



Questions and Answers (Q&A) from the “ValueOptions® Double Feature: TennCare Select Transition Presentation and Grier PIN Process Update and Refresher” Webinar

**Q:** Where do we submit CRG/TPG assessments? We will outreach rater agencies on the specifics of CRG/TPG assessments via secure email.

**A:** We will outreach rater agencies on the specifics of CRG/TPG assessments via secure email.

**Q:** Grier Consent Question - At an A&D Rehab if a client is being disruptive we have to wait 2 days to discharge?

**A:** Per Grier, the member is entitled to a 2 day notice. If the member is willing to waive those rights, you can discharge as soon as the PIN letter is received.

**Q:** What is MHS#?

**A:** An MHS# is your unique VO assigned six digit provider number. This number is needed for ProviderConnect registration, but should not be confused with your BCBST ID(s), which are needed for BlueAccess and claims filing purposes.

**Q:** The state has always added the two Grier days post discharge, which is why they developed the waiver for clients who chose not to stay. Has the state changed this directive?

**A:** Grier states member are entitled to two business-days notice before discharging it does not state these are to be days that are not medically necessary or days that are added on post discharge. Providing 2 business days for every inpatient or residential stay would be unnecessary.

**Q:** If a client uses a private psychiatrist who does not call us back with an appointment time, how do you want to see that on the PIN?

**A:** Every PIN notice must have an aftercare appt. You can call a different provider for an appt, schedule a PCP appt, or continue to call for an appt with the private psychiatrist.

**Q:** At a recent audit we were told treatment plans are updated every 6 months, not every 90 days.

**A:** The Provider Manual indicates treatment plans should be updated at least every 6 months, but more frequently if the situations change.

**Q:** The Grier presentation indicated Grier letters would be faxed to the provider within 24 hours of submission of the PIN. We aren't getting them and when we contact the



Valueoptions<sup>®</sup> Grier department we are told they will mail them and that they do not fax them. We aren't always getting the mailed letters. What do we need to do?

**A:** PINs for inpatient and residential treatment levels of care are faxed to the facility. All other levels of care are mailed and cannot be faxed. If you are not receiving your letters, please contact us and we will send them to the address you specify.

**Q:** If we are submitting a PIN because a client consistently doesn't keep appts in a CCFT or CCT program, do we need to continue to go to the home during the time between when the PIN was submitted and the date of d/c?

**A:** Yes, the member is entitled to receiving notice before discharge. If the member is willing to waive those notice days, you do not have to continue with services.

**Q:** If a member receiving CCFT services is hospitalized, do we request a PIN?

**A:** No. If the member is discharging to a higher level of care, it is not an adverse action and no PIN is needed.

**Q:** When we received training on this from Magellan, we were instructed that if we were providing services through the period of the authorization, we didn't need to request a PIN because they automatically sent notice 30 days prior to d/c, as per their requirements. Am I understanding your instructions correctly that we are to send a PIN even if we are providing services throughout the pre-authorized services (this is in regards to CCFT specifically).

**A:** Yes, please continue to send in PINs even if you are providing services through the pre-authorized time period.

**Q:** re: my first question, Magellan sent a notice 30 days ahead of time and said we didn't have to because the member had already received notice from them (Magellan).

**A:** We do not send the 30 day notice and we will need you to send in a PIN.

**Q:** Can a client be authorized for more than 20 visits per year without having a CRG-TPG Assessment?

**A:** Yes, though the need for a CRG/TPG assessment should be seriously considered, and a care manager may strongly encourage that the member be referred for the assessment.

**Q:** If a client has commercial insurance as a primary and TennCare Select as secondary, should the provider collect co-pays that are required of the primary insurance? Where TennCare is secondary, you should always follow the primary payor's rules and guidelines in the delivery and billing of services.

**A:** Where TennCare is secondary, you should always follow the primary payor's rules and guidelines in the delivery and billing of services.

**Q:** Are the treatment plans due every 90 days for level II cm services as well as level I cm services? In the past it has been 90 days for level I and 120 days for level II. Thanks!



**A:** The Provider Manual indicates treatment plans should be updated at least every 6 months, but more frequently if the situations change.

**Q:** Who can I call to learn more about paper billing?

**A:** Please review the Provider Administration Manual carefully regarding paper claims filing. If you have questions at that point, please contact your regional provider relations representative for assistance in getting answers to those questions.

**Q:** If we are submitting a PIN because a client consistently doesn't keep appts in a CCFT or CCT program, do we need to continue to go to the home during the time between when the PIN was submitted and the date of d/c?

**A:** Yes, the member is entitled to receiving adequate notice. If they will sign the waiver, you do not have to continue care during that time period. Also, if the member leaves the level of care AMA, no notice is needed.

**Q:** If a member receiving CCFT services is hospitalized, do we request a PIN?

**A:** No. If the member is discharging to a higher level of care, it is not an adverse action and no PIN is needed.

**Q:** For example I would ask for a 3 hour assessment that was paid & then write a report for how many hours would be needed for services

**A:** Report writing is not a covered service under Medicaid. The timeframes allowed for an instrument includes the report writing time.

**Q:** With Magellan we would request an assessment prior to conducting ABA therapy & then would submit recommendations for services. Will we still follow this process for getting clients approved for therapy?

**A:** Yes, we will approve a 30 day period for the assessment and review the results of the assessment for the medical necessity for continued services.

**Q:** Do we need referral notes from doctors for ABA therapy?

**A:** ABA is a service that requires an order.

**Q:** For ABA do we still submit monthly progress notes or reports for continuation of services?

**A:** The ORF2 should be submitted to request additional service, but progress notes will help to show progress and reduce the amount of additional information care managers will need to get.

**Q:** How will cases currently in the appeal process for ABA services be dealt with in this transition?

**A:** Magellan handed off all appeal cases to VSHP and they will be processed.



**Q:** When a request for ABA services is received and a 30 day authorization is given, are there a specific number of billable hours approved at that time to complete assessment? Do you have to have prior authorization to complete assessment?

**A:** Prior authorization is needed for the assessment and the amount of units needed can be discussed directly with the care managers when requesting the authorization.

**Q:** Are authorizations for ABA services still given for 30 day periods?

**A:** Authorizations are based on medical necessity and can be for as long as 30 days, but could also run for a shorter period if there are questions to be addressed and feedback needed.

**Q:** Please clarify how Value Options defines unit duration. For example, one payer may define this as 1 unit = 1 - 19 minutes; another may define this as 1 unit = 1 – 15 minutes.

**A:** For Services that are billed in 15 minute increments, we follow CMS guidelines, available at the following link:

<http://www.cms.hhs.gov/transmittals/downloads/R1019CP.pdf>

**Q:** For the priority population, the first 10 visits each month do not require prior auth and an auth is required by visit 11. Do the first 10 visits each month for the priority population apply only to those services rendered by the CMHA that is providing services? If they also apply to services rendered by other providers, how do we know the number of visits a consumer may have already received from another provider?

**A:** The first ten visits are member specific, not provider specific. This was by design to encourage coordination of care between providers and decrease duplicative and/or counter-productive delivery of services.

**Q:** After we receive the training via the Webinar, will we be able to submit test files for claims?

**A:** You should make sure you are appropriately registered for electronic transactions and that you have the correct BCBST ID(s) for the type of transactions you will be conducting. Your regional provider relations representative can assist you with obtaining the appropriate registration materials. The EDI helpdesk can assist you in troubleshooting your setup and can tell you if your test file was successful.

**Q:** If a non licensed Masters level clinician provides the service, do we bill with the NPI of the facility or bill with the NPI of the licensed Masters level clinician that is providing the supervision for the non licensed Masters level clinician?

**A:** Currently, licensed outpatient mental health facilities billing for outpatient services on a CMS 1500 should bill under the facility NPI. Where you would typically supply the rendering practitioner's NPI, you should file the licensure level modifier of the rendering or the licensure level modifier of the supervising clinician if the service was rendered by a non-licensed master's level clinician.



**Q:** The ValueOptions<sup>®</sup> rate sheet lists rates for licensed Masters level clinicians. Do these same rates apply to non licensed Masters level clinicians?

**A:** For licensed mental health outpatient facilities only, services rendered by a non-licensed master's level practitioner are billed and reimbursed according to the supervising practitioner's licensure level.

**Q:** You have mentioned that for case management, four 15 minute units equal 1 visit. You have mentioned there is a calculator that CMS uses to define the length of a unit for a specific service. Does this mean that for CTT or a lower level of case management, 1 to 15 minutes of services equals 1 unit?

**A:** Please refer to the CMS link below:

<http://www.cms.hhs.gov/transmittals/downloads/R1019CP.pdf>

**Q:** 1 - 15min = 1 unit; 16-30 min = 2units?

**A:** We employ CMS guidelines on billing for services that are rendered in 15 minute increments. If you are not familiar with these guidelines, please contact your regional provider relations representative for the link to those guidelines on CMS' website.

**Q:** Are there any plans for provider initiated notices to be submitted electronically?

**A:** Yes, but we do not have an ETA on this yet.

**Q:** As a new provider under ValueOptions<sup>®</sup>, am I automatically a provider under VSHP?

**A:** As a credentialed and contracted provider for the Tennessee Managed Medicaid networks, you are considered a provider for BlueCare and TennCare Select. However, you may not be a provider for VSHP's other government services division accounts.

**Q:** Back to the first question, if the provider collects the co pays from a primary insurance that subsequently denies payment or all is applied to a deductible, and TennCare is billed as the secondary, should the provider pay back the co pays that were originally collected to the client?

**A:** VSHP's expectation is that you follow the primary payor's rules and guidelines. If the primary payer denies the claim and, for instance, it was denied because the service is not a covered benefit, VSHP's expectation would be that you follow VSHP's and TennCare rules around the service at that point. If the service is a covered service, VSHP pays, and there were no co-pay requirements for that service, then the member should not be charged or should be refunded those co-pay dollars.

**Q:** Please explain ORF. Do we use that to request additional visits above the 20 allowed visits? Do we need to use the ORF for anything else?

**A:** The ORF can be used for outpatient services that always require prior authorization, such as psych testing, or for authorization of services beyond the monthly or yearly visit thresholds.



**Q:** Can a CMHA provider bill for an intake (90801) and a psych eval (90801) on the same day

**A:** Yes, though we are testing the system on how well it auto-adjudicates correctly.

**Q:** If there are transportation problems and providers have contacted Southeastrans and feel that Blue Care needs to be aware as well, is there a contact person?

**A:** Yes, please notify your regional provider relations representative with the specifics and he/she will work directly with VSHP toward resolution.

**Q:** Do Blue Care and TennCare Select use the same provider number?

**A:** Generally, yes, but providers can have multiple provider numbers if they conduct more than one type of billing. For example, a provider that conducts both 837i and 837p transactions will have a provider number designated for each type of billing.

**Q:** How will the 15-minute doctor's visit count against the 10 hour/10 session limit; will it count as 1/4 of an hour or one session which is 1 hour?

**A:** This would still count as one visit. Special provisions were made for case management.

**Q:** Do CRG/TPG assessments include psych testing and, if so, number of units?

**A:** No, CRG/TPG assessments are conducted by certified rater agencies and utilize basic diagnostic and level of functioning information to determine if the member should be classified as Priority.

**Q:** Procedures for authorizing psych testing?

**A:** You can call the UM line to request authorization, or in-network providers who are registered for ProviderConnect can complete the request online. The ORF2 and the psych testing forms are available on ProviderConnect for this purpose.

**Q:** For Crisis Stabilization Unit clients, do PINs have to also be submitted?

**A:** No, this is the one exception that has been approved by the Bureau.

**Q:** can I get a copy of the Grier presentation for my records?

**A:** Yes we will send you the presentations after today's webinar via email

**Q:** I have not received my welcome letter from Value Options and have authorizations from Magellan until September 30. Where do I submit these billing forms and will they be reimbursed since I am not an approved provider yet?

**A:** We will work with non-network providers who have members in their care during the transition period.



**Q:** Do we send our requests to conduct assessments & therapy to our regional provider?

**A:** No, these requests should be directed to the UM team using the contact info provided in the presentation materials.

**Q:** For IOP SA members (All adol in custody) currently being treated, we should fax the Magellan auth we have currently or start all over with ValueOptions® with a new precert

**A:** If their current authorization spans into the month of September, you can either call the UM line to get that care registered, or fax a copy of the authorization to the attention of Debbie Dukes at 423-591-9107.

**Q:** How can a provider in private practice obtain a CRG/TPG assessment for a client from a CMHC?

**A:** You can refer clients to your local CMHC for the assessment. Should you experience difficulty with the process, please contact your regional provider relations representative.

**Q:** How do we go about billing for services online - I wanted to confirm the place where I go to file our claims online?

**A:** In network providers can register for electronic billing at VSHPTN.com. On VSHPTN.com, you will find there are a couple of options available for online billing - Real-Time adjudication, 835/837 transactions submitted directly, and 835/837 transactions submitted via clearinghouse.

**Q:** Who would I need to contact if I have problems with the online billing?

**A:** Once you've determined which option is best for you, support is available at 423-535-5717.

**Q:** How will we submit our 837 claims? We current use Capario as our clearinghouse. Will this work to send our claims?

**A:** We will work with providers who wish to file claims electronically to identify compatible clearinghouses and work with you on setup and testing on 835/837 transactions.

**Q:** I am asked to see residents in Skilled Nursing Facilities. Do I need to get prior authorization? Are they treated as in- or out-patient status?

**A:** For services that are rendered in nursing homes or other skilled nursing type facilities, they are billed and treated as outpatient services.

**Q:** If we currently submit 837P claims for our ValueOptions® book of business to you, will we have to do anything in order to send in the TennCare Select claims?

**A:** If you are currently conducting 835/837 transactions with VSHP for BlueCare members, the only difference in the process will be the eligibility information you include on the claim.



**Q:** Just to verify, we will be getting both of these PowerPoint presentations emailed to us?

**A:** Yes. We will email the presentations to you within 24 hours after the call.

**Q:** Please remind us where we can find this presentation - Thanks

**A:** This presentation is posted on the network specific page for TennCare on ValueOptions.com

**Q:** Will Magellan be handling all outstanding claims with dates of service prior to 9/1 or will these also move to ValueOptions®?

**A:** Unless it is a case where eligibility for TennCare Select was retro-active, Magellan will be processing TennCare Select claims for DOS prior to 9/1. If it is a case of retro-active eligibility, VSHP will process those claims.

**Q:** Related to case management: If a case manager in one visitation with a client spend 1.5 hours, 6 -15 minutes units, with the client would that be counted as 1.5 visits in the VO system?

**A:** When counting the CM visits toward the number of visits in a month before authorization is required, 6 units (still billed as 6 units) would equal 1.5 visits.

**Q:** Is there a charge for using electronic billing services, in using your website?

**A:** If you currently must utilize a clearinghouse for electronic claims submission, those clearinghouses do charge a fee. If you have the technology to complete 835/837 transactions directly with us, no fees are charged. Real-Time adjudication for outpatient billing is also available at no charge.

**Q:** How long after seeing someone, before you have to submit a treatment plan (Is it measured in days or the number of sessions)?

**A:** A treatment plan should be completed within thirty days of the initial appointment, but there are no general treatment plan submittal requirements. We would review this in the event of an audit, or may request it for concurrent review purposes.

**Q:** For a child (under 18) in DCS custody, are they limited to 20 sessions per year?

**A:** This authorization threshold would apply if the child has not been assessed as a priority member or if the assessment has expired (is more than twelve months old). Authorizations can still be given, however, based on medical necessity.

**Q:** Are you allowed one unit psychological testing

**A:** All psych testing requires prior authorization.

**Q:** Is the billing software available to download from your website? How do you get the software?



**A:** If you are filing electronically, there is a registration process that must be completed. Once registered, any tools and resources you need for filing claims will be available at VSHPTN.com.

**Q:** Are you allowed one unit of psychological testing without authorization?

**A:** All psych testing requires prior authorization.

**Q:** the mic was full of static as the Grier presenter took it. What is her name?

**A:** The first broadcast presenter was Debbie Dukes. The second broadcast presenter was Christine Lewis.

**Q:** The 10 sessions that are available with out pre-auth --- do these 10 include purely medical visits (i.e.: yearly GYN exam) or only Behavioral?

**A:** These visits only include behavioral health outpatient services such as medication management, therapy and case management. Medical services are not included in the counts.

**Q:** regarding the question of intake and initial med eval being done on the same day -- would the modifier make a difference in the ability to get both accepted?

**A:** The MD would be 90801, and the intake would most probably be 90801HO. We are testing this and hope to have an answer soon. Theoretically, it should pay.

**Q:** Want to confirm that med management and therapy can be done on the same day?

**A:** Non-duplicative medication management and therapy services can be billed on the same day.

**Q:** We bill on UB04 form, we are an A&D tx center with an MD who signs off on us. Will we need to use the licensure modifier?

**A:** Licensure level modifiers are to be used when filing services that are billed on a CMS 1500. The rule of thumb in determining if services should be billed on a CMS1500 versus a UB04 is that if the services are CPT code services or HCPCS code services, they should be billed on a CMS1500. If the services are revenue code services or revenue code services billed in conjunction with a HCPCS code, they should be billed on a UB04. Please utilize your fee schedule and our Service Class Grid (posted on the website) for guidance.

**Q:** Was there a Broadcast 1 and if so how can I obtain the information?

**A:** Yes, the Broadcast 1 is the same information. So the information you receive on this webinar is not different. We will send you the info and PowerPoint after today's call

**Q:** Will ValueOptions® provide eligibility files? If so, will we receive them weekly?

**A:** We will not be providing weekly eligibility files. For this implementation, your current TennCare Select membership will in most cases remain TennCare Select. If you experience a significant volume of issues in trying to determine eligibility, please contact



your regional provider relations representative and we will work with you on an individualized basis.

**Q:** Will CRG/TPGs be submitted using the same file format as Magellan?

**A:** The file format is essentially the same, but we will contact each rater agency not already submitting CRG/TPG assessments with more instructions on how to get set up to exchange this information via secure email.

**Q:** Will we be able to get copies of the presentations today to share with staff?

**A:** We will send the PowerPoint presentation via email within 24 hours after the presentation. We have your email from when you registered. Thanks for your question.