

## **Residential Rehabilitation Services (RRS) Level 3.1**

### **Frequently Asked Questions**

*(Updated 4/5/2018)*

#### **Contracting**

**Q: I haven't heard from the MBHP contracting department. What should I do?**

**A:** Applications and supporting documents were emailed in early December to the contacts for each program that were provided to MBHP by the Bureau of Substance Addiction Services (BSAS). Please check your spam and junk folders to make sure that they weren't erroneously flagged. If you have not received the application and supporting documents, please contact Garland Russell, Director, Network Operations at [Garland.Russell@beaconhealthoptions.com](mailto:Garland.Russell@beaconhealthoptions.com) or the department email address at [MBHPNetworkOperations@beaconhealthoptions.com](mailto:MBHPNetworkOperations@beaconhealthoptions.com).

**Q: How frequently will we need to re-contract?**

**A:** MBHP requires all contracted providers to complete a re-credentialing process every three years.

**Q: How can I obtain an NPI number?**

**A:** You can apply for an NPI number online at <https://nppes.cms.hhs.gov>.

#### **Registration and Requesting Units**

**Q: Do we need to register all of the MBHP Members on March 1? Is it possible to do this earlier?**

**A:** Yes, you will need to register all of the MBHP Members on March 1 (or within the seven-day grace period). Unfortunately, RRS services will not be accessible in the ProviderConnect system until the actual go-live date of March 1 so there is not an opportunity to register Members in advance. Moving forward, you may register Members up to seven days prior to admission so long as you use the admission date as the service start date on the registration form.

**Q: Will the number of days that an individual spends at an Acute Treatment Services (ATS), Clinical Stabilization Services (CSS), or Transitional Support Services (TSS) program before being admitted to our program be deducted from the 90 days?**

**A:** No, each MBHP Member will receive 90 units upon initial registration in ProviderConnect regardless of his/her prior treatment.

**Q: Will units be authorized for individuals who have been in the RRS program prior to March 1?**

**A:** Yes. MBHP will begin paying for clinical services effective March 1, 2018. All MBHP Members in the RRS program on March 1 should be registered in ProviderConnect with a service start date of March 1. Providers will receive authorization for 90 units during a 90-day period regardless of how long they were in your program prior to March 1.

**Q: Many individuals remain in residential programs for well over 90 days, so why are only 90 units being approved at registration?**

**A:** The decision to use 90 units for the initial registration period was based on data indicating this to be the average length of stay in the RRS programs. MBHP will continuously review and evaluate utilization to determine future changes.

**Q: Many programs are designed to be a certain length of time often longer than 90 days. After the initial 90 days, how can we request more time?**

**A:** MBHP is asking providers to focus on each Member's individual treatment needs and recovery goals utilizing American Society of Addiction Medicine (ASAM) dimensions. Prior to the end date of the initial 90-day request, if you have determined that the Member needs additional time in order to accomplish the goals as outlined in their treatment/recovery plan, you should request additional units using ProviderConnect. You may request as many additional units as you think necessary to accomplish the treatment/recovery plan goals. The concurrent review request form includes a text box where you are asked to indicate the number of units requested, provide a brief description of the outstanding treatment goals, and identify any barriers that exist in achieving them. Be thoughtful of the request to ensure that it is Member-centered, as there is a character limit in the text box. Additional documentation is not required. Each request will be reviewed by an MBHP clinician. If the request is approved, that approval is posted in ProviderConnect. If additional information is needed to make a determination, the clinician will contact the individual whose name was provided on the request. This should be the person at your program who knows the most about the Member, their treatment goals, the barriers that have been identified, and the steps that have been taken to address those barriers so far. In most instances, the MBHP clinician will be able to tell you the decision regarding additional units.

**Practice Tip: Be prepared to discuss the ASAM dimensions and how they apply to the Member. Asking for additional units because you have a six-month program will not be sufficient as each decision will be based on the individual Member's needs.**

**Q: Is there a limit on the number of days an individual can remain in a program?**

**A:** No, there is no limit so long as the Member continues to meet the ASAM dimensional criteria for Level 3.1. A program should request as many days as they think will be needed to accomplish the goals in the treatment/recovery plan.

**Q: How often can additional units be requested?**

**A:** As often as needed for that Member to achieve the goals on their treatment/recovery plan. When you request additional units, MBHP is asking that you request the number of units that you think are realistically needed for this particular Member to attain their particular goals. However, if you have requested additional units and, towards the end of the authorization period, you realize that additional units are needed, you may request them using the same process as outlined above.

**Q: If an individual leaves our program during the initial 90 days and returns back three weeks later, do we need to register them again?**

**A:** If you still have a valid registration for that Member (there are still units available and the end date has not passed) and the Member meets medical necessity criteria for admission, you do not need to re-register the Member. You can simply resume billing for that Member.

**Q: If an individual leaves our program during the initial 90 days and is admitted to a different RRS program that we run three weeks later, do we need to register them again?**

**A:** Because registration happens based on site and the Member is being admitted to a different site or location, even though it is within your organization, you would need to register them as a new admission.

**Q: What if there are still units available but the end date of the registration has passed?**

**A:** There may be times when units will not be utilized during the registration period. The end date of the registration is what triggers the need to request more units, even if there are units remaining. Providers have seven days before and seven days after the end date to submit a request for additional units.

**Q: If MBHP denies continued stay, can the decision be appealed? Will payment continue during the appeal process?**

**A:** Yes, MBHP's appeal process is available for this service and can be accessed in the event of an adverse decision with which you disagree. If you are successful in your appeal, the services provided during the appeal period will be covered.

**Q: If MBHP determines that a Member no longer meets Medical Necessity Criteria and the program disagrees, will BSAS pay for the clinical services?**

**A:** If it is determined that the Member no longer meets the criteria for Level 3.1 as outlined in the ASAM dimensions and MBHP denies continued stay, BSAS will not pay for the clinical services.

**Q: In that case, would BSAS continue to pay for room and board?**

**A:** MBHP's understanding is that BSAS will not continue to pay for room and board in that situation. Please contact your BSAS contract manager directly if you have questions or need additional information.

**Q: Will the initial 90 days be authorized regardless of how many times the individual has been in the RRS level of care?**

**A:** Yes, every new registration will result in an authorization for 90 units in 90 days.

**Q: Is there a limit on the number of residential programs a Member can be admitted to during a given time period?**

**A:** No. MBHP currently has no plans to limit the number of programs a Member can be admitted to or the timing of those admissions. We may track open registrations and contact providers if there are multiple open registrations in multiple programs for the same Member and audit claims to ensure that there are not multiple claims for service for the same Member on the same day submitted by different programs. We want to make sure that Member's care is coordinated and meeting the Member's needs. Multiple registrations for one Member that overlap may be a sign that the Member needs more or different services, and MBHP would like to assist.

**Q: If we admit an individual and later learn that the referring 24-hour level of care provider did not notify MBHP of the discharge, will we be able to register them and receive payment?**

**A:** Yes, you will be able to register that Member and submit claims to MBHP for clinical services.

**Q: My program works with people who have MassHealth Standard and are not assigned to an MCO or ACO, but have MBHP listed as the behavioral health (BH) vendor. Should these individuals be registered in ProviderConnect?**

**A:** Yes, RRS providers should register individuals in MBHP's ProviderConnect and bill MBHP for the clinical component **any time MBHP is listed as the BH vendor - with the exception of BeHealthy Partnership**. This includes, but is not limited to, those DCF/DYS youth who have MBHP listed as the

BH vendor and RRS clients whose primary insurance is a commercial policy that does not cover RRS and MassHealth/MBHP is secondary.

**Q: When I check EVS, the Member is listed as having a Model B Primary Care ACO Plan, but MBHP is not listed as the behavioral health provider. What should be done in that situation?**

**A:** If you are checking a Member's eligibility and you see Community Care Cooperative (C3), Steward Health Choice, or Partners HealthCare Choice, **please register that Member in ProviderConnect even if EVS does not explicitly list MBHP as the behavioral health provider.** You may register these Members now with a service start date of March 1 (or the actual date of admission if it is after March 1). These registrations will pend if they are outside of the registration time frame, but MBHP will be manually approving these registrations. You will receive 90 units as of the start date that you have entered. If the registration attempt is unsuccessful, please contact Long Banh at (617) 350-1960 or [Long.Banh@beaconhealthoptions.com](mailto:Long.Banh@beaconhealthoptions.com) with your contact information, and he will reach out to you. MBHP will notify you when the registration process has been manually completed.

**Q: I submitted registrations for RRS and/or requests for additional units, and my request is pended. How do I check the status of a pended authorization?**

**A:** To check the status of pended authorizations in ProviderConnect:

1. Log on to ProviderConnect.
2. Click on "Review an Authorization" from the Home Page.
3. You will be directed to the "Search Authorizations" page. On this page, you can look up the pended authorizations by entering the Member's ID and the authorization number, or by setting the dates of the authorizations. Once you enter the fields you would like to search, click on "Search" and it will generate pended authorizations within the parameters. **OR**, you can see general agency activity by entering the "Activity Dates" from and to and click "View All."
4. When you click "View All" or "Search," you will be directed to the "Authorization Search Results" page. On this page, you will see a list of pended authorizations.
5. Click on the "Authorization Number" of the request you would like to check.
6. Confirm that the correct information (Member ID, name and authorization number) is displayed.
7. Click on the "Auth Details" tab to check the status of the authorization. On this page, you can check the "Dates of Service," "Visits Requested/Approved," "Visits Actually Used (As of Today)," and "Reason." The approval status is found in the "Reason" column.

A PowerPoint presentation entitled "Reviewing an Authorization" is available on MBHP's website and can be accessed using the link below. The presentation provides instructions and screen shots that you can review and print as a reference.

<https://www.masspartnership.com/provider/EventsAndTrainings.aspx#SUD>

## Billing and Claims

**Q: The billing codes that have been presented do not match the billing codes that are currently used by BSAS. Can that be changed so they match?**

**A:** MBHP has made changes to the proposed billing codes so that they align with the billing codes used by BSAS. A slide outlining these updated codes can be found on MBHP's website.

**Q: How will providers know if someone is eligible? Do providers have to check eligibility every day?**

**A:** Eligibility is verified using the Eligibility Verification System (EVS), accessed through the Virtual Gateway. During the application process, you completed a form that MBHP sends to MassHealth requesting authorization to access the EVS system. You can search eligibility using MassHealth number, name, and DOB or SSN. You should be verifying eligibility for every date of service.

**Q: If an individual loses their insurance or there is a gap in insurance, can we bill the clinical services to BSAS?**

**A:** BSAS should be billed for both clinical services and room and board under these circumstances.

**Q: If a Member has MBHP as a secondary insurance, will we need to obtain a denial from the primary payer (referred to as an EOB or Evidence of Benefits) in order to bill MBHP?**

**A:** An EOB is NOT required to bill MBHP for RRS services.

**Q: If a Member is eligible for MBHP, but that eligibility is not accurately reflected in EVS, can I retroactively bill MBHP for those units?**

**A:** EVS is the source of truth regarding Member eligibility. If there are updates to EVS and a Member has retroactive eligibility, MBHP will backdate registrations and reprocess claims when necessary. The Member should be directed to notify MassHealth to ensure that their eligibility is updated in EVS.

**Q: How long will it take to get paid once a claim has been successfully submitted?**

**A:** Per your provider agreement, MBHP will process all clean claims (i.e., a claim submitted without any errors) within 30 days of submission. Payment is issued on the Tuesday following the successful processing of the claim. Claims that are submitted on paper take much longer to process, and thus payment could be delayed. This is why MBHP highly recommends that providers submit claims through EDI electronic submission or through our provider web portal, ProviderConnect.

MBHP also recommends that providers sign up for ACH payment (Automated Clearing House Direct Deposit) through our vendor PaySpan, in which claims payments are directly deposited into the provider's bank account. This is a much quicker and more efficient method of payment when compared to paper checks that are mailed and that can take a week or more to arrive. For more information on PaySpan ACH Direct Deposit, please visit [www.payspanhealth.com](http://www.payspanhealth.com) or call our Customer Service Engagement Center at 1-800-494-0086.

**Q: Can we batch RRS claims with claims from our ATS program?**

**A:** No, RRS claims cannot be submitted in the same electronic batch submission as ATS claims. MBHP utilizes the REV (Revenue) code 1002 for ATS services. REV codes must be electronically submitted through an 837i file. RRS services use the HCPCS (Healthcare Common Procedure Coding System) code H0019 with various modifiers. HCPCS codes must be electronically submitted through an 837p file. If you would like assistance with setting up electronic claims submissions, please call the Customer Service Engagement Center at 1-800-495-0086.

**Q: How often should I submit a claim?**

**A:** Claims for RRS services must be submitted within 90 days of the date of service to be considered for reimbursement; all claims submitted after 90 days will be denied. Claims for RRS services can be

date-ranged billed, meaning multiple units/days can be billed on the same claim (1 unit = 1 day of service). Though claims may certainly be submitted sooner, in order to promote efficiency MBHP suggests that providers submit claims monthly per Member (example: billing one claim for a Member in an adult RRS program for the entire month of March – dates of service 03/01/2018 to 03/31/2018; code H0019; 31 units). For more information on claims submissions, please consult the MBHP Provider Manual, Chapter 3: Administrative Operations, or call the Customer Service Engagement Center at 1-800-495-0086.

**Q. What do I do if a claim denies?**

**A:** It is the provider's responsibility to "work their claim denials." Each week, Provider Summary Vouchers (PSVs) are posted on ProviderConnect. These PSVs are issued by General Ledger/Member's MassHealth Plan, so a provider may receive multiple weekly PSVs. These PSVs list every claim from the provider that was processed the prior week and whether that claim paid or denied. If the claim denied, an EOP Code (Explanation of Payments) will indicate the reason for denial.

If the reason for denial was due to a provider error that can be corrected (such as missing/wrong modifier; wrong service facility address; etc.), the provider should correct the claim and resubmit. Claims must be resubmitted for payment consideration within 90 days from the date of denial by MBHP. For questions regarding a claim denial, please have the claim number available and call our Customer Service Engagement Center at 1-800-495-0086.

Most corrections can be easily made by the provider utilizing our web portal ProviderConnect. MBHP highly recommends that providers establish a procedure for immediate review of their PSVs for claim denials, in order to get all claim corrections submitted within the timely filing limits.

**Q: Historically, individuals in residential programs receive food stamps and may receive SSI/SSDI or have an income which the programs collect and subtract from the amount billed to BSAS. How will this be handled as of March 1, 2018?**

**A:** Any collected treatment fees or contributions to care, including food stamps, should continue to be subtracted from the room and board invoice that is submitted to BSAS.

**Q: Will the bed retention policy still be in place for residents who step up to higher levels of 24-hour care? Currently, programs can bill BSAS for clinical and room and board for three days with the ability to request a waiver for additional time. What about when a pregnant woman is hospitalized for delivery? What about when they have been discharged from the hospital, but are rooming in with the baby, so not technically sleeping in the program?**

**A:** CMS rules do not allow MBHP to pay for clinical services provided in two 24-hour level of care settings for the same Member on the same day. MBHP will not be able to pay for RRS clinical services when the Member is in a higher level of care. It is MBHP's understanding that BSAS will follow the bed retention policy, and clinical services for MBHP Members can be billed to BSAS under these circumstances. Specific questions related to the bed retention policy and its application should be directed to BSAS.

**Q: My program is eligible to bill for the Pregnant and Post-Partum Enhancements from BSAS. How will that be handled for MBHP Members?**

**A:** Programs should bill MBHP for clinical services for any Member who is pregnant using billing code H0019 and modifier TH. Once the Member has given birth, the program should bill MBHP for clinical



services using the billing code H0019 for adults and invoice BSAS for the post-partum enhancement along with room and board.

**Q: Can Case Consults, Collateral Contacts, or Family Consults provided by program staff be billed to MBHP as a separate service?**

**A:** These services are included in the daily unit rate and cannot be billed separately when provided by program staff.

**Q: As part of an individual's treatment/recovery plan and reintegration into the community, they may be allowed to go on overnight passes. How will this be handled?**

**A:** If the absence from the program is the result of a planned element of the treatment/recovery plan, the program should bill MBHP for clinical services for that date.

**Q: Will there be different billing codes for the various services that are provided in the program, example: a code for group, a code for individual counseling, etc.?**

**A:** MBHP is paying for this service using a daily rate which encompasses all of the services the Member receives on a given day. There are no separate codes related to each clinical activity.

**Q: Should my program submit a claim for clinical services for the date that an eligible Member is discharged?**

**A:** When you submit claims, **do not** submit a claim for the date of discharge. You should submit a claim for the date of admission.

**Q: What should be entered in the Place of Service field on the claim form?**

**A:** Place of Service codes can be found on MBHP's Benefit Grid. For RRS, use 55 as the Place of Service code.

## **General Questions**

**Q: Can I get a copy of the slides that were used during the webinar?**

**A:** The slide deck and the webinars have been posted on MBHP's website at [www.masspartnership.com](http://www.masspartnership.com). Click on the Behavioral Health Providers tab. Select Events and Training from the drop down menu. Click on the hyperlink for Past Trainings for Substance Use Disorder Providers.

**Q: Why do we need to bill both BSAS and MBHP for these services?**

**A:** The 1115 Waiver that was approved by the Center for Medicare and Medicaid Services (CMS) allows MassHealth to pay for the clinical services provided in residential rehabilitation programs for all MassHealth Members. CMS rules do not allow for payment of charges related to room and board. In order to be in compliance with CMS rules, BSAS will be paying all charges related to room and board. MBHP will begin paying for the clinical services on March 1, 2018. All other MCOs will also be paying for these clinical services for their MassHealth Members as of January 1, 2019.

**Q: How will providers know which MassHealth plans are reimbursing for the RRS level of care?**

**A:** As of March 1, MBHP is the only managed care entity that is paying for these clinical services. In order to submit a claim, you must verify that the Member has MBHP managing their behavioral health services because the Member is part of the PCC Plan or a Model B ACO (Partners HealthCare



Choice, Steward Health Choice, or Community Care Cooperative). Members with BeHealthy Partnership are not eligible, and you should bill BSAS for their care as you currently do. The plan is for this service to expand to the other MassHealth products on January 1, 2019.

**Q: What is an ACO?**

**A:** The following web sites can provide information regarding Accountable Care Organizations (ACOs):  
[https://www.mass.gov/files/documents/2017/11/10/PCDI-FS-BH%20%2811-17%29\\_0.pdf](https://www.mass.gov/files/documents/2017/11/10/PCDI-FS-BH%20%2811-17%29_0.pdf).  
<https://www.mass.gov/lists/provider-pcdi-resources>

**Q: Will providers still be required to fill out EIM/ESM forms for all clients in addition to MBHP registration?**

**A:** You will need to complete EIM/ESM forms on every admission as you currently do.

**Q. Will I need to maintain a medical/health record for each individual served?**

**A:** Yes, please refer to MBHP's Health Records Guidebook for more information. The manual can be found on MBHP's website, [www.masspartnership.com](http://www.masspartnership.com), in the Quality Management section.

**Practice Tip: Be sure to document amount and duration of all clinical activities. It must be a minimum of five hours of individual and/or group sessions per week. All entries should be dated and signed with the full signature and credentials of the provider. Records should be securely stored in one location.**

**Q: Our contract with BSAS has a maximum contract obligation. Do we need to offset the payments we receive from MBHP on our billing to BSAS?**

**A:** Questions related to the impact of this initiative on BSAS contracts should be directed to your BSAS contract manager.

**Q: Are we required to have all of our residents transition to MBHP?**

**A:** No. Individuals in your programs should select the MassHealth option that works best for them and that most effectively meets their medical needs. Individuals should not be encouraged to change insurance coverage simply to obtain benefits through MBHP.

**Q: I have a question that is not addressed in this document. What should I do?**

**A:** Please email your question to Jonna Hopwood at [Jonna.Hopwood@beaconhealthoptions.com](mailto:Jonna.Hopwood@beaconhealthoptions.com) or call her at (617) 350-1926.

**Q: What other services are MBHP Members eligible to receive while in RRS?**

**A:** MBHP Members are eligible to receive the full complement of covered outpatient services while they are in the RRS program, including but not limited to co-occurring disorders. Based on Member needs, services may include, but are not limited to SOAP, MAT, outpatient counseling, outpatient psychiatry, and community support program services. These services are not intended to replace contractually required program-provided clinical services. ASAM Level 3.1 programs are required to offer at least five hours per week of low-intensity treatment for substance-related disorders. Treatment is characterized by services such as individual, group, and family therapy; medication management; and psychoeducation. MBHP Regional Network Managers can assist you if you are having trouble accessing any of these services. In addition, the MBHP Regional Provider Guides and the Provider Search Function are available on the MBHP website at [www.masspartnership.com](http://www.masspartnership.com).