Medicaid Direct Tailored Care Management Provider 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 Tailored Care Management 7/1/2023 through 9/30/2023. The information contained in the guide is targeted for Department certified Tailored Care Management providers – Advanced Medical Home Plus (AMH+) and Care Management Agencies (CMA).

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 be assigning eligible TCM Beneficiaries to certified Tailored Care Management (TCM) entities i.e., AMH+, CMA, or a Medicaid Direct PIHP to receive TCM services.

- Continuing 7/1/2023, AMH+ and CMAs shall submit TCM claims to their contracted Medicaid Direct PIHP for the first TCM qualifying contact with a member per month. Medicaid Direct PIHPs will process and pay valid claims.

- Continuing 7/1/2023 TCM providers (AMH+ and CMAs) will be paid at a TCM blended rate. Care Management providers with members eligible for Innovations/TBI and/or 1915i will receive add-on payments.

    - Note: For instances where a TCM provider submits a claim with the incorrect rate amount, PIHPs have discretion to process and pay claims at the correct amount, or they may deny the claim and work with the provider to resubmit.

- 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.

- The PIHP pays the TCM payment for any month in which the member is assigned to the AMH+/CMA and the AMH+/CMA 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.
- The PIHP will not withhold payment or adjust the payment rate during a month in which an AMH+/CMA delivers at least one qualifying contact, even if the TCM provider has not delivered the minimum number of contacts during the month based on the member's acuity tier.

Tailored Care Management Claims Billing Guidance for TCM Services Furnished by AMH+/CMAs:

AMH+ and CMAs will submit TCM claims to their contracted PIHP. AMH+ and CMAs which furnish TCM services should use the following PIHP TCM billing guidance as reference for submission.

AMH+ and CMAs which furnish TCM services are required to submit a TCM claim to their respective contracted Medicaid Direct PIHP for only the first TCM interaction with a member per month. Guidelines for submission of TCM claims to the Medicaid Direct PIHPs are below:

- AMH+/CMAs should identify a beneficiary's first TCM interaction of a given month based on date of service.
- Duplicative Services:
    - Beginning 7/1/2023, AMH+s and CMAs should not bill for or perform TCM services if a member is concurrently receiving one of the below duplicative services:
        - 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 HA – applies to Tailored Care Management service claims with the Healthy Opportunities (HOP) Add-on
        - Note: The HOP Add-on is billed for TCM Services rendered to Healthy Opportunities Pilot-enrolled members by delegated Care Management Entities (AMH+/CMA only). HOP enrollment shall be completed (with a referral executed) or confirmed through the NCCARE 360 platform prior to billing this code. T1017 HA code must be billed on the same claim as the T1017 HT code on separate claim lines.
    - T1017 HTCG – applies Tailored Care Management service claims with the Innovations/TBI add-on.
        - <u>Note:</u> 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.
        - <u>Note:</u> 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:

  - AMH+ providers should submit the NPI of the provider that furnished the services as the billing and rendering provider for TCM claims.
  - CMAs providers should submit the NPI of the Administrative Site of the provider that furnished the services as the billing and rendering provider for TCM claims.

- Billing Taxonomy code:
  - AMH+/CMAs should submit the appropriate taxonomy for which they are enrolled with NC Medicaid.

- Place of Service Code:
  - AMH+/CMAs 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:
  - AMH+/CMAs should submit claim amount based on the TCM blended rate for all TCM beneficiaries. The Department will communicate the TCM blended rate once available.

Medicaid Direct PIHP Adjudication of AMH+ and CMA TCM claims:
After receiving the TCM claim(s), Medicaid Direct PIHPs will adjudicate the AMH+/CMAs Tailored Care Management claim(s). Their adjudication process must:

- 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 AMH+/CMAs 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 duplicative services are not paid for post 7/1/2023. PIHPs should reference the billing guidance and contract for list of duplicative services.

- Only the procedure code and modifier combinations below are allowed for TCM:

  - 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.

- Submit all claims to NCTracks and all corresponding encounters to the EPS.

- Medicaid Direct PIHPs should not place parameters or restrictions on diagnosis codes.

- Medicaid Direct PIHPs should follow the CMS guidelines for Place of Service code identification/processing and should ONLY deny claims with a telehealth Place of Service code if the service was in person. All claims submitted with non-CMS approved Place of Service codes should be denied.

- Medicaid Direct PIHPs should accept TCM claims with taxonomies assigned to the submitting provider.

Payment to AMH+/CMAs:

Tailored Care Management Claims that meet all the requirements and rules will be processed and paid by the Medicaid Direct PIHPs at a TCM blended rate plus any

applicable add-on regardless of the claim billed amount and no lesser of logic will be used.

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