

PEER TO PEER DOUBLE BILLING UPDATES
MAY 27, 2015
BEHAVIORAL HEALTH ADMINISTRATION

Scope of Issue: Kathleen Rebbert-Franklin

Double billing occurs when providers who receive grant funds for substance use services that are also reimbursable by Medicaid get paid twice for the same person, in the same time period, for the same service.

Medicaid Reports Overview: Sheba Jeyachandran

ValueOptions to release Provider Alert for Eligibility Re-Determination Reports early June. Will be made available on VO's website and subscriber e-mail listserv. Screenshots and instructions will be included on the Provider Alert.

- REPORTS: See two attached reports provided during meeting
 - **Medicaid Eligibility Expiration Report**, attached
 - **New Medicaid Eligibility Report**, attached
 - **Claims Based Report**, to be made available after 7/1

Presentation: Epoch Counseling, Sue Tangires and Lindsey Smith

- Epoch providers have recently transitioned to an Electronic Health Record (EHR).
- Process is to EVS new clients on Medicaid site and the electronic EVS batching system, submit to clearinghouse, and match to payer in system to check weekly eligibility.
- For new clients approved for Medicaid but not yet showing up in EVS, if the client is able to provide a letter confirming their MA eligibility, then they are considered approved.
- When a client is in a grant funded slot, if they have applied for MA, a claim is submitted to VO and VO zeros out the claim. If Medicaid retro pays, the providers uploads remittance file, and it will show as a Credit.
- Client payments remain on client's account as a Credit. When the client is discharged, the client is refunded based on the sliding scale fee they paid.
- Authorization for grant clients is not an issue when become active with MA, program is not running out of grant funded slots.
- Payments have been received from VO which should have been grant funded (i.e. AVATAR) – had to pay VO back. Reports will be helpful in flagging these and resolving quickly. VO reported that this issue is being corrected.

Presentation: Anne Arundel County Department of Health, Bill Rufenacht and Shannon Evans

- Anne Arundel County Department of Health provides assessments utilizing ASAM criteria and performs weekly redeterminations.

- Few outpatient treatment options in the county. The health department runs 2 of 6 MAT programs located in the county.
- EVS check done weekly and at point of billing. Evaluation of treatment need occurs weekly, to make sure assessment matches up with total picture; somatic, mental health needs and a referral to a provider that can meet all of the needs of the client.
- Opportunity for Treatment Fund (OTF): county provided funds of last resort.
- Department of Health provides much Case Management to prevent double billing.
- Many tracking systems in place to track funding sources and multiple grants.
- Department of Health contacts insurance company to arrange single case agreements only for clients with catastrophic coverage.
- Department of Health does not use grant funds for co-pays, not allowed.

Questions & Answers

- **Q:** Will there be a Coordination of Benefits Law in Maryland?
A: No knowledge of one at this time.
- **Q:** What to do with clients that make too much money for MA and the sliding scale fee (SSF) goes away July 1?
A: SSF does not go away July 1.
- **Q:** If a client refuses to apply for benefits, how long can they remain in a grant funded slot?
A: Every provider should create their own policy for clients who refuse to apply for benefits.
A: The State does not intend to implement a regulation or law, so if you have a policy, and decide on an appropriate length of stay, do what you think is appropriate so that client is not in crisis, and follow the policy to justify to any auditors.
A: Make sure your clients apply for Medicaid and regularly check EVS to make sure they actually applied.
- **Q:** For clients in residential treatment, who covers other costs? For example, Primary Care visits, Dental visits, and Prescriptions?
A: We have an IMD federal rule, identifies providers with 16+ beds, designated IMD. Cannot bill for reimbursable outpatient services. Residential programs can make the appointments with the labs, Primary Care Physicians, Dentists, in the community. Clients can use their MA card to pay for the services and the program does not have to discharge the client.
A: See attached **DHMH Maryland Medical Assistance Program Residential Treatment Center Transmittal No. 7, Intermediate Care Facilities-Alcoholic Type D Transmittal No. 2, December 16, 1994, Re: Re-statement of Reimbursement Policies.**

- **Q:** We have a 30 day attendance rule with VO, requiring assessments to be redone but cannot bill for it. Do we continue with the additional OMS if a 30 day lapse occurred?
 - A:** If a client does not attend for 30 days, the authorization span continues. OMS info is available on the VO website.
 - A:** Do whatever is clinically necessary to have the client engage. You may have to discharge, but to reopen all you have to do is update the info. Feds require the data at discharge but no need to reevaluate.
 - A:** TEDS Data – the TEDS manual allows for reinterpretation. BHA will evaluate and inform. Discussion of possible waiver to the 30 day discharge rule. BHA will provide guidance in writing to clarify or change rule.
 - A:** Check COMAR for re-assessment requirements.
 - A:** Contact your BHA Regional Manager to ask questions and/or to clarify.