health Managed Care plans:
• North Sound Behavioral Health Org</td></tr>
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#	Topic	Question	HCA/MCO/BH-ASO Response
			• Thurston-Mason Behavioral Health Organization • Great Rivers Behavioral Health Organization • Salish Behavior Health Organization • AMG Fully Integrated Managed Care • AMG Behavioral Health Services Only • CCW Fully Integrated Managed Care • CCW Behavioral Health Services Only • CHPW Fully Integrated Managed Care • CHPW Behavioral Health Services Only • MHC Fully Integrated Managed Care • MHC Behavioral Health Services Only • UHC Fully Integrated Managed Care • UHC Behavioral Health Services Only **THEN** 4. The client is AI/AN Fee-For-Service
Note: Questions combined for streamlining; there are breaks or changed order in numbering below.			
25	**Medicare Clients/Dual-Eligibles**	Is it true 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?	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**	Where can BH providers find a list of the residential and inpatient facilities that the MCOs are contracted with across the state that providers can use to determine which facilities they can refer their patients to?	The MCOs suggested using their websites for locating facilities under contract, but they have also offered to create these lists for distribution to providers.
27	**Discharge Notification**	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

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			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	**Authorizations**	In regards to the process for obtaining prior authorization for SUD inpatient, does the SUD outpatient (OP) provider complete a SUD IP referral form and send it to an MCO, then the SUD IP provider admits the patient and then gets the authorization from the MCO? It would be very helpful if EACH MCO could please send providers the correct information/form/process for each of their services.	Individual problems should be routed to the BH UM Manager of each MCO for assistance. The MCO's BH UM Manager can facilitate communication between the agencies and work to resolve authorization issues. In addition, MCOs have distributed authorization guidance relating to different services. (NOTE: these were current as of March 2019; you should refer to provider handouts from North Sound training.) Coordinated Care: Please find attached CCW's Prior Authorization Summary and UM Leadership contacts for reference. 2019 CCW PA Summary.docx CCW Leadership Contacts Utilization M CHPW: Go to CHPW webpage for proper forms and processes. Providers can also call customer service. Either outpatient or inpatient provider can submit clinical information for authorization. AMG: Kathleen Boyle is now the point of contact for Amerigroup for these issues. 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

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			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.  2019 MHW BH Authorization Request Form Final.pdf  MHW BH UM TEAM Contact List update
29	**Authorizations**	What are the wait times for pre-authorization for Amerigroup and Molina? (CHPW will authorize urgent SUD IP referrals in 72 hours.)	MCOs distributed authorization guidance to providers. Molina: 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 additional 14 days can be requested. A total of 28 days. All MCOs adhere to these TATs.
30	**Authorizations**	During the first several weeks after IMC implementation providers noted that the	MCOs acknowledge this and noted that they were just then receiving the information they needed. To get

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		MCOs were taking a while to approve authorizations.	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. Molina: It is to be expected that there would be delays at the onset of IMC 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.
34	**Authorizations**	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.
37	**Authorizations**	Do providers have to get prior authorization for IOP level of care?	See the 2019 MCO Combined PA Grid distributed at North Sound provider trainings. Document available on request until posted on the HCA website.
38	**Coordination of Authorizations With Other Regions**	How does a provider get authorization for treatment for a patient who resides in a different IMC region (for example, if the provider has a FFS arrangement for out-of-network services)?	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 HCA guidance document on this topic is available upon request until posted on the HCA website.

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39	**Authorizations/ Notification and Concurrent Review**	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	**Authorizations/ Notification and Concurrent Review**	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 timeframes are very similar; see Prior Authorization handout from provider trainings in North Sound. The MCOs are continuing to work towards greater standardization of forms and information requested for prior authorizations/notifications with concurrent review.
41	**Jail Transitions/ Authorizing Services for Incarcerated Individuals**	How should regions coordinate jail pre-authorizations for inmates needing direct placement to inpatient/residential SUD treatment upon release from jail?	In coordinating jail transitions, follow the steps below: 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 integratedmcquestions@hca.wa.gov 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 will need clinical documentation to process the authorization- same as any request for this service. 3. If the county is having trouble, let HCA or the provider know and we can help coordinate. 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

#	Topic	Question	HCA/MCO/BH-ASO Response
			inmate upon release. Then they will work with that MCO to get the prior authorization. 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 hours to process this enrollment on HCA's end, so the provider won't see it in the system until the following day. HCA's guidance document on this issue is available upon request until posted on the HCA website. 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.
42	**Notification vs. Prior Authorization**	1. What is the authorization process for crisis triage? 2. What about when stepping down to a lower level of care?	The process is notification with concurrent review, including when stepping down to a lower level of care. 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

#	Topic	Question	HCA/MCO/BH-ASO Response
			provider would need to obtain prior authorization for those services as they are planned.
43	**Notification with Concurrent Review**	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?	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. 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.)
44	**Authorization Notification Requirement**	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 provider need to send	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.

#	Topic	Question	HCA/MCO/BH-ASO Response
		the notification by Sunday, or the following Monday?)	
45	**Billing for Withdrawal Management/Sub-Acute Detox**	How do providers bill for withdrawal if less than 24 hour stay? 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.
103	**Secure Detox facility/out-of-state-patient**	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?	Yes, the BH-ASO is responsible for covering the individual's placement.
46	**Private Insurance & Authorizations**	1. If a client with private insurance is detained on an ITA, does the BH-ASO have to authorize this? 2. Would the BH-ASO need to enter this into ProviderOne?	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. HCA is putting together guidance on who covers what regarding hospitalizations.
47	**Private Insurance**	If a patient comes into a facility under an ITA with commercial insurance carriers the facility is not credentialed with, and the facility	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

#	Topic	Question	HCA/MCO/BH-ASO Response
		cannot get payment or can get only partial payment, how do they get reimbursed for the remaining balance due?	in the past, the facility should try reaching out to the BH-ASO to see if they would be willing to consider these for retroactive authorization and reimbursement. 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 the provider to reach out to the BH-ASO to develop a relationship and process for handling these types of cases.
96	**Crisis Stabilization payment**	Who pays for crisis stabilization for clients with commercial insurance? Should we be directing clients to services private insurance or Medicare does cover, or use state only funds? Very few E&T facilities will take a voluntary admit if covered by Medicare. Could use a lower level like crisis stabilization, but not covered traditionally.	Follow the rules for third party liability. The HCA guidance document on this topic is available upon request until posted on the HCA website.
48	**WISe- CANS Report**	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: Coordinated Care: 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.

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			CHPW: CHPW is now able to access the CANS through BHAS, so no need to submit CANS with notification for CHPW members. AMG: Yes Amerigroup does need the CANS report. Molina: We do not require the CANS assessment be sent with the notification form, as we can access the assessment through the BHAS system.
52	**Billing/Who Responsible for What?**	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.
54	**Billing/Coding**	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.
55	**Billing/Coding**	Can the MCOs confirm that submitting a claim/encounter with the HH modifier will not create a rejection?	Coordinated Care: The HH modifier is accepted and will not create a rejection. Molina: Submitting the HH modifier will not impact claim processing. It would include as informational.
56	**Billing/Coding**	How do we bill for crisis services provided by non-crisis service agencies? 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 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. 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

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			whatever the typical individual service code would be for the therapy/treatment session. 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.
57	**Billing/Coding**	Would an FQHC run into any billing issues in hiring a Licensed Advanced Social Worker for their children's behavioral health program? Would the MCO confirm whether: 1. LASW (Licensed Advanced Social Worker) encounters are reimbursed the same as LMHC's and LMFT's, and 2. Whether they qualify for FQHC (T1015) encounter billing?	Amerigroup: 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. Coordinated Care: 1. Yes, they are reimbursed the same. We currently do not pay FQHCs using encounter billing (T1015). 2. No, as long as services are appropriate for their license.
58	**MHP Attestation Form**	One of our providers is applying for a Mental Health Professionals Attestation Form, how do we do this?	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. 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.

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#	Topic	Question	HCA/MCO/BH-ASO Response
59	**Encounter Submission Attestations**	Do providers need to do attestations with MCOs regarding encounter submissions moving forward? If so, how do providers send this? Is there a universal form?	Yes, this is on the delegation grids for all MCOs.
61	**Primary Care Provider Assignment**	How can a provider help a client find a PCP if the client is enrolled with an MCO in a different region, but is temporarily in the provider's region for residential care?	The provider should work with the MCO to get authorizations through a single case agreement or non-participating provider agreement.
62	**Address Confidentiality Program (ACP)**	How can providers help clients in the ACP navigate through the HCA to update their profile?	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. **Important Note:** They will always show the Thurston County PO Box even when HCA updates the program code. 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. Note: ACP clients do not change to IMC automatically. They must call in and ACP clients are eligible for managed care. HCA Guidance will be released shortly.

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63	**Serving Clients From Non-IMC Regions**	How should a provider handle serving patients who live in one of the 2020 regions?	The provider should contact the BHO to work out a single case agreement, which may not involve the whole credentialing process.
66	**Eligibility**	Is there a way to do batch eligibility checks?	The instructions for doing batch eligibility checks may be in the ProviderOne enrollment guide, or providers can contact ProviderOne staff. The provider could also call the general Medical Assistance Customer Service Center **(**MACSC) number below: **Phone:** 1-800-562-3022 (choose "provider services") **Online**: Secure web form
67	**Eligibility/Enrollment**	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.
69	**Eligibility/Enrollment**	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	**Enrollment**	If a person moves to a new region and has to enroll with a new MCO, do they have to wait until the following month to be covered under this plan?	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. 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

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			are usually backdated to the 1st of the month, but we can do up to 3 months for retroactive enrollment. Note: Enrollment is the responsibility of the MCO, not the BH-ASO. For more information on enrollment, please see the "Welcome to Washington Apple Health" Booklet at https://www.hca.wa.gov/health-care-services-supports/apple-health-medicaid-coverage/apple-health-client-booklets.
106	**Eligibility checks and timing**	In which circumstances will MCO enrollment be back-dated to the 1st of the month? Do providers have to check the eligibility of every client every day to ensure a change has not been made and back-dated to the 1st of the month?	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. 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)). HCA may have to do retro-enrollment to make sure there are no access to care issues.
97	**MCO Retro-enrollment and provider payment**	1. What happens when MCO enrollment is back-dated and services were already provided and paid for by the ASO? 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? 3. If a client is retro-enrolled:	If a **crisis related service**, use the process of reconciling twice a year between MCO and ASO. The provider does not need to re-bill. If a **non-crisis** 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.

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		• Does the provider deny or invalidate the authorization; • Does the provider change data in ProviderOne and, • Does the provider have to get a retrospective review for authorization from the MCO? Example: An individual who was not enrolled in Medicaid at the time of the admission into a psychiatric unit.	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. <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. The MCOs do need the clinical information about the client and the Prior Authorization information from the ASO or the provider.
99	**Clients not yet on Medicaid**	Who takes responsibility for clients who will eventually be on Medicaid?	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. – or – 2) MCO hospital liaison takes responsibility to get services prior authorized. HCA can assist to make sure the liaison is assigned to help this process.

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71	**Benefits Booklet**	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.
76	**SUD Assessments**	How often can intake assessments be billed? Every 12 months, or every treatment episode or medical necessity?	Intake assessments should be updated every 6 months. 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). Coordinated Care: 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 information every 7- 14 days depending on the service and the LOS. AMG: Amerigroup would seek any new clinical information or changes to status- update to dx or presenting problems, etc.

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			Molina: 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. 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; • that the member is actively engaged in treatment • that we are addressing any barriers to transition from this level of care
78	**Complaints/ Grievances**	The BH-ASO employs an Ombuds that deals with client complaints and grievances, but 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	**Critical Incident Reporting**	Providers were told that every referral call to Child Protective Services (CPS) must be submitted to the MCOs by completing an	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

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		Incident Report. Providers make a large amount of CPS reports that are mostly low level, and each agency manages its own risk and has procedures in place to mitigate that risk. Providers expressed concern that requiring them to complete an incident report on all CPS reports is overly burdensome and unnecessary.	critical incident if it meets other criteria for a CI (e.g. death, serious injury, likely to have media attention).
81	**Critical Incident Reporting**	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.
83	**State Hospital Liaison**	Will state hospital liaisons working for individual BHAs still be able to work on transition planning now that the MCOs also have their own state hospital liaisons?	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	**State Hospital & Community Long-Term Bed Access**	1. When a person is already in an E&T and has a 90-180 day order, how does the patient get on the Western State Hospital (WSH) waitlist? 2. What is the process/criteria for getting a patient into a community hospital bed?	1. When a person in the E&T receives a 90 day court order, the facility should reach out to the MCO/ASO 'Waitlist approver'. See the link to MCO contacts at https://www.hca.wa.gov/about-hca/healthier-washington/regional-resources. 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

#	Topic	Question	HCA/MCO/BH-ASO Response
			contact Sharon Regan (Admissions Person) to place a person on the waitlist. 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 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. **Admits to facilities under contract with HCA to provide 90-180 day civil commitment beds are prioritized as follows:** 1) Individuals currently in facility a. Clinically appropriate i. Co-morbidity (mental health/physical health) 1. Plan/facility agree b. From the region of facility c. Court order; date/time (first come, first served) 2) Outside Placement a. From that region & clinically appropriate i. Co-morbidity (mental health/physical health)

#	Topic	Question	HCA/MCO/BH-ASO Response
			b. Current location is not clinically appropriate i. i.e. Emergency Room c. Court Order; date/time (first come, first served) 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? Answer: 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.
85	**Interpreter Services**	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.	HCA has created FAQ documents that contain detailed information about our brokered interpreter services vendor. This information is posted on HCA's website at https://www.hca.wa.gov/billers-providers-partners/programs-and-services/interpreter-services. The links to the individual FAQs are also included below: IMC - FAQ IMC webinar - FAQ

Sample Questions from 2019 IMC Mid-Adopter Rapid Response Calls

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87	**Non-Emergency Medical Transportation (NEMT)**	Residential treatment facilities (RTFs) are responsible for transporting patients back to the homes once they have completed their stay. Does the RTF have to pay for this? Can NEMT reimburse for bus tickets (pre-arranged)?	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. This is true for both managed care and FFS clients. The requestor must certify that the client is safe for transport without an attendant to qualify for NEMT transportation. If the provider has SABG funds in their contract, they can pay for NEMT. Check with the ASO regarding payment/ reimbursement process. The provider would make arrangements and pay for this, not a client. <u>For HCA's NEMT program:</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. Let HCA know if you need any assistance with this guidance.
90	**NEMT**	For inmates in county jails that are going from jail to inpatient SUD treatment, providers are having the same issue with the Medicaid Transportation Brokers: Since the Medicaid is suspended, the Transportation Broker won't let us schedule the "trip." Can HCA do	Providers can use the NEMT brokered transportation system for incarcerated people to SUD residential treatment. In order to do this, the provider (the facility to which the person will be admitted) needs to fill out a form to

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		something with the Medicaid Transportation Brokers like they did with the MCOs?	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. For additional questions or information, please contact HCA's NEMT department at HCANEMTTRANS@hca.wa.gov.
102	**NEMT & IMD Facilities**	Updated NEMT Policy	NEMT is now covering transportation to and/or from SUD or MH treatment at an IMD for any length of stay. Brokers have received the message and are accepting trip requests.  NEMT and IMD Facilities--Clarificatic
91	**Early Warning System**	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**	Which entity is responsible for sending the CLIP referral?	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. Molina: In SWWA, Molina actually helps facilitate this and can help facilitate in other regions.
101	**UA For Clients Newly Released Jail**	How is a provider paid for providing UAs to folks (Medicaid and non-Medicaid) who are	Beacon has the CJTA funds that cover UA's. HCA has recently shared guidance for coverage for UAs for drug testing.

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		newly released from jail and who have to take a UA twice a week as a court condition?	The HCA guidance document on this topic is available upon request until posted on the HCA website.
110	**Non-Medicaid UAs**	What codes do the MCOs want submitted for non-Medicaid covered UAs?	Amerigroup: 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 GFS funds. We are also willing to use code H0003 in order to align with other plans. CHPW: 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. Coordinated Care: 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. Molina: Molina is using H0003 for non-Medicaid UA's. As these are non-Medicaid funds, payment is subject to availability of funds. UHC: United Healthcare is able to accept H0002 & H0003 for Non Medicaid UAs.