Residential Rehabilitation Services (RRS) Level 3.1 Frequently Asked Questions

Covered Products

Q: What plans does Tufts Health Public Plans offer?

A: The plans offered are: Tufts Health Unify, Tufts Health Together – MassHealth MCO Plan and Accountable Care Partnership Plans (ACPPs) (Tufts Health Together with Atrius Health, Tufts Health Together with Boston Children's ACO, Tufts Health Together with BIDCO and Tufts Health Together with CHA).

Contracting

Q: I haven't heard from the Tufts Health Plan Contracting Department. What should I do?

A: Applications and supporting documents were emailed on October 22, 2018 to the contacts for each program that were provided to Tufts Health Plan by the Executive Office of Health and Human Services (EOHHS). Please check your spam and junk folders to make sure that they weren't erroneously flagged. If you have not received the application and supporting documents, please contact Tufts Health Public Plans Contracting at THPP_BH_Contracting@tufts-health.com.

Q: How frequently will we need to re-contract?

A: Tufts Health Plan contracts are auto-renew unless terms need to be changed.

Q: How can I obtain an NPI number?

A: You can apply for an NPI number online at nppes.cms.hhs.gov.

Notifications and Authorizations

Q: Do we need to notify Tufts Health Plan of all Tufts Health Plan Members on January 1, 2019?

A: Yes, you will need to notify Tufts Health Plan of all Members within the two week grace period in the first two weeks of January 2019. Moving forward, you may notify Tufts Health Plan up to one week prior to admission so long as you use the admission date as the service start date on the Notification form.

Q: Will the number of days that an individual spends at an Acute Treatment Services (ATS), Clinical Stabilization Services (CSS) or Transitional Support Services (TSS) program before being admitted to our program be deducted from the 90 days?

A: No, each Tufts Health Plan Member will receive 90 days upon submission of an initial notification of his/her prior treatment.

Q: Will services be authorized for individuals who have been in the RRS program prior to January 1, 2019?

A: Tufts Health Plan will begin paying for clinical services effective January 1, 2019. There will be no payment of services prior to January 1, 2019.

Q: Many individuals remain in residential programs for well over 90 days, so why are only 90 days being approved for the initial notification?

A: The decision to use 90 days for the initial period was based on data.

Q: Many programs are designed to be a certain length of time often longer than 90 days. After the initial 90 days, how can we request more time?

A: Tufts Health Plan is asking providers to focus on each Member's individual treatment needs and recovery goals utilizing American Society of Addiction Medicine (ASAM) dimensions. Prior to the end date of the initial 90-days, if you have determined that the Member needs additional time in order to accomplish the goals as outlined in their treatment/recovery plan, you should request additional days using the Concurrent Review Form. You may request as many additional days as you think necessary to accomplish the treatment/recovery plan goals. The Concurrent Review Form asks about a Member's progress since admission, goals of intervention, detail on how the member meets ASAM criteria, a copy of the individual treatment plan and detail on the aftercare plan. Each request will be reviewed by a clinician. If the request is approved, you will receive an authorization letter. If additional information is needed to make a determination, the clinician will contact the individual whose name was provided on the request form. This should be the person at your program who knows the most about the Member, their treatment goals, the barriers that have been identified, and the steps that have been taken to address those barriers so far.

Practice Tip: Be prepared to discuss the ASAM dimensions and how they apply to the Member. Asking for additional days because you have a six-month program will not be sufficient as each decision will be based on the individual member's needs.

Q: Is there a limit on the number of days an individual can remain in a program?

A: There is no limit so long as the Member continues to meet the ASAM dimensional criteria for Level 3.1. A program may request as many days as they think will be clinically appropriate to accomplish the goals in the treatment/recovery plan.

Q: How often can additional days be requested?

A: As often as needed for that Member to achieve the goals on their treatment/recovery plan. When you request additional days, Tufts Health Plan is asking that you request the number that you think are realistically needed for this particular Member to attain their particular goals. Please note that after the first concurrent review, a telephonic review will be required when requesting additional days.

Q: If an individual leaves our program during the initial 90 days and returns back three weeks later, do we need to notify Tufts Health Plan again?

A: If you still have a valid authorization for the Member (there are still days available and the end date has not passed) and the Member meets medical necessity criteria for admission, you do not need to notify us again. You can simply resume billing for that Member until the 90 days are exhausted (excluding the time the Member was not in the program).

Q: If an individual leaves our program during the initial 90 days and is admitted to a different RRS Program that we run three weeks later, do we need to notify Tufts Health Plan again?

A: Because notification is based on a site and the Member is being admitted to a different site or location, even though it is within your organization, you would need to send a notification for a new admission.

Q: What if there are still days available but the end date of the authorization has passed?

A: There may be times when days will not be utilized during the authorization period. The end date of the notification is what triggers the need to request more days, even if there are days remaining. Providers have one week before and one week after the end date to submit a request for additional days.

Q: If Tufts Health Plan denies continued stay, can the decision be appealed? Will payment

continue during the appeal process?

A: Yes, the Tufts Health Plan appeal process is available for this service and can be accessed in the event of an adverse decision with which you disagree. If you are successful in your appeal, the services provided during the appeal period will be covered.

Q: If Tufts Health Plan determines that a Member no longer meets Medical Necessity Criteria and the program disagrees, will BSAS pay for the clinical services?

A: If it is determined that the Member no longer meets the criteria for Level 3.1 as outlined in the ASAM dimensions and Tufts Health Plan denies continued stay, BSAS will not pay for the clinical services.

Q: In that case, would BSAS continue to pay for room and board?

A: Tufts Health Plan's understanding is that BSAS will not continue to pay for room and board in that situation. Please contact your BSAS contract manager directly if you have questions or need additional information.

Q: Will the initial 90 days be authorized regardless of how many times the individual has been in the RRS level of care?

A: Yes, every new notification will result in an authorization for 90 days?

Q: Is there a limit on the number of residential programs a Member can be admitted to during a given time period?

A: No, as long as the member meets medical necessity criteria for level 3.1. We may track open notifications and contact providers if there are multiple open notifications in multiple programs for the same Member and audit claims to ensure that there are not multiple claims for service for the same Member on the same day submitted by different programs. We want to make sure that Member's care is coordinated and meeting the Member's needs. Multiple notifications for one Member that overlap may be a sign that the Member needs more or different services. Tufts Health Plan would like to assist.

Q: If we admit an individual and later learn that the referring 24-hour level of care provider did not notify Tufts Health Plan of the discharge, will we be able to provide notification and receive payment?

A: Yes, you will be able to send a notification form for that Member and submit claims to Tufts Health Plan for clinical services.

Q: I submitted a notification or request for authorization for additional day and my request is pended. How did I check the status of a pended authorization?

A: Pended requests may be seen on the Tufts Health Public Plans secure Provider portal. Instructions for signing up and using the secure Provider portal can be found at: https://tuftshealthplan.com/documents/providers/guides/secure-provider-portal-user-guide

Billing and Claims

Q: How will providers know if someone is eligible? Do providers need to check availability every day?

A: Eligibility is verified using the Eligibility Verification System (EVS), accessed through the Virtual Gateway. You can search eligibility using MassHealth number, name, and DOB or SSN. You should be verifying eligibility for every date of service.

Q: If an individual loses their insurance or there is a gap in insurance, can we bill the clinical services to BSAS?

A: BSAS should be billed for room and board.

Q: If a Member has Tufts Health Plan as a secondary insurance, will we need to obtain a denial from the primary payer (referred to as an EOB or Evidence of

Benefits) in order to bill Tufts Health Plan?

A: Yes, If the member has other insurance which is primary to Tufts Health Plan, then the other insurance would need to be billed first, since Tufts Health plan needs to see the final outcome of the primary insurers processing of the claim. A member receives an EOB. A provider receives an EOP. Tufts Health Plan would require the applicable documentation, depending on who submits a claim to us for the secondary benefits.

Q: If a Member is eligible for Tufts Health Plan, but that eligibility is not accurately reflected in EVS, can I retroactively bill Tufts Health Plan for those days?

A: Providers are required to bill the insurer of record (based on EVS) within that insurer's timely filing parameters. If a member's enrollment changes from another insurer to THP, and the provider previously billed the other insurer, that provider's timely filing window begins when the other insurer notifies the provider that the member is no longer enrolled in their plan for that service date. This usually comes in the form of an EOP from the insurer to the provider. If the provider did not submit the original claim to the other insurer in their timely filing window, THP would not allow the claim as having not filed timely. The premise of the guidelines is based on a provider's good faith effort to submit a claim to the appropriate insurer in the appropriate timeframe.

Q: How long will it take to get paid once a claim has been successfully submitted?

A: Per your provider agreement, Tufts Health Plan will process all clean claims (i.e., a claims submitted without any errors) within 30 days of submission.

Q: Can we batch RRS claims with claims from our ATS Program?

A: No, RRS claims cannot be submitted in the same electronic batch submission as ATS claims. ATS services are billed with a revenue code and are submitted on the 873-I X12 file. RRS services use the Healthcare Common Procedure Code system) HCPCS code H0019 with various modifiers. HCPCS codes must be electronically submitted through a 873-P X12 file. For questions relating to the Tufts Health Plan's EDI process, please contact the EDI Operations Department at 888.880.8699 ext. 54042 or email your questions to EDI_Operations@Tufts- Health.com

Q: How often should I submit a claim?

A: Claims for RRS services must be submitted within 90 days of the date of service to be considered for reimbursement; all claims submitted after 90 days will be denied. Tufts Health Plan encourages direct electronic claim submission. To submit any questions regarding electronic claim submission to EDI Operations by email at edi_operations@tufts-health.com or by calling 888.880.8699, ext. 54042. Paper claims should be mailed to the following address:

Tufts Health Plan
P.O. Box 8115
Park Ridge, IL 60068-8115

For additional information about the submission of new/original claims, refer to the Claims Submission Policy available in the Resource Center of the public Provider website.

Q: What do I do if a claim denies?

A: Providers have the right to file a payment dispute if they disagree with a decision regarding the denial or compensation of a claim. When submitting a payment dispute by mail, the Request for Claim Review Form, along with any supporting documentation, is required. The form can be found in the Forms section of the Resource Center at tuftshealthplan.com/provider. For complete information, refer to the Provider Payment Dispute Policy found in the Payment Policy section of the Resource Center on the public Provider website.

Q: Will the bed retention policy still be in place for residents who step up to higher levels of 24- hour care? Currently, programs can bill BSAS for clinical and room and board for three days with the ability to request a waiver for additional time. What about when a

pregnant woman is hospitalized for delivery? What about when they have been discharged from the hospital, but are rooming in with the baby, so not technically sleeping in the program?

A: CMS rules do not allow Tufts Health Plan to pay for RRS billable clinical services codes when the member is in another 24 hour setting Please contact BSAS directly for questions relating to their bed retention policies.

Q: My program is eligible to bill for the Pregnant and Post-Partum Enhancements from BSAS. How will that be handled for Tufts Health Plan Members?

A: Programs should bill Tufts Health Plan for clinical services for any Member who is pregnant using billing code H0019 and modifier TH. Please contact BSAS for information on their enhanced payment policy.

Q: Can case consults, collateral contacts, or family consults provided by program staff be billed to Tufts Health Plan as a separate service?

A: These services are included in the daily unit rate and cannot be billed separately when provided by program staff.

Q: As part of an individual's treatment/recovery plan and reintegration into the community, they may be allowed to go on overnight passes. How will this be handled?

A: If the absence from the program is the result of a planned element of the treatment/recovery plan, the program should bill Tufts Health Plan for clinical services for that date.

Q: Will there be different billing codes for the various services that are provided in the program, example: a code for group, a code for individual counseling, etc.?

A: Tufts Health Plan is paying for this service using a daily rate which encompasses all of the services the Member receives on a given day. There are no separate codes related to each clinical activity.

Q: Should my program submit a claim for clinical services for the date that an eligible Member is discharged?

A: When you submit claims, do not submit a claim for the date of discharge. You should submit a claim for the date of admission.

Q: What should be entered in the Place of Service field on the claim form?

A: For RRS, use 55 as the Place of Service code.

General Questions

Q: Why do we need to bill both BSAS and Tufts Health Plan for these services?

A: The 1115 Waiver that was approved by the Center for Medicare and Medicaid Services (CMS) allows MassHealth to pay for the clinical services provided in residential rehabilitation programs for all MassHealth Members. CMS rules do not allow for payment of charges related to room and board. In order to be in compliance with CMS rules, BSAS will be paying all charges related to room and board. Tufts Health Plan will be paying for clinical services for their MassHealth Members as of January 1, 2019.

Q: What is an ACO?

A: The following can provide information regarding Accountable Care Organizations (ACOs):
https://www.mass.gov/files/documents/2017/11/10/PCDI-FS-BH%20%2811-17%29_0.pdf.
https://www.mass.gov/lists/provider-pcdi-resources

Q: Will I need to maintain a medical/health record for each individual served?

A: Yes, be sure to document amount and duration of all clinical activities. It must be a minimum of five hours of individual and/or group sessions per week. All entries should be dated and signed with the full signature and credentials of the provider. Records should be securely stored in one location. Please see BH Chapter of our provider Manual and Performance Specifications.

Q: I have a question that is not addressed in this document. What should I do?

A: Please call Provider Services at the following phone numbers:

- Tufts Health Public Plans Provider Services (MA): **888.257.1985**
- Tufts Health Plan SCO Provider Relations: **800.279.9022**

Q: What other services are Tufts Health Plan Members eligible to receive while in RRS?

A: In addition to covered medical services**,** Tufts Health Plan Members are eligible to receive the full complement of covered outpatient behavioral health services while they are in the RRS program, including but not limited to co-occurring disorders. Based on Member needs, services may include, but are not limited to SOAP, MAT, outpatient counseling, outpatient psychiatry, and community support program services. These services are not intended to replace contractually required program-provided clinical services. ASAM Level 3.1 programs are required to offer at least five hours per week of low-intensity treatment for substance-related disorders. Treatment is characterized by services such as individual, group, and family therapy; medication management; and psychoeducation. In addition, the Tufts Health Plan Provider Search function is available on the Tufts Health Plan website.