MBHP
Massachusetts Behavioral Health Partnership
a Beacon Health Options company

Billing BHCA/CBHI Services For Members With Third Party Liability:

The EOB Issue

August 13, 2020

- This is a follow-up training to the webinar *Reimbursement for Behavioral Health for Children and Adolescents (BHCA) Services for Members with Third-Party Liability* held on October 10, 2019 and found in the "Events & Trainings" section of our website, www.masspartnership.com.
- We recommend that providers review that original webinar.
- This training will focus on the Explanation of Benefits (EOB) issue (i.e., what actions providers should take when they cannot obtain an EOB from the primary insurer).

Agenda

1. Reviewing Background Info
2. Reviewing Basic MBHP Requirements
   a. Eligibility
   b. Authorization/registration
   c. Transposing service codes
3. Reviewing EOB Requirement
4. What If You Cannot Obtain An EOB?
   a. Other documentation
   b. Letter of benefit denial
   c. Last resort option – composing a letter
5. Final Recommendations

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Chapter

01

Reviewing Background Information

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Background Information

- The Division of Insurance and the Department of Mental Health jointly issued Bulletin 2018-07 stating that all health plans must cover certain intermediate child-adolescent mental health services meeting certain requirements, with coverage starting on July 1, 2019 for fully insured Members.
- This group of services, known as Behavioral Health for Children and Adolescents (BHCA) has been covered by MassHealth/MBHP as part of the court-mandated program called the Children's Behavioral Health Initiative (CBHI).
- After a transition period that received multiple extensions, MBHP will enforce an EOB requirement for most of these services effective September 1, 2020.

September 2020

1. Effective for dates of service (DOS) starting September 1, 2020, all MBHP-contracted CBHI providers will be required to submit an EOB from the primary insurer for Members with TPL when submitting claims for these services.
    a. Claims without an attached EOB or COB information or without other approved documentation will deny with the code "BH – RESUBMIT WITH PRIMARY INSURANCE EOB."
    b. Claims must be submitted within timely filing requirements (within 90 days of the date on the primary insurer's EOB).
2. CHBI services requiring an EOB from the primary insurer include In-Home Behavioral Services (IHBS), In-Home Therapy (IHT), and Intensive Care Coordination (ICC).
    a. Community-Based Acute Treatment (CBAT) and ICBAT already require an EOB.
    b. Family Support and Training (FS&T) and Therapeutic Mentoring (TM) will require an EOB sometime in the future.

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Challenges

Providers will have to navigate the differences between **BHCA** and **CBHI:**

- Definite differences in billing codes, modifiers, and units
- Possible differences in payment types (case rate vs. fee-for-service)
- Possible differences in authorization requirements
- Possible differences in medical necessity requirements and performance specifications
- Inability of MBHP to determine if the Member who has a primary insurer is fully insured and has the benefit
- Difficulty in obtaining an EOB from self-funded plans which do not have the benefit

Chapter

02

Reviewing Basic MBHP Requirements

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Requirements

1. Three requirements need to be met for services to receive either full or partial payment from MBHP:
   a. **Eligibility**
      i. The Member must be eligible with MBHP for every date-of-service.
   b. **Authorizations/Registrations of Services**
      i. The Member must have authorization(s) in place with MBHP, *even if MBHP is the secondary payer*.
   c. **Correct Coding**
      i. MBHP can only accept its code set for CBHI services.
      ii. Providers will have to transpose between different code sets.
         - Bill the primary insurer utilizing its code set.
         - Bill MBHP utilizing our code set.
2. Claims will be denied if these three requirements are not met.

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Eligibility

- Per the MBHP Provider Manual, providers are responsible for verifying Member eligibility on every date of service.
- Member eligibility is verified through the MassHealth Eligibility Verification System (EVS), accessed on the Provider Online Service Center (POSC) of the MassHealth Virtual Gateway – www.mass.gov.
- EVS will list Member eligibility information, including MassHealth plan, primary payer (if applicable), and secondary payer.

Authorizations/Registration of Services

1. Even though MBHP is the secondary payer, providers must obtain authorizations with MBHP in order to submit claims and receive payment for Member liability.
2. All requests for authorizations are done through our telephonic Interactive Voice Registration (IVR) line (for most services), or through our provider web-portal, ProviderConnect.
3. Providers have 14 days from the first DOS to obtain an authorization for most CBHI services.
4. For more information, please see our website, www.masspartnership.com; click “Behavioral Health Providers,” then “Service Authorizations.”

Different Payers/Different Coding

1. Primary insurers are using different billing codes, modifiers, and unit definitions for BHCA services than what MassHealth/MBHP utilizes for CBHI services.
2. One set of codes must be billed to the primary insurer; a different set of codes must be billed to MBHP.
3. Providers will have to "transpose" between code sets.
    a. Knowing the description of each service is vital.
    b. Be aware that what different insurers call the service can be different.
        i. Example: Family Stabilization Treatment (FST)/In-Home Therapy (IHT)
    c. If you need help, utilize resources such as coding sets available from the ABH.

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Chapter

03

Reviewing EOB Requirement

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Billing Basics

- If the Member has any other insurance coverage, Medicaid will be secondary to that coverage. The primary insurer is responsible for that Member.
- When the Member has a primary insurer (e.g., Aetna, BCBS, Cigna, etc.), then the provider must make diligent efforts to obtain payment from the primary insurer. These diligent efforts should be similar to what a provider would do if the Member did not have MBHP as secondary insurance and are proven through EOBs or other submitted documentation.

Medicaid is always the payer of last resort

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What MBHP Will Cover

1. In cases of TPL, secondary insurers like MBHP cover eligible charges not covered by the primary insurer.
2. These charges include Member liability such as co-pays, coinsurance, and deductibles, and under certain circumstances, claims denied by the primary insurer.
    a. MBHP will cover the Member liability, up to our contracted rate.
    b. MBHP will cover total cost if the claim was denied by the primary, up to our contracted rate, and *provided that all administrative policies of the primary insurer were followed.*
3. Providers are required to bill MBHP for Member liability. Under no circumstances can providers directly bill a Member for these charges.
4. Providers are required to accept assignment (from both the primary insurer and MBHP), and cannot balance bill the Member the difference between charged amount and contracted rate.

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The Explanation of Benefits (EOB)

1. An EOB from the primary insurer that covers the date of service must be submitted along with the claim. This EOB should list:
   a. Amount of Member liability, such as a co-pay or a deductible
   b. Or, if the claim was denied, the denial code used and reason listed
2. Providers must be contracted with the primary insurer in order to obtain an EOB.
3. If the EOB indicates that the claim was denied due to the provider failing to follow the administrative policies of the primary insurer (such as failure to obtain a required authorization), then MBHP will also deny that claim, and it must be written off.

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Chapter

04

What if You Cannot Obtain an EOB?

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First and Foremost

1. First and foremost, try and get at least one claim to the primary insurer.
    a. Try even if you know the company does not cover the benefit and you are not in their network.
2. Mail a paper claim and cover letter by certified mail with signature confirmation.
    a. The cover letter should describe coding and service; state that these services must be covered per state mandate; and request either reimbursement or a letter of denial so you can seek payment from the secondary insurance.
    b. Document the date and address you sent this, and keep a copy in office records.
3. Now the “ball in is their court,” and the primary insurer must choose how to respond.

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When an EOB is Not Possible

1. There are two situations where obtaining an EOB from the primary insurer may not be possible:
   a. The primary insurer is located out-of-state.
   b. The primary insurer is a self-funded plan that does not cover the benefit.
2. In these situations, another form of documentation will be permitted.

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Out-Of-State Plans

- BHCA/CBHI are services mandated by *Massachusetts*
  - Insurance plans based out-of-state may not recognize/cover these services
  - This is especially true of smaller insurance companies/plans
  - If it is a larger company like BCBS, there is a chance another state's services may be covered, so again the first recommendation is always to *get a claim to them* and see how they respond
- Another form of documentation that will be acceptable is a copy of the member's insurance card (front & back) that clearly indicates the plan is based out-of-state
  - Please ensure the member's name, DOB, and MassHealth ID number is also clearly typed/written above image of insurance card

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Self-Funded Plans

1. Self-funded plans (or self-insurance) are not subject to certain state requirements, and thus may not cover the BHCA benefit.
2. The Division of Insurance and MassHealth have made efforts to reach out to many self-funded plans in the state to request that they issue a letter of denial for the BHCA benefit.
3. If it is a larger company that offers both fully funded and self-funded plans and you are in their network, bill them a claim and attempt to receive an appropriate EOB or a letter of denial.
4. If it is a company that only offers self-funded plans, reach out to the plan and attempt to receive a letter of denial.
    a. Be assertive (i.e., state that these services are mandated by the state, and you require a letter of denial from them so you can seek reimbursement from secondary insurance.)

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The Option of Last Resort – a Letter You Compose

1. When sustained and substantial efforts at either obtaining an appropriate EOB (i.e., one that states "benefit/service not covered") or a letter of denial have failed, a letter you compose may serve as a last resort.
2. The letter must be reviewed and approved by MBHP before we accept it in place of an EOB.
3. The letter must contain certain elements:
   a. Typed or printed on company letterhead with logo and dated
   b. Must include Member name and MassHealth ID number as displayed in EVS
   c. Must include a statement that you utilized EVS to verify primary insurance and coverage

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The Option Of Last Resort *(continued)*

1. Additional elements that the letter you compose must contain:
    a. Must list ***sustained*** and ***substantial*** efforts to receive either an appropriate EOB or a letter of denial from primary insurer, with bullet points, that include ***dates*** and ***names***
        i. It is expected that you make attempts to escalate the issue.
        ii. It is expected that you communicate that these are state-mandated services and that you explicitly request either an appropriate EOB or a letter of denial.
    b. Must end with a statement that you attest to these efforts and the unresponsiveness of the primary insurer, so you are requesting reimbursement for these services from the secondary insurer
    c. Must be signed (by either COO/director of AR/office manager/ senior biller, etc.)
2. The letter is not required to be long.
    a. Again, please utilize bullet points.

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Reviewing a Sample Provider Letter

Boston Children Services
Any Street, Boston MA 00000

September 1, 2020

ATTN: MBHP Claims Department

BCS is currently providing BHCA/CBHI services to John Doe, MassHealth ID number 100000000000. The MassHealth Eligibility Verification System (EVS) indicates that John Doe has HomeTown Insurance in Springfield, MA as primary coverage, with MassHealth/MBHP as secondary coverage. BCS has done the following actions to obtain payment from HomeTown Insurance for provided BHCA/CBHI services:

- On 8/1/20, spoke to Jane at HomeTown Insurance Provider Relations, who stated that John Doe had a self-funded plan, which did not cover the BHCA benefit.
- On 8/2/20, mailed a paper claim to HomeTown Insurance, expecting to receive back a letter of denial stating, "Services not covered". Instead, on 8/15/20 received back a letter stating, "Services not authorized".

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Reviewing a Sample Provider Letter (continued)

- On 8/15/20, spoke to Matthew Smith, the supervisor of HomeTown Insurance Provider Relations, who again stated that John Doe had a self-funded plan that did not cover the BHCA benefit. We asked for a letter of benefit denial in order to obtain payment from secondary insurance. Matthew stated that was not the company's procedure, and suggested parent obtain a letter from employer stating services not covered.
- On 8/25/20, Mrs. Doe informed us that she spoke to her HR Department, which stated that they did not issue such letters.

We attest to the actions above, which show that John Doe has a self-funded plan from HomeTown Insurance, which does not cover the BHCA benefit. We are requesting full coverage and payment for these services from MBHP.

Signed,
Lucy Jones
Office Manager, BCS

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Length of Acceptance of Letters

1. For both letters of denial issued by a commercial payer and letters that you compose yourself, it is not a “once and done” issue.
    a. People’s insurance coverage can change.
    b. Providers should be following standard practice of verifying insurance and eligibility before each service is rendered.
    c. MBHP may partner with the DOI to outreach to unresponsive, self-funded plans requesting that they issue letters of denial.
2. If no changes occur regarding the situation and a letter composed by the provided is accepted, MBHP will accept that letter until January 2022.
    a. Providers will need to make additional outreach efforts to obtain a new letter for services in 2022.

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Using Other Documentation as the EOB

1. Submitting paper claims
   a. TPL paper claims must be processed with certain batch numbers, so a copy of the letter must be attached to every paper claim submitted.
   b. Treat the letter exactly as you would an actual EOB and submit for every service.
2. Submitting claims through ProviderConnect
   a. You must upload a copy of the letter for every claim submitted through ProviderConnect.
   b. Ensure the letter is saved with an appropriate file name such as the Member's initials and DOB.
   c. Utilize the "Attach An EOB" screen and the "Upload File" section.
   d. Treat the letter exactly as you would an actual EOB and submit for every service.

Using Other Documentation as the EOB *(continued)*

1. Submitting claims electronically
   a. First you must send a copy of the letter to MBHPClaimsTPL@beaconhealthoptions.com for approval.
      i. ***That email address is only used for this function***. For other questions/issues you must utilize the Call Center.
   b. If the letter is approved, it will be attached to the Member file, and you should submit electronic claims per standard procedure.
2. Be careful that you do not fall into an "out of sight, out of mind" attitude.
   a. Providers are still legally responsible for ensuring that the letter on file pertains to each and every date of service billed.
   b. Continue your due diligence so that you are billing appropriately and correctly.

Chapter

05

Final Recommendations

Final Recommendations

1. Get started now.
    a. Send in a paper claim with a cover letter to self-funded plans in order to give them time to reply.
2. Ensure you have clear, concise documentation of your efforts to obtain payment from the primary insurer.
3. Ensure standard practices are in place for verifying insurance coverage and eligibility on EVS as well as with the Member's parent on an ongoing basis.
    a. If changes occur, you must bill appropriately.

Thank You

Contact Us

1-800-495-0086

www.masspartnership.com