Medicaid Direct PIHP Tailored Care Management Claims Billing Guidance

Purpose:

This billing guide serves as an overview of the Medicaid Direct Tailored Care Management claims and encounters processes and procedures for 7/1/2023 through 9/30/2023. The information contained in the guide is targeted for Department certified PIHPs which furnish Tailored Care Management services.

Background:

Through Tailored Care Management (TCM), Medicaid Direct members will have a single designated care manager supported by a multidisciplinary care team to provide whole-person care management that addresses member needs: physical health, behavioral health, I/DD, traumatic brain injuries (TBI), pharmacy, long-term services and supports (LTSS) and unmet health related resource needs.

Main Billing Guidance Takeaways:

- Continuing 7/1/2023, Medicaid Direct PIHPs will assign eligible TCM Beneficiaries to certified TCM entities (AMH+, CMAs) for TCM services.

- Continuing 7/1/2023, Medicaid Direct PIHPs will submit adjudicated AMH+ and CMA claims for the first monthly TCM contact per member to NCTracks, along with all corresponding encounters to the EPS.

- Continuing 7/1/2023, Medicaid Direct PIHPs providing TCM services will submit TCM claims for the first monthly TCM qualifying contact per member to NCTracks, along with all corresponding encounters to the EPS.

- Continuing 7/1/2023, Medicaid Direct PIHPs, AMH+, and CMAs will receive payment based on the TCM blended rate. Care Management providers with members assigned and eligible for Innovations/TBI and/or 1915i will receive add-on payments.

- All TCM interactions/contacts should be documented by the respective TCM entity performing the service(s). TCM Providers should submit that data to their respective PIHPs through the Patient Risk List (PRL).

- Medicaid Direct PIHPs should submit all TCM interactions/contacts for their eligible TCM population to the Department through the BCM051 operational report. PIHPs should include their TCM contacts as well as providers' contact for their members.

- Medicaid Direct PIHPs should have processes to archive historical Tailored Care Management claims data submitted to the State for Federal and/or State audit purposes. Please refer to the PIHP contract for detailed information.

- DHB pays the TCM payment for any month in which the member is assigned to the PIHP and the PIHP delivers at least one qualifying contact.

    - A qualifying contact is the delivery of one or more of the six health home services through phone/video/in-person with the member/guardian.

Tailored Care Management Billing Guidance for TCM Services Furnished by Medicaid Direct PIHPs

Medicaid Direct PIHPs will submit TCM claims to NCTracks along with all corresponding encounters to the EPS for services they furnish. Medicaid Direct PIHPs should use the following PIHP TCM billing guidance as reference for submission.

Medicaid Direct PIHPs which furnish TCM services are required to submit a TCM claim for only the first TCM interaction with a member per month. Guidelines for submission of TCM claims to the Medicaid Direct PIHPs are below:

- PIHPs should identify a beneficiary's first TCM interaction of a given month based on date of service.

- Duplicative Services:
    - Beginning 7/1/2023, PIHPs should not bill for or perform TCM services if a member is concurrently receiving a duplicative service. Duplicative services include:
        - Members receiving Assertive Community Treatment (ACT);
        - Members residing in Intermediate Care Facilities for Individuals for Intellectual Disabilities (ICF-IIDs);
        - Members obtaining care management from the Department's PCCM vendor (including members participating in EBCI Tribal Option);
        - Members receiving case management through the CAP/C and CAP/DA programs;
        - Members participating in the High-Fidelity Wraparound program as described in Section IV.G.7. Other Care Management Programs;
        - Members obtaining Child Assertive Community Treatment (Child ACT);
        - Members obtaining Critical Time Intervention;
        - Members receiving services through SNFs for more than ninety (90) Calendar Days;
        - Members participating in Care Management for At-Risk Children; and
        - Members receiving any approved ILOs that are deemed duplicative through the Department's ILOS approval process.
    - The Department will communicate any additional services identified as duplicative to TCM as appropriate.
    - Please note that there is a one-month transition period for members that transition from a duplicative service to TCM in which a claim for TCM and a claim for a duplicative service can be paid.

- Procedure codes:
  - T1017 HT – applies to all Tailored Care Management service claims.
  - T1017 HTCG – applies Tailored Care Management service claims with the Innovations/TBI add-on.
    - Note: PIHPs should receive the Innovations Add-On when the individual is given an Innovations slot. TCM claims with the innovations add-on will not be paid until a member is deemed eligible and the IN indicator is added to the member's eligibility record. The service can be backdated if the service happened after the initial Level of Care.
  - T1017 U4 -- Tailored Care Management service claims with the 1915i add-on
    - Note: T1017 U4 code must be billed on the same claim as the T1017 HT on separate claim lines
  - No further procedure code and modifier combinations are permitted for TCM. AMH+ and CMAs should work with contracted PIHPs for accurate claims submissions.

- Billing & Rendering Provider:
  - PIHPs should submit their Medicaid Direct ID as the billing and rendering provider for TCM claims.

- Billing Taxonomy code:
  - PIHPs should submit the appropriate taxonomy for which they are enrolled with NC Medicaid.

- Place of Service Code:
  - PIHPs should submit the location where the service was rendered such as in a School, Home, Place of employment, etc. per CMS approved codes:
    - https://www.cms.gov/Medicare/Coding/place-of-service-codes/Place_of_Service_Code_Set
    - Please note that telehealth is not a valid billable service or Place of Service code if the service was performed in-person, but may be used for telephonic or video services.

- Diagnosis Code(s):
  - All claims submissions require diagnosis codes for processing. TCM claims need to have at least one Medicaid Recognized diagnosis code to process. Other than validation a diagnosis code is present, there shall be no edits specific to Diagnosis code for TCM claims.

- Claim Amount:

- PIHPs should submit a claim amount based on the TCM Blended rate for all TCM beneficiaries. The Department will communicate the TCM Blended rate to the PIHPs and the TCM Providers once available.

NCTracks Adjudication of Medicaid Direct PIHP TCM claims:

- Validate that Billing and Rendering Provider information aligns with the guidance shared above based on date of service.

- Validate accurate TCM beneficiary assignment.

- Validate that Medicaid Direct PIHPs are only submitting one claim per member per month for the first TCM claim of the month. The first TCM claim received for a date of service within the month would be paid and any claims received after that date of service in the same calendar month would be denied.

- Validate only the following TCM procedure code and modifier combinations are submitted on TCM claims:
  - T1017 HT – applies to all Tailored Care Management service claims.
  - T1017 HTCG – applies Tailored Care Management service claims with the Innovations/TBI add-on.
    - Note: PIHPs should receive the Innovations Add-On when the individual is given an Innovations slot. TCM claims with the innovations add-on will not be paid until a member is deemed eligible and the IN indicator is added to the member's eligibility record. The service can be backdated if the service happened after the initial Level of Care.
  - T1017 U4 -- Tailored Care Management service claims with the 1915i add-on
    - Note: T1017 U4 code must be billed on the same claim as the T1017 HT on separate claim lines
  - No further procedure code and modifier combinations are permitted for TCM. AMH+ and CMAs should work with contracted PIHPs for accurate claims submissions.

- NC Tracks will not place parameters or restrictions on diagnosis codes.
- Validate place of service codes per CMS guidelines for Place of Service code. All other claims submitted with non-CMS approved Place of Service codes will be denied.

- Validate accurate taxonomy assignment.

- NCTracks will process and pay Tailored Care Management claims at the TCM blended rate regardless of billed amount with no lesser of logic.

Tailored Care Management interactions and the BCM051 Report:

Medicaid Direct PIHP will populate the BCM051 report with all Tailored Care Management interactions that they provided as well as those interactions provided by Tailored Care Management providers who will submit those on the Patient Risk List (PRL) to their respective Medicaid Direct PIHPs. This report will be submitted on monthly cadence to NC Medicaid by Medicaid Direct PIHPs. Medicaid Direct PIHPs and Tailored Care Management providers should reference the Data Specification Guidance (Patient Risk List) for more detailed information regarding the use of the Patient Risk List (PRL) File.

Supporting Tailored Care Management Reference Documentation:

Medicaid Direct PIHPs and TCM Providers shall utilize the Tailored Care Management Billing Guide in conjunction with the Beneficiary Assignment file and the TCM Duplicative Services and identification criterion as sources of truth when submitting and/or adjudicating TCM claims.

Resources/Links:

- Data Specifications and Requirements for sharing Patient Risk List File
- https://www.cms.gov/Medicare/Coding/place-of-service-codes/Place_of_Service_Code_Set

Contact:

- Medicaid.ProviderOmbudsman@dhhs.nc.gov