Reimbursement for BHCA/CBHI Services for Members with Third-Party Liability (TPL)

October 10, 2019

Chapter

01

Background

MBHP

Background

- In December 2018, 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), includes In-Home Behavioral Services, Intensive Care Coordination, In-Home Therapy, etc. and has been covered by MassHealth/MBHP as part of the court-mandated program called the Children's Behavioral Health Initiative (CBHI).

Transition Period

- Pursuant to Bulletin 2018-07 and federal law stating that Medicaid is the payer of last resort, MassHealth is allowing for a transition period of six months in order to facilitate the change to commercial coverage of these intermediate child/adolescent services:
  - The transition period lasts until December 31, 2019.
  - The purpose of this transition period is to give time for providers to enter into networks/contracts with commercial insurers.
  - MBHP will not require an explanation of benefits (EOB) from the primary payer, but will instead invoice the primary payer for any services provided.
    - If the provider is already in network with the primary payer and contracted for these services, he/she should proceed to bill the primary payer as soon as possible before the transition period ends.

January 2020

- Effective on January 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.
  - Claims without an attached EOB or COB information will deny with the code "BH – RESUBMIT WITH PRIMARY INSURANCE EOB."
  - Claims must be submitted within timely filing requirements (within 90 days of the date on the primary insurer's EOB).
- CHBI services requiring an EOB from the primary insurer include In-Home Behavioral Services, In-Home Therapy, and ICC.
  - CBAT and ICBAT already require an EOB.
  - Family Support and Training and Therapeutic Mentoring will require an EOB starting July 1, 2020.

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

Chapter

02

Requirements

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Requirements

- Two requirements need to be met for services to receive payment:
  - **Eligibility**
    - The Member must be eligible with MBHP for every date-of-service.
  - **Authorizations**
    - The Member must have authorization(s) in place with MBHP, *even if MBHP is the secondary payer*.
- Claims will be denied if these two requirements are not met.

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.

Checking Eligibility On EVS

Click on "Date Range" to expand information

MassHealth Plan listed here

Primary Insurer listed here

Verify MBHP eligibility here

Verify Member Eligibility

Member Information | Eligibility

Dates of Eligibility

Click on the Date Range to view Eligibility information for Member ID

	Date Range	Eligiblity Status
➜	09/01/2019 09/26/2019	MASSHEALTH COMMONHEALTH

The information below refers to the **MASSHEALTH COMMONHEALTH** coverage for **09/01/2019** to **09/26/2019**.

Eligibility Restrictive Messages

Restrictive Messages	
	33 / 505 MassHealth CommonHealth member. For questions, call 1-800-841-2900
	246 / 246 EXEMPT FROM COPAY ON PHARMACY SERVICES UNDER 130 CMR 450.130(D).
	186 / 186 EXEMPT FROM COPAY ON NON-PHARMACY SERVICES UNDER 130 CMR 450.130(D).

List of Other Insurance Plans

	Policy #	Carrier Name	Coverage Type	Date Range
		BLUE CROSS BLUE SHIELD OF MA	PHARMACY - COST AVOIDANCE	09/01/2019 09/26/2019
		BLUE CROSS BLUE SHIELD OF MA	PPO	09/01/2019 09/26/2019
		BLUE CROSS BLUE SHIELD OF MA	VISION CARE	09/01/2019 09/26/2019

List of Behavioral Health

	Provider Name	NPI	Provider Phone	Date Range
	MASSACHUSETTS BEH HLTH PRT	1548385057	(800) 495-0086	09/01/2019 09/26/2019

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Authorizations

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

Chapter

03

Billing

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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

What MBHP Will Cover

- In cases of TPL, secondary insurers like MBHP cover eligible charges not covered by the primary insurer.
- These charges include Member liability such as co-pays, coinsurance, and deductibles, and under certain circumstances, claims denied by the primary insurer.
    - MBHP will cover the Member liability, up to our contracted rate.
    - 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.*
- Providers are required to bill MBHP for Member liability. Under no circumstances can providers directly bill a Member for these charges.
- 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.

The Explanation of Benefits (EOB)

- An EOB from the primary insurer that covers the date-of-service must be submitted along with the claim. This EOB should list:
  - Amount of Member liability, such as a co-pay or a deductible
  - Or, if the claim was denied, the denial code used and reason listed
- Providers must be contracted with the primary insurer in order to obtain an EOB.
- 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.

What if You Cannot Obtain an EOB?

- The only foreseeable situation where an EOB from the primary insurer is not obtainable is when that primary insurer is located out-of-state.
- In these situations, another form of documentation may be permitted, such as:
  - A letter generated by the primary insurer to the Member or the provider stating that the services billed are not covered
  - A copy of information from a primary insurer's Member handbook stating that the services billed are not covered
- Please discuss these types of situations with the MBHP director of Member and Provider Services before submitting claims.

Members Who Do Not Have the Benefit

- In some instances, the Member may not be fully insured by the primary insurer (i.e., he/she may have a partial plan), and BHCA services may not be covered by his/her benefits:
  - In these cases, MBHP will fully cover the services (provided all other requirements are met).
  - *Providers should be able to obtain an EOB from the primary insurer stating "benefit/service not covered."*
  - However, if the provider can obtain another form documentation, this can be submitted in place of the EOB.
    - This will save time and speed up payment from MBHP since the provider will not be continually billing the primary insurer for non-covered services.

Submitting Other Documentation as the EOB

- After you have discussed the situation with MBHP and have obtained approval to use other documentation in place of an EOB, you should treat that documentation exactly as you would treat an EOB.
  - These claims can only be submitted to MBHP through ProviderConnect or on paper (no electronic batch submissions through clearinghouses).
  - Documentation serving as an EOB must be submitted with each and every claim.
  - For example, if you are submitting paper claims and using a letter from the primary insurer as the EOB, a copy of that letter must be submitted with each and every claim.
  - After a certain amount of time, other documentation serving as an EOB will need to be updated.
    - Providers will be notified when this is required.

Different Payers/Different Coding

- Primary insurers are using different billing codes, modifiers, and unit definitions for BHCA services than what MassHealth/MBHP utilizes for CBHI services.
- This can be very challenging for providers when billing for Members with TPL.
  - One set of codes must be billed to the primary insurer; a different set of codes must be billed to MBHP.
- Providers will have to "transpose" between code sets.
  - Knowing the description of each service is vital.
  - Be aware that what different insurers call the service can be different.
    - Example: Family Stabilization Treatment (FST)/In-Home Therapy (IHT)

BCBSMA Compared To MBHP

Example of differences in coding between BCBSMA and MBHP:

Bulletin 2018-07 Service	Description Sample	BCBSMA Coding	BCBSMA Billing	MBHP Coding	MBHP Billing
In-Home Behavioral Services	Combination of behavioral management therapy and monitoring	H0040 HK	Day Rate	H2014 HO/HN	15-minute units
Intensive Care Coordination	Targeted case management for Members with serious emotional disturbance	H0023 HK	Monthly Rate	H0023	Day Rate

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Example of Transposing the Codes

- A Member with BCBSMA as primary and MassHealth/MBHP as secondary has two hours of In-Home Behavioral Services from a master's-level therapist on a certain DOS.

Bulletin 2018-07 Service	Description Sample	BCBSMA Coding	BCBSMA Billing	MBHP Coding	MBHP Billing
In-Home Behavioral Services	Combination of behavioral management therapy and monitoring	H0040 HK	Day Rate	H2014 HO/HN	15 minute units

- You would bill BCBSMA one unit of H0040 HK for that DOS.
- You would then bill MBHP eight units of H2014 HO for the Member copay/deductible, attaching the BCBSMA EOB to the claim.

Service Facility Address Requirements

- MBHP contracts by provider *location* (i.e., each office/clinic location of a provider is contracted for a certain set of services).
- It is necessary to list a CBHI-contracted address in the Service Facility Address section of the claim or the claim will deny.
  - Loop 231D for 837P electronic submissions
  - Box 32 for paper claim submissions
- Do ***NOT*** list a Member's home address or a school address in the Service Facility Address section:
  - List the CBHI-contracted address the therapist is leaving from or is stationed at.
  - Utilize POS Codes 12 for Home or 03 for School to indicate where the service occurred.

Regarding CANS

- When the Member has MassHealth/MBHP as primary and is receiving certain child-adolescent mental health services, a diagnostic evaluation utilizing the Child and Adolescent Needs and Strengths (CANS) tool must be completed (90791 HA).
- If the Member has a primary insurer, a CANS is *not* required (since the primary insurer may utilize a different assessment tool).
- In these situations, billers can bypass the CANS requirement when billing MBHP for Member liability by utilizing the primary modifier UL and submitting the EOB from the primary insurer.

Description	HIPAA COMPLIANT DESCRIPTION	CPT HCPCS Code Use CMS 1500, 837p	Mod 1	Mod 2 (if required)	Units	EOB Required
Diagnostic Evaluation - Members Under 21 with TPL - CANS not required	Psychiatric diagnostic interview evaluation	90791	UL	U3, U4, U6, UG, UF, SA, HO, AH	1 Unit = 1 hour. Max 1 unit per day.	Yes

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Helping Us Pay You

- The MBHP claims processing team looks at hundreds of EOBs per day for many different services ranging from outpatient behavioral health to inpatient substance use disorders.
- Each insurance company produces EOBs in a different way.
- To help reduce processing error and ensure we adjudicate TPL claims correctly, please circle the copay or deductible listed before you upload the EOB into ProviderConnect or mail it in with a paper claim.

Helping Us Pay You *(continued)*

P.O. BOX 981106
EL PASO TX 79998-1106
USA

Explanation Of Benefits

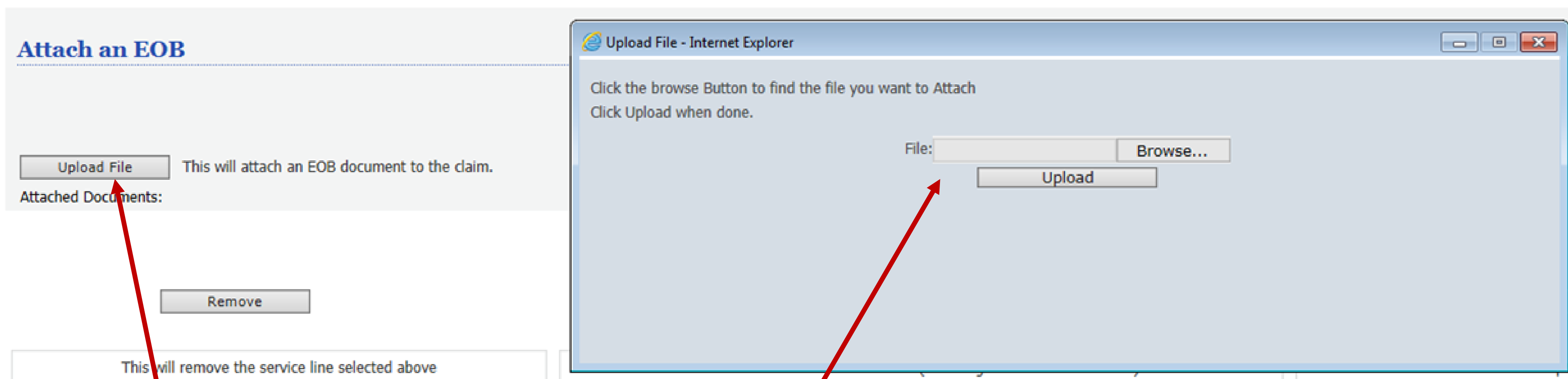
Please Retain for Future Reference

SERVICE DATES	POS	SERVICE CODE	NUM. SVCS.	SUBMITTED CHARGES	ALLOWABLE AMOUNT	COPAY AMOUNT	DEDUCTIBLE	COINSURANCE	PATIENT RESP	PAYABLE AMOUNT
8/24/16	12	0364T	1.0	62.50	32.50	10.00			10.00	22.50
8/24/16	12	0365T	6.0	375.50	214.50	60.00			60.00	154.50
TOTALS				**438.00**	**247.00**	**70.00**			**70.00**	**177.00**

- Circle the amount to indicate payment requested from MBHP.

Helping Us Pay You *(continued)*

- When uploading an EOB into ProviderConnect, please rename the file name from the scanner software annotation number to something associated with that particular claim.
  - For example, use the Member's initials and the date-of-service ("JN011520").
  - This will help ensure the EOB attaches to the claim and is retrievable.



  - Click on "Upload File."
  - Upload the EOB with a file name associated with the claim (such as "JN011520").

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Recommendations

- Providers should be making a note of which of their clients have TPL and who the primary insurer is.
- Providers should be diligently working to become contracted with those primary insurers before the transition period ends on December 31, 2019.
- Once contracting is done with those primary insurers and coding sets are obtained, the billing staff should develop coding crosswalks to make TPL billing easier.
- Utilize your resources from MBHP, including our Benefit Service Grid, our website (www.masspartnership.com), and our web-portal, ProviderConnect.

Thank You

Contact Us