WellCare of Kentucky
Behavioral Health Claims System Re-Configuration
Spring/Summer 2017

Topic	*All Prescribers: MDs, DOs, APRNs & PA's*	*Residential BHSO's*	*Non-residential BHSO's*	*BH Multi-Specialty Groups*	*Independent BH PhDs, LBAs, LCSWs, LMFTs, LPATs, LPCCs, LPPs, etc.*
Billing Forms Used	**HCFA 1500**	**HCFA 1500**	**HCFA 1500**	**HCFA 1500**	**HCFA 1500**
Claims Payment by Fee Schedules	Paid according to the KY DMS Physician's fee schedule	Paid according to the KY DMS Behavioral Health Facility fee schedule	Paid according to the KY DMS Behavioral Health Non- Facility fee schedule	Paid according to the KY DMS Behavioral Health Non-Facility fee schedule	Paid according to the KY DMS Behavioral Health Non- Facility fee schedule
Credentialing	All licensed autonomous providers must be credentialed	All licensed autonomous providers must be credentialed	All licensed autonomous providers must be credentialed	All licensed autonomous providers must be credentialed	All licensed autonomous providers must be credentialed
Evaluation and Management (E/M) Codes	Reimbursed according to the KY DMS Physician's fee schedule	***Reimbursed when billed with the MD, DO, PA or APRN as the rendering provider***	***Reimbursed when billed with the MD, DO, PA or APRN as the rendering provider***	***Reimbursed when billed with the MD, DO, PA or APRN as the rendering provider***	***Not covered under the BH Non-Facility Fee Schedule***
Labs/Urine Drug Screens (UDS)	CLIA certification or CLIA waiver **REQUIRED** to be on file with WellCare for payment	***Cannot be reimbursed for lab services. These services are reimbursed when billed with the MD, DO, PA or APRN as both the billing and rendering provider***	***Cannot be reimbursed for lab services. These services are reimbursed when billed with the MD, DO, PA or APRN as both the billing and rendering provider***	***Cannot be reimbursed for lab services. These services are reimbursed when billed with the MD, DO, PA or APRN as both the billing and rendering provider***	***Not covered under the BH Non-Facility Fee Schedule***
Medication Management	Must follow CPT guidelines	***Reimbursed when billed with the MD, DO, PA or APRN as the rendering***	***Reimbursed when billed with the MD, DO, PA or APRN as the rendering provider***	***Reimbursed when billed with the MD, DO, PA or APRN as the rendering provider***	***Not covered under the BH Non-Facility Fee Schedule***

		provider			
Modifiers	Not required outside of CPT billing guidelines	**REQUIRED** on all claims	**REQUIRED** on all claims	**REQUIRED** on all claims	**REQUIRED** on all claims

Please see attached document, “Behavioral Health (Non-CMHC) Frequently Asked Questions”, for additional details as well as instructions for the WellCare Health Plans website.

Behavioral Health (Non-CMHC) Frequently Asked Questions

CLAIMS PAYMENT AND FEE SCHEDULES

Q. My contract says that I'm reimbursed according to my licensure—what is that?

A. For behavioral health services, reimbursement is tiered based on individual practitioners' professional licensure.

Q. What are correct coding guidelines?

A. The CMS National Correct Coding Initiative (NCCI) promotes national correct coding methodologies and reduces improper coding which may result in inappropriate payments of Medicare Part B claims and Medicaid claims. For information about edits for the Medicare NCCI program, please visit: https://www.medicaid.gov/medicaid/data-and-systems/ncci/index.html

Q. How do I submit a claim for payment?

A. The WellCare website has multiple resources which includes instructions for claims submission. Additionally your provider manual contains specific information regarding the claims submission process. Behavioral Health claims are submitted on a HCFA 1500 form. Information about paper and electronic submission can be found at: https://www.wellcare.com/en/Kentucky/Providers/Medicaid/Claims

Q. How do I submit a corrected claim?

A. Detailed instructions on submitting a corrected claim can be found by downloading the form entitled *Process for Corrected Claims and Voided Claims* from: https://www.wellcare.com/en/Kentucky/Providers/Medicaid/Claims. This information is also available in your provider manual.

Q. Who do I contact for claims or other types of questions?

A. You can reach out to your assigned provider relations representative or to **Customer Service at** 1-877-389-9457. Additionally, an email box has been set up to assist with questions regarding specific behavioral health billing issues: BH_Provider_Inquiry@wellcare.com. It is helpful to send specific examples with any claims related questions

Q. Who do I contact regarding questions I have on my WellCare contract?

A. Karen Dean, Manager Network Management Kentucky
Office Phone: 502-253-5292
Email: Karen.Dean@wellcare.com

MODIFIERS

Q. Are modifiers required to be billed?

A: Modifiers are required for codes on the behavioral health facility and non-facility fee schedules. WellCare requires appropriate modifiers to be billed on the claim in order to be reimbursed correctly based on the licensure of the rendering provider. Modifiers within each BHSO fee schedule can be located via the following link: http://chfs.ky.gov/dms/fee.htm.

CREDENTIALING

Q: Does WellCare require that ALL providers be credentialed?

A: At this time, all licensed providers practicing in a stand-alone practice or a multi-specialty group must be credentialed by WellCare. Additionally, if they are working for a BHSO, all physicians, APRNs, and physician assistants must be credentialed. Other licensed providers (LCSWs, LMFTs, LPCCs, etc.) will need to be credentialed within the next 180 days (please refer to attached letter).

Q. What does WellCare require for Credentialing?

A. All providers must be credentialed to be a participating WellCare provider. For any and all new providers the credentialing process may take up to 90 days to be completed. *Please respond to any requests for additional information during the credentialing process as soon as possible in order to facilitate timely completion of your application*.

Q. How long does re-credentialing take?

A. If you are currently a participating provider, the re-credentialing process is completed much sooner. Claims payment for existing contracted providers will not be suspended during the re-credentialing process.

Q. What credentialing documents are needed to complete my application?

A. The following information is required when providers are being added to an existing group:

1) Provider letter on company letterhead requesting to participate in the Kentucky WellCare network including the following information for all providers who are to be added:
   - National Provider Identifier (NPI)
   - CAQH number
   - KY Medicaid number
   - Medicare number

EVALUATION AND MANAGEMENT (E/M) CODES

Q. Do E/M codes require prior authorization?

A. No, WellCare does not currently require prior authorization for an evaluation and management (E/M) code. PLEASE NOTE: If an appropriately licensed and credentialed physician, APRN or physician's

assistant working for a BHSO renders E/M services, the physician, APRN or physician's assistant must bill for the E/M consultation under his or her unique NPI as the rendering provider.

LABS, URINE DRUG SCREENS (UDS)

Q. How many urine drug screens are covered by WellCare?

A. There is a detailed document that outlines our coverage of drug testing; Claims Edit Guideline: Drug Testing, policy number HAS-247. This document can be downloaded using our search function from: https://www.wellcare.com/Kentucky/Providers/Clinical-Guidelines/CCGs#

Q. Are there other coverage guidelines that WellCare uses?

A. WellCare has Clinical Coverage Guidelines (CCGs) and Clinical Practice Guidelines (CPGs) for these services. Please follow the links below to review these resources:

Clinical Coverage Guidelines (CCGs)
https://www.wellcare.com/Kentucky/Providers/Clinical-Guidelines/CCGs
Clinical Practice Guidelines (CPGs)
https://www.wellcare.com/Kentucky/Providers/Clinical-Guidelines/CPGs

Q. Can a BHSO bill for laboratory services performed within the BHSO?

A. According to KY Medicaid, lab services are not covered in the BHSO setting; however lab services may be billed by individual prescribing providers or independent laboratories. Prescribing providers are defined as an appropriately licensed and credentialed physician, APRN or physician's assistant in accordance with KY Medicaid regulations. If an appropriately licensed, credentialed and participating prescribing provider working for a BHSO renders lab services, the prescribing provider must be on the claim as rendering and billing for the lab service under his or her unique NPI.

Likewise, if an independent laboratory provides lab services, they must be on the claim under the lab's unique NPI and NOT under the BHSO provider NPI.

In order to bill for lab services, a CLIA (Clinical Laboratory Improvement Amendment) or CLIA waiver must also be on file with WellCare.

MEDICATION MANAGEMENT

Q. Are BHSO's able to provide medication management services?

B. Medication management services are used to determine a member's need for a prescribed drug or to evaluate the effectiveness of the prescribed drug as noted in the treatment plan. Medication management does not have a stand-alone CPT code and must be performed in conjunction with an E/M

service. If an appropriately licensed and credentialed physician, APRN or physician's assistant working for a BHSO renders E/M services, the physician, APRN or physician's assistant must bill for the E/M consultation under his or her unique NPI and not under the BHSO Provider NPI.

Q. Can all BHSOs provide residential substance abuse services?

A. In order to provide residential or inpatient treatment for substance abuse, a BHSO must be licensed as an AODE (Alcohol & Other Drug Entity). For more information on the AODE license, please visit: http://www.lrc.ky.gov/kar/908/001/370.htm

Q. Can a BHSO provide individual therapy while a member is in residential treatment?

A. A provider cannot be paid for a therapy code (examples: 90832, 90834, 90837) on the same day as a per diem service (example: H0018/H0019 for residential; S9485 for CSU; or S9480 for IOP). The per diem services are inclusive of therapy services.

PRIOR AUTHORIZATION, APPEALS, PEER-TO-PEER, WEB PORTAL, ETC.

Q. What are the authorization requirements on behavioral health services?

A. Authorization requirements for every CPT code can be found using the WellCare authorization look up tool at: https://www.wellcare.com/Kentucky/Providers/Authorization-Lookup.

Additionally, forms for requesting authorizations are located at: https://www.wellcare.com/Kentucky/Providers/Medicaid/Behavioral-Health.

Guidelines for completing the forms can also be found on our website: https://www.wellcare.com/Kentucky/Providers/Medicaid/Behavioral-Health

Q. Which CPT codes are included in the 20 Sessions that do not require prior authorization per member per year (Effective 1/1/17)?

A. 90832, 90834, 90837, 90846, 90847, 90853

Q. What if a member has seen another provider, can a BHSO still bill the first 20 sessions without authorization?

A. No, the first twenty sessions per year is based on the **member** and is not provider-specific. You should coordinate services with any other provider.

Q. How do I Appeal a decision?

A. To appeal a decision, fax the appeal request to the Appeals Department at fax #: 1-866-201-0657. You may also mail your appeal request to:

WellCare of Kentucky
Attn: Appeals Department
P.O. Box 436000
Louisville, KY 40253

Q. <u>What are some overall tips for the authorization process?</u>

A. See below:

- We do not allow back-dated authorization requests. The only exception would be for retro-added members.
- Standard turn-around-time to process an authorization request is two (2) business days from the date received. Urgent requests are responded to within 24 hours
- Services cannot be requested in more than 90-day timeframes to assist with monitoring utilization
- All codes and amount of units for each code must be included
- ICD-10 diagnosis codes must be included on all requests
- Clinical information should be attached to the form. Simply filling out the 2nd page of form is not sufficient in most cases
- Request should only be marked 'expedited' or 'urgent' if applying the standard time frame may seriously jeopardize the life or health of the member or the member's ability to regain maximum function
- Coordinate with the member's other service providers to ensure that there is no duplication of services as well as to gather clinical history
- Requests should not be submitted ***<u>more than</u>*** 14 days in advance to allow time for a clinical review/determination
- The service/treatment plan with updated goals/progress noted for ongoing requests (once no authorization needed units are exhausted) must be included
- Targeted case management and therapy authorizations will be separated
- If post-service dates are requested, you will receive an authorization or determination for dates prior to the date the request was received and an authorization/determination for the date received going forward
- Request forms must be filled out in entirety. Information including member's symptoms, past treatment involvement and engagement, access to services, support system, medical, developmental and substance abuse issues, are needed for a complete clinical criteria review
- Psychological and neuropsychological requests must be submitted on the corresponding form and include past treatment attempts, current symptoms & medication and testing measures/scales to be used
- Criteria utilized for medical necessity reviews include but are not limited to: LOCUS, CASII, InterQual, ASAM and ECSII in accordance with KY Medicaid requirements.

Q. <u>What is the QRG?</u>

A: The Quick Reference Guide (QRG) is a valuable tool. WellCare's Kentucky Medicaid QRG is available online at https://www.wellcare.com/Kentucky/Providers/Medicaid. This guide contains information about claims submissions, appeals, and authorizations.