Bassett Healthcare Network
Community Health Navigation

Policy Title: Billing Requirements Policy	**DOH Policy Name: Billing and Documentation Guidance for Health Home Adult Rates with Clinical and Functional Adjustments** **DOH Reference Number: N/A** **Effective Date: 03/2019**
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Original Date: 11/11/2022 **Revision Date: 6/16/2023, 11/17/2023** **Date of Issue: 6/16/2023, 11/20/2023**	**Created by: Kali Angell** **Approved by: Miranda Blakeslee**

POLICY STATEMENT

Bassett Community Health Navigation Health Home (BCHNHH) provides this policy to set guidelines for partnering Care Management Agencies (CMA) to set the standard for oversight, management, and accountability related to billing. Setting standards will help to ensure that any program requirements are standards and improve member care to ensure consistent services and billing are occurring timely.

SCOPE

Generally, the care management agency determines eligibility of each member for Health Home services. Information may be obtained from the member's health care providers and MCO to support the eligibility determination as such entities often have more detailed information on a member's diagnosis and care utilization. Health Homes, MCOs, and CMAs must have policies and procedures in place for determining and documenting Health Home eligibility.

The Department has built systems into the MAPP HHTS to help HHs ensure that claims do not go through for members who are not eligible for services. The Medicaid biller – the Health Home – remains ultimately responsible for ensuring that only those individuals who are eligible for Health Home services are enrolled into the Health Home program.

OBJECTIVES

After reading this policy, staff will understand the billing process from questionnaire completion to receiving payment. Defining and developing standard around the BCHNHH billing processes and procedures allows for improved billing completion for services billed through the Health Home program.

Ensuring that all members billed for meet the minimum requirements as defined by NYSDOH, as well providing transparency around the billing process is a primary goal of BCHNHH. This policy is meant to enhance, not supersede guidance set forth by NYSDOH. After reading this staff will be able to understand the importance of complying with all DOH State guidelines related to programmatic billing.

DEFINITIONS

Medicaid Analytics Performance Portal (MAPP)
Used to provide tools and program performance management technologies supporting care management efforts for the State's Health Home programs.

Health Home High, Medium, Low Billing for Adults (HML)
An assessment tool used to determine the monthly rate code under which to bill a member.

ROLES AND RESPONSIBILITIES

Health Home Administration:
Will ensure that communication with partnering CMAs is taking place to ensure staff directories are as up to date as possible to ensure all staff are trained and aware of all policies and procedures. BCHNHH administrative staff will ensure that billing procedures are being followed and that MAPP is being updated with correct information.

Care Management Agency:
Will ensure that all their staff is up to date on all trainings of policies and procedures and are aware of any updates. The supervisor is responsible to ensure that staff is competing their HML Billing Questionnaires on time and are submitting all billing on time.

PROCEDURES

Monthly Billing for Health Home Services

1. A billing questionnaire must be completed for each member assigned in the Care Management Record by the 3rd business day of the following month.

2. All billing questionnaires must be answered accurately with supporting documentation for the billing rate.
    a. Must be answered as billable or non-billable.
    b. The answers to these questions are critical and any questions that don't apply to a member or any questions that cannot be answered may be answered with Unknown.
    c. If no questions are answered, or all are answered Unknown, the rate must be billed as Health Home Care Management.
    d. Each CMA will determine what staff is responsible for completing monthly billing questionnaires and verifying documentation requirements have been met.

3. In order to be able to bill for a member in a given month the following must be complete:
    a. Once enrolled, a member's Medicaid eligibility and coverage must be confirmed each month. If the provider does not verify eligibility prior to rendering services, the provider will be at risk for non-payment for services provided. The State will not compensate a provider for a service rendered to an individual who is not enrolled with the appropriate Medicaid coverage. For further information please refer to *Medicaid Restriction-Exemption Code Guide.*

i. Care Managers must ensure they are documenting in a non-billable contact note or written first in the billable note prior to providing services that Medicaid has been verified for the member.

b. Core Health Home Service(s) were provided and documented in the Members Record as Billable Care Manager Note(s).
c. Medical documentation verifying eligibility, initialed/signed DOH-5055, and DOH-5234 are uploaded.
d. A Comprehensive Assessment and signed initial Plan of Care (POC), and/or Person-Centered Care Plan (signed) have been completed/uploaded.
    i. After the initial POC the Person-Centered Plan of Care must be completed within 60 days of enrollment and annually thereafter, to continue billing.
e. Upon request for disenrollment the Bassett Disenrollment summary, DOH 5235, Disenrollment Letter with attached resources should be completed in full, and uploaded to bill for the month of disenrollment.

4. If any HML Billing Questionnaires are not completed by the 3rd business day of the following month, designated CMA staff must:
    a. Notify BCHNHH by email, stating:
        i. Client ID(s)
        ii. Reason why not complete
        iii. Anticipated completion date
    b. Complete or correct HML in the Care Management Record
    c. Complete or correct HML in MAPP-HHTS
        i. This will delay billing for that member for that month.
5. CMAs have 90 days from the 1st day of the service month to bill for services.
    a. An attempt to bill for services after 90 days from the first day of the month will result in a denial of payment.
6. BCHNHH will be monitoring and tracking the CMA network to identify:
    a. Maintenance of a 90% billing rate each month.
        i. Any CMA that falls below 90% for three consecutive months will be reviewed by the HH.
        ii. BCHNHH will conduct a meeting with a CMA to discuss barriers to billing and will determine a resolution.
            1. A review may result in a CMA being placed on a Performance Improvement Plan (PIP), based on historical patterns and reasons for not meeting billing expectations.

Billing Documentation Standards and HML Completion

HIV/AIDS Status

1. CD4 (T-cells) testing is recommended at 12 weeks and every four months after initiation of ARV until CD4 is > 200 cells/mm3 on two measures.
2. For those who are virally suppressed, CD4 testing is recommended at least every six months if CD4 is less than or equal to 300 cells/mm3.
3. Every 12 months if CD4 >300 cells/mm3 and less than or equal to 500 cells/mm3.
4. Optional if CD4 greater than 500 cells/mm3.
5. Practitioners agree that a six-month period of more aggressive care management is appropriate for an HIV+ member with a medium or high range viral load, even though they should be tested again within that period.
    a. Quarterly for HIV+ persons with recent history of non-adherence, MH disorders, SU, poor social support, or other major medical conditions;

b. Every four months for most individuals after complete viral suppression;
c. Every six months for those with complete suppression for over one year and CD4 counts greater than 200 cells/mm3;
d. Note, when a person is failing viralogically, testing is recommended within four (4) weeks from a change in ARV, and at least every eight (8) weeks until completely suppressed.

6. **External Documentation** – Lab results, medical records, or documented conversation from collateral contact. For the purposes of this documentation a collateral contact must be documented as a service provider or managed care organization that can confirm lab results and/or have access to the individual's medical record.

7. **Observation** – Substantiation of reports from care providers, the person, family, or other third-party sources that support the level of intensity, level of need, and billing category. Documentation would include progress notes and a care plan that reflects the intensity of services needed to address the category of billing claimed. The documentation of a care plan and progress notes would maintain billing for 90 days until external documentation is obtained.
    a. The goal is to secure needed community services including outpatient care, routine testing and illness self-management, food resources, etc. Objectives may include:
        i. Secure primary care physician (PCP) and/or specialty care, mental health or substance abuse services;
        ii. Secure transportation to/from appointments for behavioral and/or physical health appointments for assessment labs, etc.;
        iii. Reestablish benefits including Medicaid, public assistance; and,
        iv. Address homelessness by completing applications for housing such as HRA2010E, or secure shelter placement or other supportive housing intervention.

Homelessness

1. Definition of Homelessness
    a. **HUD Category 1** - An individual who lacks a fixed, regular, and adequate nighttime residence.
        i. An individual who has a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings, including a car, park, abandoned building, bus or train station, airport, or camping ground; An individual or family living in a supervised publicly or privately-operated shelter designated to provide temporary living arrangements (including hotels and motels paid for by Federal, State or local government programs for low-income individuals or by charitable organizations, congregate shelters, and transitional housing); or
        ii. An individual residing in a shelter or place not meant for human habitation and who is exiting an institution where he or she temporarily resided.
    b. **HUD Category 2** - An individual or family who will imminently lose their housing.
        i. As evidenced by a court order resulting from an eviction action that notifies the individual or family that they must leave within 14 days;
        ii. Having a primary nighttime residence that is a room in a hotel or motel, and where they lack the resources necessary to reside there for more than 14 days, or credible evidence indicating that the owner or renter of the housing will not allow the individual or family to stay for more than 14 days; and,

iii. Any oral statement from an individual or family seeking homeless assistance that is found to be credible shall be considered; has no subsequent residence identified; and lacks the resources or support networks needed to obtain other permanent housing.

c. **Date Housed** – If Category 1 or Category 2 they will maintain that level of billing category for six months.

d. **If Category 1 or 2 and not housed**, they will maintain that level of billing category with appropriate observation documentation until housed or discharged from the program.

2. **External Documentation** - Letter from shelter or other homeless housing program, hospital discharge summary, eviction notice, documentation from local Homeless Management Information System (HMIS), or self-report.

3. **Observation** - Substantiation of reports from care providers, the person, family, or other third-party sources that support the level of intensity of need and billing category. Documentation of this observation would include progress notes and a care plan that reflects the intensity of service needs to address the category of billing claimed. The documentation of care plan and progress notes would maintain the category of billing until external documentation is obtained.
    a. The Goal is to find safe and stable housing. Objectives may include:
        i. Submit applications;
        ii. Landlord list;
        iii. Re-establish benefits;
        iv. Interventions would be evidence that more than routine care management services of a greater scope or frequency are necessary.

Incarceration

1. **Definition of Incarcerated** – Released from state prison or county jail after sentence is served. May be on probation or parole, but that is not required to meet the definition of incarceration. Incarceration would also include detention or arrest for charges not adjudicated or sentenced; violations of probation/parole; released on bail awaiting arraignment; or other criminal justice status in which the person has an ongoing criminal justice issue requiring care management intervention.

2. **External Documentation** - Release papers; documentation from parole/probation; documented conversation from collateral contact; print-out from Webcrims or other criminal justice database; letter from halfway house; or self-report (for 90 days).

3. **Observation** – Substantiation of reports from care providers, the person, family, or other third-party sources that support the level of intensity of need and billing category. Documentation of this observation would include progress notes and a care plan that reflects the intensity of service needs to address the category of billing claimed. The documentation of care plan and progress notes would maintain the rate for 90 days until external documentation is obtained.
    a. The Goal is to secure needed community services including outpatient care, financial benefits, food resources, etc. Objectives may include:
        i. Secure primary care physician (PCP), mental health or substance abuse services;
        ii. Secure transportation to/from appointments for behavioral or physical health;
        iii. Reestablish benefits;
        iv. Reestablish housing.

4. If a member is in AOT the current court order must be uploaded and all AOT requirements have been met.

Inpatient (IP) Stay for Physical Illness (PI)

1. **Definition of IP for PI**- Inpatient admission, regardless of duration, that would require significant care coordination post discharge. Significant will be defined as a member disengaged from care prior to hospitalization or the discharge plan requires linkage to care not currently established requiring additional care coordination needs such as arranging appointments, transportation, and follow-up testing.

2. **External Documentation**- Hospital discharge summary; documented progress note (including name, title, contact information of person on inpatient unit who verified patient's discharge date); print out from PSYCKES; RHIO alerts of inpatient admission or MCO confirmation of admission. Self-report does not meet criteria as sufficient documentation.

3. **Observation** – Substantiation of reports from care providers, the person, family, or other third-party sources that support the level of intensity of need and billing category. Documentation of this observation would include progress notes and a care plan that reflects the intensity of service needs to address the category of billing claimed. The documentation of care plan and progress notes would maintain the category of billing for 90 days until external documentation is obtained.
    a. The Goal is to secure needed community services including outpatient care, financial benefits, food resources, etc. Objectives may include:
        i. Secure PCP, mental health or substance abuse services, follow up appointments;
        ii. Secure transportation to/from appointments for behavioral or physical health;
        iii. Re-establish housing if in jeopardy or as part of discharge plan.

Inpatient (IP) Stay for Mental Illness (MI)

1. **Definition of IP Stay for MI** – Inpatient admission, regardless of duration, that would include CPEP under an observation status or other psychiatric emergency/respite programs. Inpatient admission for MI that includes a transfer to other units for complex needs, including physical health, would qualify as an inpatient stay for MI. For example, a member is admitted to a MH IP unit, then transferred to the medical floor, and discharged from a medical bed to community.

2. **External Documentation** -- Hospital discharge summary; documented progress note (including name, title, contact information of person on inpatient unit who verified patient's discharge date); documentation of Mobile crisis episodes; print out from PSYCKES; RHIO alerts of inpatient admission or MCO confirmation of admission; Self report does not meet criteria as sufficient documentation.

3. **Observation** – Substantiation of reports from care providers, the person, family, or other third-party sources that support the level of intensity of need and billing category. Documentation of this observation would include progress notes and a care plan that reflects the intensity of service needs to address the category of billing claimed. The documentation of care plan and progress notes would maintain the category of billing for 90 days until external documentation is obtained.
    a. The Goal is to secure needed community services including outpatient care, financial benefits, food resources, etc. Objectives may include:
        i. Secure PCP, mental health or substance abuse services, follow up appointments;
        ii. Secure transportation to/from appointments for behavioral or physical health;

iii. Re-establish housing if in jeopardy or as part of discharge plan.

Inpatient (IP) Stay for Substance Use Disorder (SUD) Treatment

1. **Definition of IP Stay for SUD Disorder** – Inpatient admission in a hospital or community-based setting regardless of duration that could include detoxification services (medically managed, medically supervised or medically monitored, but not ambulatory detox), inpatient rehabilitation, residential stabilization and rehabilitation or other inpatient services as defined by OASAS.

2. **External Documentation** -- Hospital or provider discharge summary; documented progress note (including name, title, contact information of person on inpatient unit who verified patient's discharge date); print out from PSYCKES or MCO confirmation; and self-report.

3. **Observation** – Substantiation of reports from care providers, the person, family, or other third-party sources that support the level of intensity of need and billing category. Documentation of this observation would include progress notes and a care plan that reflects the intensity of service needs to address the category of billing claimed. For High category of billing, the documentation of care plan and progress notes would maintain the category of billing for 90 days until external documentation is obtained.
    a. Goal could be accessing community services, financial stability, developing safety plans, accessing higher levels of care, housing issues, food insecurity, access to medication, transportation, to attending medical or behavioral outpatient services.
    b. Objectives must include:
        i. Secure primary care physician (PCP), mental health or substance abuse services, follow up appointments;
        ii. Reestablish housing if in jeopardy or as part of discharge plan.

Substance Use Disorder Active Use/Functional Impairment

1. **Definition of SUD Active Use/Functional Impairment** – Positive lab test for Opioids, Benzodiazepines, Cocaine, Amphetamines, or Barbiturates; OR care manager observation (with supervisor sign off) of continued use of drugs (including synthetic drugs) or alcohol with supervisor sign off ; OR MCO report of continued use of drugs or alcohol; AND demonstration of a functional impairment including continued inability to maintain gainful employment ; OR continued inability to achieve success in school OR documentation from family and/or criminal courts that indicates domestic violence and/or child welfare involvement with the last 120 days; OR documentation indicating Drug Court involvement AND the presence of six or more criterion of SUD under the DSM-5 which must also include pharmacological criteria of tolerance and/or withdrawal.

2. **External Documentation** - Based on assessment and information gathered by the care manager from substance use providers, probation/parole, and court ordered programs, domestic violence providers, local DSS, and other sources.

3. **Observation** – Substantiation of reports from care providers, the person, family, or other third-party sources that support the level of intensity of need and billing category. Documentation of this observation would include progress notes and a care plan that reflects the intensity of service needs to address the category of billing claimed. For High category of billing, the documentation of care plan and progress notes would maintain the High category of billing for 90 or more days if, and only if, progress notes clearly document evidence of care management interventions to support SUD intervention. This includes motivational interviewing, education, referral and linkage to

recovery coaching, and other peer supports. External documentation is preferred and every effort must be clearly documented, including specific efforts to engage the individual in harm reduction and safety planning.

a. Goals related to barriers to attending medical or behavioral outpatient services, as a result of substance use; or evidence of motivational interviewing or stages of change related goals or objectives related to the attainment of vocational and educational goals.
    i. For example, goals and objectives might be utilizing motivational interviewing and stages of change approaches to move people towards active participation in treatment. In this case, a goal would be something like “I want my children back” in the person’s words.
    ii. The objectives would be to participate in programming or treatment and the interventions would be using these approaches to help the person see how addressing their substance use issues might help them reach their goals.

Lead HH Submission of Billing to Payors

1. BCHNHH will download billing support file from Netsmart and upload to MAPP-HHTS by the 6th business day of the month following service provision
2. BCHNHH will download billing support Error Report from MAPP-HHTS by the 10th business day of the month and notify appropriate staff of any errors
    a. CMA staff will make necessary corrections as needed in Netsmart and notify Systems Analyst by email of completion.
    b. Systems Analyst will update MAPP-HHTS to reflect corrected information for the final monthly billing submission.
    c. System Analyst will submit the downloaded MAPP-HHTS billing support download file to Millin Associates via Millin Portal.
    d. System Analyst will generate and send a billing roster to each CMA via HCS that includes all paid claims for the month.
    e. CMA billing contact and Systems Analyst will communicate to resolve any questions or discrepancies regarding the billing roster.
3. When BCHNHH receives payment remits from the State:
    a. eMedNY and MCO will send Millin a Remit Advisory to be uploaded to the Millin Pro Application.
    b. Lead HH will check weekly if new remits have been loaded into the Millin Application.
        i. All claims submitted on behalf of the CMA will be viewable via the Millin Pro Provider Portal and associated to the CMA MMIS number.

Changes to Billing and Recoupment of Claims Previously Billed or Paid

1. If it is determined at any time that billing occurred improperly or for an improper amount, appropriate actions must be taken to ensure proper billing and recoupment is completed:
    a. If discovered by CMA staff:
        i. notify the lead HH,
        ii. correct the HML Questionnaire in Netsmart, and
        iii. correct the HML in MAPP-HHTS for the corresponding month.
    b. If discovered by the Lead HH:
        i. BCHNHH will notify CMA supervisor/billing staff of the discrepancies found.
        ii. Any impact to payment will be represented on the CMAs next payment invoice.
2. BCHNHH will process billing changes and when a recoupment is processed in Bassett’s internal accounting, the amounts will be represented in the following month’s remittance.

Additional Billing Requirements

- For Medicaid Enrolled Providers:
  - Network partners providing care management services should be NYS Medicaid enrolled providers with a Medicaid Management Information System (MMIS) – a MMIS is required to communicate HH member billing, process, and metrics between the DOH, MCPs, and HHs.
- For Non-Medicaid enrolled providers all payment agreements include the following:
  - Must certify that information submitted in support of services is complete and accurate.
  - Must agree to comply with laws designed to prevent fraud and abuse.
  - Must agree to report to the HH any incidents, suspected fraud, waste, or abuse or criminal acts.
  - Agrees to be bound by the confidentiality provisions (2.9 of the Administrative Health Homes Services Agreement).
  - Must certify that none of its owners, employees, or contractors is an ineligible person – person or entity who is:
    - Ineligible to participate in Federal health care programs, or;
    - Has been convicted of a criminal offense subject to OIG's mandatory exclusion authority described in section 1128(a) of the Social Security Act, or;
    - Currently ineligible to participate in State medical assistance programs, including Medicaid of CHIP, or State procurement of non-procurement programs as determined by a State governmental authority.

COMMUNICATION/TRAINING/IMPLEMENTATION

All staff will be provided and expected to attest to understanding this policy and a training will be provided at minimum semi-annually by BCHNHH. Additional requirements found in this policy is up to the CMA Supervisors to ensure is in place and being utilized, the HH will ensure that each CMA has a system in place with their staff within 1 month of obtaining attestation forms back.

It is the responsibility of BCHNHH to ensure that all or partnering CMAs and HH employees are up to date on policies and procedures including monthly billing. Supervisors should be knowledgeable on how to submit billing, proper completion of an HML, and training new employees on proper procedure. The HH will ensure that all staff attest to understanding this policy and procedure and through monthly chart reviews will monitor proper completion.

Quality Management & Performance Improvement

BCHNHH will review a random sample of cases for appropriate billing and documentation support the billing rate as part of the quality management and performance improvement program. BCHNHH will identify and track billing trends on a monthly basis to monitor.

BCHNHH will closely monitor quality management and billing process, CMA network performances based on MAPP. Monthly reporting requirements, dashboard analytics, and billing errors will be effectively identified and corrected. BCHNHH will monitor the staff directory for BCHN and partnering agencies to ensure that all staff are up to date on policies and procedures and any trainings necessary. CMA's must develop internal quality assurance processes to assure appropriate and timely billing submissions.

RELATED FORMS

- *Bassett CHN Core Health Home Services and Care Management Policy*
- *Bassett CHN Standards and Requirements of HH+ Member Service Provision*
- *Medicaid Restriction-Exemption Code Guide*